STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676163	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Post Acute Care	4510 27th St Lubbock, TX 79410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm 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. Based on interview and record review the facility failed to provide 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 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment for 7 of 23 confidential residents reviewed . The facility failed to provide sufficient staffing to prevent long wait times to answer call lights. This failure could place residents at risk of injury, pain, hospitalization, skin breakdown, poor self-worth, and a diminished quality of life.Findings include: During a confidential interview at an undisclosed date and time with a confidential resident in their room, they stated it often took 30 to 45 minutes for staff to answer their call light. They stated they were in the process of recovering from an injury and needed assistance from staff getting out of bed and into their wheelchair to do other things such as getting dressed or to use the restroom. They stated it was frustrating and they felt the wait was far too long. They stated it happened during all shifts. They stated they had complained to staff about the wait time. During a confidential interview at an undisclosed date and time with a confidential resident in their room, they stated it often took around 30 minutes for staff to answer their call light. They stated they felt it was too long, especially if they had an emergency. They stated it happened during all shifts. During a confidential interview at an undisclosed date and time with a confidential resident in their room, they stated it often took around 45 minutes for staff to answer their call light. They stated they felt it was too long, especially if they had an emergency. They stated sometimes they would get up and walk to the nurses' station to find a nurse and get the assistance they needed because they waited over 30 minutes. They stated it happened during all shifts. They stated they felt something needed to be done about it. During a confidential interview at an undisclosed date and time with a confidential resident in their room, they stated they often waited 45 minutes to 1 hour for staff to answer their call light. They stated the CNAs pass by their room and said they had to wait until a staff member could get to them. They stated they felt it was too long to wait as they needed help getting out of bed and dressing. They stated they had complained to staff about it but felt nothing had changed. They stated there had not been a regularly scheduled aide in their hall for 3 or 4 months. During a confidential interview at an undisclosed date and time with the resident council , four confidential residents stated they often waited 30 to 45 minutes for staff to respond to call lights. A confidential resident stated they were afraid their roommate would get out of bed and fall due to the excessive call light response time. A second confidential resident stated staff told them to be patient when they complained about call light response times. A third confidential resident stated a staff member who was covering the other side of their hall responded to her call light and said they would tell the nurse that covered their side of the hall that they needed assistance rather than that staff member just helping them. The third confidential resident also stated they had to walk to the nurses' station for help because their call light had been on for 45 minutes without response, and they felt sick and wanted to go to the hospital. Confidential Residents stated there had been ongoing complaints about call light response. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Confidential Residents stated the call light issues caused them to feel like poop, irritated, aggravated, and unhappy. The Confidential Residents stated they felt the facility was often short-staffed. Record review of Resident Council Meeting notes, dated 11/13/25, revealed in part: Open Floor for Resident's Concerns: Nursing Concerns: call lights. Record review of Resident Council Meeting notes, dated 12/30/25, revealed in part: Open Floor for Resident's Concerns: Nursing Concerns: answering lights in a timely manner. Record review of Resident Council Meeting notes, dated 1/7/26, revealed in part: Open Floor for Resident's Concerns: Nursing Concerns: call lights timely. Record review of Resident Council Meeting notes, dated 2/13/26, revealed in part: Close remarks: night CNA answering call lights. Record review of Resident Council Meeting notes, dated 4/13/26, revealed in part: Nursing Department information: not answering the call light; they are turning off call lights and leaving and not addressing issues. During an interview on 05/19/26 at 11:44 AM LVN D stated she was the charge nurse for Hall 200. She stated she needed more staff as she had no nursing assistants to help her with nursing duties. LVN D stated the other 2 halls had two aides assigned. LVN D stated it was not possible for her to document residents' vital results in the EMAR as she took them because she was busy answering call lights, changing briefs, linens, answering the phone, and had no help. She stated in the mornings she had to check food trays before they were passed to residents. LVN D stated this all prevented her from being able to answer call lights timely. LVN D stated residents had complained to her about waiting a long time for their call light to be answered. LVN D stated she tried to answer call lights timely for residents that could not wait. She stated staff from other halls finished all duties on their halls before they came to help her. LVN D stated she was not aware of a system the facility had to ensure call lights were answered timely. She stated she was trained to answer call lights as soon as they went off. LVN D stated she was responsible for ensuring call lights were answered timely. LVN D stated a potential negative outcome was that a resident's blood pressure could bottom out while waiting for their call light to be answered. During an interview on 5/20/26 at 2:30 PM, CNA E stated she was the only CNA on Hall 200, and it was hard for her to answer call lights timely. CNA E stated there was a staff that floated to all three halls to help but they were not always available to help. She stated sometimes, it took her a while to take care of the residents before she could get to another call light that was going off. She stated it could take her up to 20 minutes to respond to a call light when she was showering another resident. CNA E stated she felt 20 minutes was too long for residents to wait. CNA E stated residents had complained to her that it took too long for staff to answer their call lights and she told management, but she was told this was the easiest hall and that this hall did not need more than one CNA assigned to it. She stated she did everything for residents in her hall and sometimes she forgot to get back to the residents. She stated she was trained that call lights were supposed to be answered as soon as they went on, and she was told to leave the call lights on until she got to them so they would not be forgotten. CNA E stated she was trained that everyone was responsible to answer call lights timely, but that was not always the case. She stated a potential negative outcome was that a resident could fall or not be breathing, residents may not be able to get help to go to the restroom or not be changed timely and they could get a yeast infection, urinary tract infection (a bacterial infection in the kidneys, bladder, ureters, and urethra), or something else that was harmful to them. During an interview on 5/21/26 at 11:30 AM, the DON stated there was no policy for staffing or call light response. The DON stated she was aware there were ongoing complaints about call light response times in the monthly Resident Council meetings and she had addressed it and in-serviced staff on call lights. She stated she was aware that most complaints were regarding the night shift. The DON stated call lights should have been answered as quickly as possible, but it could vary based on residents' needs. The DON stated staff were trained to fix problems at the time they walk in the room, if possible. The DON stated 30 minutes to wait for a call light to be answered was not timely. The DON stated 10 minutes to wait for a call light to be answered was about the time limit of where she would be concerned. The DON stated everyone in the building could answer call lights of which included but not limited to all nursing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff, dietary, and housekeeping were all responsible for answering call lights. She stated non-nursing staff could at least ask residents what they needed and find someone if they could not resolve the issue themselves. The DON stated she expected all staff to respond to call lights. The DON stated sometimes they scheduled and assigned aides to cover one and a half halls, or they had one aide in each hall and an aide that floated to help all the halls. The DON stated a potential negative outcome was skin breakdown for residents that needed to be changed and falls because residents could try to do it themselves and then fall. During an interview on 5/21/26 at 1:10 PM, the ADM stated there was no written policy on call light response. The ADM stated she was aware that in general there had been complaints of call light responses, but it was a while back. The ADM stated there had not been complaints recently that she was aware of. The ADM stated she was not aware concerns of call lights were discussed in resident council meetings monthly. The ADM stated she wanted staff to respond to call lights as soon as possible. The ADM stated she was not aware residents were waiting 30 minutes to 1 hour for call lights to be answered. The ADM stated she felt 30 minutes was too long to wait for a call light response. The ADM stated nursing leadership completed spot checks in the facility to ensure call lights were answered timely. The ADM stated that expectation was that anyone could answer the call lights, and that all staff should be helping answer call lights. The ADM stated nursing leadership had all staff meetings where they discussed answering call lights. The ADM stated she expected anyone who saw a call light activated to answer it. The ADM stated a potential negative outcome was it could affect the safety of the residents if they needed something urgently and could not get help timely.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 15.38% based on 4 out of 26 opportunities, which involved 4 of 5 Residents (Residents #12, # 20, #24 and #31) reviewed for medication administration. 1. LVN A failed to give Resident #20's dose of the medication Escitalopram at the ordered time, due to not having the medication available, resulting in a late dose. 2. LVN A failed to give Resident #31's doses of the medications Oxybutynin and Hydrochlorothiazide at the ordered time, due to not having the medication available, resulting in a late dose of each medication. 3. LVN A failed to give Resident #12's dose of the medication Citalopram at the ordered time, due to not having the medication available, resulting in a late dose. 4. LVN A failed to verify the dosage of the medication Clozapine prior to administering the medication to Resident #24, resulting in Resident #24 being underdosed. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and a decline in health.1. Record review of Resident #20's face sheet dated 05/21/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: frontotemporal neurocognitive disorder (a progressive, irreversible brain disease), major depressive disorder (a mood disorder causing feelings of sadness and loss of interest in activities), and hypertension (high blood pressure). Record review of Resident #20's physician orders dated 05/21/26 reflected an order for Escitalopram Oxalate Oral Tablet 20 mg. Give 1 tablet my mouth one time a day related to Major Depressive Disorder with a start date of 04/29/26. Record review of Resident #20's MAR, dated 5/1/2026-5/31/2026, reflected the medication Escitalopram Oxalate Oral Tablet 20 mg was to be administered at 0600 (6:00 AM). During a medication administration observation and interview on 05/21/26 at 8:34 AM, for Resident #20, LVN A was unable to give the medication Escitalopram Oxalate Oral Tablet 20 mg due to the medication being unavailable on the medication cart or in the emergency kit in the medication storage room. LVN A stated the medication should be available for dispensing and had been ordered but must not have been delivered yet by the pharmacy. LVN A wrote the medication down and stated she would check with the pharmacy once she completed her medication pass. 2. Record review of Resident #31's face sheet dated 05/21/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: multiple sclerosis (a chronic autoimmune disease of the central nervous system), dementia (a progressive decline in mental abilities), and hypertension (high blood pressure). Record review of Resident #31's physician orders dated 05/21/26 reflected an order for Hydrochlorothiazide oral tablet 25 mg. Give 1 tablet by mouth one time a day for fluid related to hypertension with a start date of 04/20/26. Further review reflected an order for Oxybutynin Chloride oral tablet 5 mg. Give 1 tablet one time a day for bladder spasm with a start date of 04/20/26. Record review of Resident #31's MAR, dated 5/1/2026-5/31/2026, reflected the medications Hydrochlorothiazide oral tablet 25 mg and Oxybutynin Chloride oral tablet 5 mg were to be administered at 0600 (6:00 AM). During a medication administration observation and interview on 05/21/26 at 9:10 AM, LVN A was unable to give Resident #31 the medications Hydrochlorothiazide oral tablet 25 mg and Oxybutynin Chloride oral tablet 5 mg due to the medications being unavailable on the medication cart or in the emergency kit in the medication storage room. LVN A stated the medications should be available for dispensing and added the medications to her list to check on following medication pass. 3. Record review of Resident #12's face sheet dated 05/21/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Disease (a progressive, irreversible brain disorder), dementia (a progressive decline in mental abilities), and Type II Diabetes Mellitus (a chronic metabolic disease characterized by high blood sugar). Record review of Resident #12's physician orders dated 05/21/26 reflected an order for Citalopram Hydrobromide oral tablet 10 mg. Give 2 tablets by mouth one time a day for depression (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a start date of 04/16/26. Record review of Resident #12's MAR, dated 5/1/2026-5/31/2026, reflected the medication Citalopram Hydrobromide Oral Tablet 10 mg. Give 2 tablets to equal 20 mg was to be administered at 0600 (6:00 AM). During a medication administration observation and interview on 05/21/26 at 9:19 AM, LVN A was unable to give Resident #12 the medication Citalopram Hydrobromide 10 mg (2 tablets to equal 20 mg) due to the medication being unavailable on the medication cart or in the emergency kit in the medication storage room. LVN A stated the medication should be available for dispensing and added the medication to her list to check on following medication pass. 4. Record review of Resident #24's face sheet dated 05/21/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: paranoid schizophrenia (a complex mental health condition), Type II Diabetes Mellitus (a chronic metabolic disease characterized by high blood sugar), major depressive disorder (a mood disorder causing feelings of sadness and loss of interest in activities). Record review of Resident #24's physician orders dated 05/21/26 reflected an order for Clozapine oral tablet 100 mg. Give 1 tablet by mouth two times a day related to paranoid schizophrenia. Give 100 mg with a start date of 03/17/26. During a medication administration observation on 05/21/26 at 9:29 AM, LVN A was observed dispensing one half tablet of 100 mg of Clozapine to Resident #24. The total dosage administered at this time was 50 mg of Clozapine. During an interview on 05/21/26 at 11:34 AM, LVN A stated it was the responsibility of the MAs to order and replenish the medications on the medication carts. She stated the MAs did routine inventory of the medication carts and faxed orders to the dispensing pharmacy. She stated the LVNs would receive a list from the MAs of medications that had been ordered but had not been delivered and the LVNs would then follow up on those medications with the pharmacy. LVN A stated the facility had recently hired new MAs who were not as familiar with the ordering process or which medications needed to be ordered as a priority before running out. LVN A stated she had been trying to assist the new MAs with the ordering process but some of the medications were not ordered in time to replenish the cart before running out of the medication. LVN A stated the facility utilized a liberalized medication pass meaning there was a window for medications to be given without being considered late. She stated the window for the morning medication pass was until 10:00 AM and there was a one-hour grace period meaning the medications could be given as late as 11:00 AM, unless the order stated a specific time for administration. LVN A stated she had ordered the medications that were not available for Residents #20, #31 and #12 after she completed her morning medication pass, but the medication would not be delivered in time to be given during the administration window. She stated any medication that was not administered during the administration window was considered late. LVN A stated late medications required calling the provider to notify of a late medication and verify the provider wanted staff to administer the medication late. She stated a late medication administration also had to be documented in the nursing progress note and passed on in report to the oncoming shift. LVN A stated a potential negative outcome for missed or late doses of medication due to the medication not being available in the facility would be residents could have increased behaviors, increased or uncontrolled pain, or uncontrolled blood pressure. LVN A stated she gave the wrong dose of Clozapine to Resident #24 after verifying with the surveyor that the blister pack of medication contained pills that were cut in half. She stated she read the order wrong and should have dispensed 2 (half tablets) of Clozapine to Resident #24 in order to give the full dose of Clozapine 100 mg as ordered. LVN A stated she had only given 50 mg of Clozapine by administering 1 (half tablet) of medication. She stated she had been trained to verify the order, then check the medication dosage prior to giving the medication in order to ensure accuracy. LVN A stated a potential negative outcome for failure to administer medications as ordered was the resident would be underdosed and could have side effects from not receiving the right amount of medication. During an interview on 05/21/26 at 12:02 PM, the ADM stated she was not aware medications had not been ordered timely, resulting in residents' having medications administered late. She stated she did not know why medications had not been ordered timely, but it was an opportunity to find out why. The ADM stated all nurses were (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trained on accurate medication administration through in-servicing and competency checks with nursing administration and the pharmacy consultant. She stated the DON was responsible for assuring medications were available and were administered accurately. She stated her expectation of staff was to have medications available in the facility and to follow orders accurately for medication administration. During an interview on 05/21/26 at 12:58 PM, the DON stated all nurses and MAs were trained on accurate medication administration. She stated she was responsible for ensuring medications were available and administered accurately. The DON stated staff were trained on accurate medication administration and monitored through skills checks conducted annually by a DON from another facility, and by competency checks conducted by the regional nurse or pharmacy consultant. She stated she was not aware medications were not being ordered timely, but she felt it was due to having new MA's in the facility and the communication system was not worked out yet. The DON stated her expectation of staff was to have medications available and to administer medications accurately by following physician's orders. She stated a potential negative outcome for inaccurate medication administration was it could kill somebody or injure a resident by giving the wrong dosage or omitting a medication. Record review of the facility-provided policy titled Medication Administration General Guidelines, dated 2007 reflected: PolicyMedications are administered as prescribed in accordance with the manufacturers' specifications. ProceduresMedication Preparation: .3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. 9. Verify medication is correct three (3) times before administering the medication. a. When pulling the medication package from the med cart b. When dose is prepared c. When dose is administered .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and stored in locked compartments for 3 of 3 medication carts (Hall 200 Nurse Medication Cart, Hall 200 Medication Aide Cart, and Hall 300 Medication Aide Cart) reviewed for medication storage. The facility failed to ensure the Hall 200 Nurse Medication Cart was secured when unattended. The facility failed to ensure the Hall 200 Medication Aide Cart did not contain loose pills. 3. The facility failed to ensure the Hall 300 Medication Aide Cart was secured when unattended and did not contain loose pills. These failures could place residents at risk of not receiving prescribed medications as ordered, having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversion.1. During an observation and interview on 05/19/26 at 11:44 AM the Hall 200 Nurse Medication Cart was observed in hallway 200 with the lock popped out without a staff member present. Two maintenance staff were observed approximately 5 feet away from the medication cart working on a door in the hallway. LVN D came out of a resident room and approached the medication cart as the surveyor stood next to it. LVN D stated she was the charge nurse and was assigned to the Hall 200 Nurse Medication Cart. The surveyor pulled on all the drawers and all the drawers opened. The drawer that contained the narcotic medications opened however the lock box was secure. Various pill blister packs and bottles of medications and medical supplies such as syringes were observed in the drawers of the medication cart that opened. LVN D stated she was in the process of passing out medications to residents and she had been dealing with a resident that was confused and wanted pain medications, and she tried to help the resident figure it out. LVN D stated the policy for medication carts was that they were supposed to be locked when left unattended. She stated she was unaware she had not locked the medication cart and should have locked the cart. She stated she was responsible for all medications on that cart, and she was responsible for ensuring the cart was locked when unattended. LVN D stated there was no system she was aware of to ensure medication carts were locked. She stated she had been in-serviced and trained in medication administration and to ensure the carts were locked. She stated a potential negative outcome was that someone could have taken the insulin, or someone could have taken pills in the cart and crushed them up and then used the syringes to shoot the meds into their body, or someone could have used the syringes as a weapon. 2. During an observation and interview on 05/20/26 at 9:35 AM, the Hall 200 Medication Aide Cart was observed with LVN A. Six loose pills were found in the drawers of the medication cart. LVN A placed the pills in a dispensing cup and gave them to the DON for identification. The DON identified the medication as Sertraline 100 mg (2 tablets), Atorvastatin 20 mg (2 tablets), Potassium Chloride 10 mEq (1 tablet), and Cyclobenzaprine 10 mg (1 tablet). The DON took the identified medications to be destroyed. LVN A stated the medication cart should not contain loose pills. She stated she was responsible for the cart while she was on duty and had possession of the keys to the cart. LVN A stated she tried to check the cart at least weekly for loose or expired medications. She stated she had been too busy to check the cart that morning because she was trying to help the new medication aide pass medications. She stated she had been trained on proper medication storage in her nursing education. LVN A stated the medication carts were audited by the pharmacy consultant and checked randomly by nursing administration for secure storage and cleanliness. She stated a potential negative outcome for loose medication on the cart was that a resident could miss a dose of medication. 3. During an observation and interview on 05/20/26 at 10:06 AM, the Hall 300 Medication Aide Cart was observed in hallway 300 with the lock popped out unattended and without a staff member present. A resident was observed propelling herself in a wheelchair near the unlocked medication cart. The surveyor was able to access all drawers on the medication cart. The controlled medications drawer was able to be (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accessed however the lock box was secure. Blister packs of medication, liquid medication and OTC medications were observed on the cart that was opened. MA B was observed coming out of a resident room and approaching the medication cart as the surveyor stood next to it. MA B stated she was responsible for the Hall 300 Nurse Medication Aide Cart. MA B stated she was a new MA and also newly hired at the facility. She stated she had been oriented to the medication cart during her training with a facility staff member and stated the medication cart should be locked at all times when she was not supervising the cart. MA B stated a potential negative outcome for leaving the cart unlocked and unattended was that a resident could access the cart and take medication that could cause them harm. During an observation and interview on 05/20/26 at 10:18 AM, the Hall 300 Medication Aide Cart was observed with MA B. Nine loose pills were found in the drawers of the medication cart. MA B placed the pills in a dispensing cup and gave them to the ADON for identification. The ADON identified the medication as Metoprolol 25mg (2 tablets), Atorvastatin 20 mg (1 tablet), Tizanidine 2 mg (2 tablets), Carvedilol 25 mg (1 tablet), Pantoprazole 40 mg (1 tablet), Gabapentin 100 mg (1tablet), and Levetiracetam 750 mg (1 tablet). The ADON took the identified medications to be destroyed. MA B stated she was responsible for the Hall 300 Medication Cart. She stated the medication cart should not contain loose medications. MA B stated she typically checked the cart for loose or expired medications in the morning when she came on duty but did not have a chance to check it before beginning medication pass. She stated she had been trained in her MA training to keep medications securely stored. She stated she had also been trained on proper medication cart storage during her facility orientation. MA B stated a potential negative outcome for loose medication on the cart was missed medication doses or medication shortages. During an interview on 05/21/26 at 11:30 AM, the DON stated the policy was that medication carts should be locked anytime staff stepped away from them. She stated she was aware yesterday that staff left medication carts unlocked while unattended. She stated one of the staff was new and was in the process of learning. The DON stated she did rounds and stood by medication carts to prompt staff and ensure they remembered to lock them. She stated she had also educated staff on how important it was to ensure they were locked. The DON stated all new staff were trained for a minimum of 3 days in medication administration. She stated the first day the new staff shadowed nursing staff to observe and learn the routine. On the second day, they helped take vitals and passed medications. She stated that on the third day, the new staff completed the medication administration process and was shadowed by a staff for training purposes. She stated they answered any additional questions and determined if the staff member was ready or if more training was needed. The DON stated staff were also in-serviced on medication administration periodically by herself or the ADON. The DON stated the staff that passed the medications was responsible for ensuring the medication cart was locked but it was also everyone's responsibility to ensure medication carts were locked. The DON stated she expected staff to lock medication carts when unattended. She stated a potential negative outcome was that medications could be removed by an unauthorized person or a resident could be harmed by obtaining medications from the unlocked medication cart. During an interview on 05/21/26 at 12:02 PM, the ADM stated she was not aware there were loose medications on the medication carts. She stated the staff member who was assigned to the medication cart was responsible for assuring medication was stored securely. The ADM stated the system for monitoring proper storage of medications was cart checks conducted by nursing administration and monthly audits conducted by the pharmacy consultant. She stated her expectation of staff for storage of medications was that medications were securely stored for each resident. The ADM stated a potential negative outcome for loose medications on the cart was that a resident could miss a dose or receive a medication that was not theirs. During a follow-up interview on 05/21/26 at 12:58 PM, the DON stated she was not aware there were loose medications on the medication carts. She stated medications should be stored securely at all times. The DON stated the staff member who was assigned to the medication cart was responsible for assuring medications were stored securely by checking the cart for loose medications. She stated staff were (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trained to check the medication carts regularly for loose or expired medications and cleanliness. She stated carts were monitored by random audits conducted by nursing administration and by the pharmacy consultant during monthly onsite visits. The DON stated a potential negative outcome for loose pills on the medication carts was drug diversions and residents missing doses of ordered medications. During a follow-up interview on 05/21/26 at 1:10 PM, the ADM stated all medication carts must be locked when unattended. The ADM stated she was not aware staff left medication carts unlocked when unattended. She stated the system in place to ensure unattended medication carts were locked was that nursing leadership did rounds and spot-checked medication carts to ensure they were locked. The ADM stated Nursing leadership (the DON and the ADON) in-serviced staff to ensure medication carts were locked when unattended. The ADM stated she expected staff to lock medication carts when unattended. The ADM stated a potential negative outcome was that anyone, including residents, could get in there and take something that may not have been safe for them. Record review of the facility-provided policy titled, Policy/Procedure - Nursing Clinical, revised 05/2007, reflected: Section: Care and Treatment Subject: Medication Access and Storage Policy: It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications: Procedures: 1. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers.2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that was palatable, attractive and at a safe, and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 2 (Breakfast) meal reviewed for food and nutrition services. The facility failed to provide food that was palatable for the breakfast meal on 05/20/26. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During confidential individual interviews 3 of 8 residents voiced concerns related to food palatability. One resident stated the food was cold and lacked flavor. One resident stated the food was lousy and not good. One resident stated the food was not good, lacked seasoning and the tortillas were served raw. During the resident council meeting on 05/20/26 at 10:00 AM, one resident stated that the oatmeal served in the morning was hard and under cooked. Observation on 05/20/26 at 7:42 AM the test trays arrived and were sampled by one surveyor at 7:43 AM with the following results: Regular TextureScrambled eggs - okaySausage - cold/lukewarmBacon - okayFrench Toast Sticks - okayOatmeal - dry/thick, some pieces were hard Mechanical Soft TextureSausage and gravy - lukewarm PureeEggs - okaySausage with gravy - cold/lukewarm, soup like consistencyCream of Wheat - cold/lukewarm During an interview on 05/20/26 at 7:58 AM, the ADM stated she thought the oatmeal was thick and stated the consistency for the puree sausage and gravy was not correct. During an interview on 05/21/26 at 11:00 AM, the DM stated she has not been the dietary manager for long at the facility and she tries to attend the resident council meetings to see what the residents were saying about the food. The DM stated she has tasted the food before it was served but she does not taste it regularly. The DM stated the residents have complained to her before about the oatmeal and the cream of wheat being too thick. The DM stated she thinks it was because the oatmeal sits for a little bit after being prepared and before serving. The DM stated she thought the oatmeal would thicken during that time. The DM stated she would love to add butter, salt, pepper and other seasonings to the food but she has had complaints before about her food being overly seasoned. The DM stated it was hard to please everyone at the facility. The DM stated a potential negative outcome to the residents was they may not eat or get fed if they did not like how it tasted. During an interview on 05/21/26 at 12:46 PM, the ADM stated she expected the food to taste acceptable and pleasing to the residents. The ADM stated she has not tasted the food with the DM being in place. The ADM stated the DM was trained on palatability of the food. The ADM stated a potential negative outcome to the residents was weight loss. Record review of the facility document titled Resident Council Notes, dated 04/13/26 revealed the following: Soups are cold and sometimes bland. Record review of the facility policy titled, General Food Preparation and Handling, undated, reflected the following: Policy: Food items will be prepared to conserved maximum nutritive value, develop and enhance flavor and keep free of harmful organisms and substances.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure foods were properly stored in the refrigerator, freezer and pantry.The facility failed to ensure the oven doors, refrigerator handles and microwave were properly cleaned. These failures could place residents at risk for food contamination and foodborne illness. The findings include: During the initial tour of the kitchen on 05/19/26 beginning at 9:40 AM the following items were observed:- 5 Dirty refrigerator handles. A dry hard/sticky substance was on inside of handles.- 1 block of a white hard food with no label and no date, wrapped in a plastic wrap in the refrigerator.- 1 small circular block of unknown white/grey food. No label and no date on plastic wrap in the refrigerator.- 1 box/bag of bacon with no date and not properly sealed in the refrigerator. The edges of the bacon appeared hard.- 1 bag of white shredded cheese not properly sealed in the refrigerator, dated 5/11/26 and use by 5/13/26.- 5 blocks of yellow cheese, dated 5/18/26 and no other label in the refrigerator.- 1 bag of French fries in the freezer not properly sealed and undated. - 2 Dirty oven handles. The handles had grease spots and were oily to the touch. - 1 box of spaghetti noodles not properly sealed and undated in the pantry.- 1 bag of cornflakes not properly sealed and undated in the pantry. - 1 gallon soy sauce on top shelf in the pantry with no lid, not properly sealed and no date on the bottle. - 1 Dirty microwave handle and inside top of the microwave. Dry food was noted on the handle and on the inside top of the microwave. During an interview on 05/19/26 at 9:58 AM, the DM stated she did not know why some of the foods were not stored properly in the kitchen. The DM stated she did not know why the refrigerator or oven handles were dirty and stated probably from cooking breakfast. The DM stated she did not know why the microwave handles or inside top was dirty. During a return visit to the kitchen on 05/20/26 at 10:40 AM, 1 box of quick cream of wheat, dated 05/12/26, was not properly sealed on a shelf in the kitchen by the refrigerators. During an interview on 05/21/26 at 11:00 AM, the DM stated all of the food stored in the kitchen should be labeled with an open and use by date and should be fully sealed. The DM stated the kitchen staff were trained on food storage and cleanliness, so she did not know why food items in the refrigerator, freezer and pantry were not labeled or sealed properly. The DM stated the evening shift handled more of the clean duties for the kitchen. The DM stated she did not know why the evening shift from 05/18/26 did not clean the kitchen properly. The DM stated the morning shift staff were responsible for sealing and labeling the food properly. The DM stated she did not know when the kitchen staff was last trained on storing and labeling the food and kitchen cleanliness. The DM stated a potential negative outcome to the residents was they could get sick. During an interview on 05/21/26 at 12:46 PM, the ADM stated she expected the food to be labeled and stored properly in the kitchen. The ADM stated the food should be properly sealed so no air could get in when it was stored. The ADM stated the kitchen staff were trained to follow a regular cleaning and deep cleaning schedule due to cleanliness and sanitation being a priority in the kitchen. The ADM stated she did not know why food was not stored properly or some of the kitchen equipment was not cleaned. The ADM stated a potential negative outcome for the residents was a potential for spoiled food if it was not stored properly and they could get sick. Record review of the facility policy titled, General Food Preparation and Handling, undated, reflected the following: Policy: Food items will be prepared to conserved maximum nutritive value, develop and enhance flavor and keep free of harmful organisms and substances.Procedure:1. The kitchen will be kept neat and orderly.a. The kitchen surfaces and equipment will be cleaned and sanitized as appropriate. 2. Food Storagea. Foods will be received, checked and stored properly.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to respect the resident's right to personal privacy and confidentiality of his or her medical records on 1 of 2 medication carts (Hall 200 Nurse Medication Cart) reviewed for privacy in that: 1. LVN D left the computer screen unlocked with a resident's medication information visible on the Hall 200 Nurse Medication Cart when she left the medication cart unattended. 2. LVN D left a list of residents' vitals exposed on top of the Hall 200 Nurse Medication Cart. These failures could place residents at risk of having medical information or care instructions exposed to others and misuse of personal/medical information.The findings included: During an observation and interview on 05/19/26 at 11:44 AM the Hall 200 Nurse Medication Cart was observed in Hallway 200 with an unlocked computer screen. The computer screen displayed a resident's EMAR. There was also a list of residents and their vital results on a sheet of paper in a clipboard lying faced-up on top of the medication cart. Two maintenance staff were observed approximately 5 feet away from the medication cart working on a door in the hallway. LVN D came out of a resident's room and approached the medication cart as the surveyor stood next to it. LVN D stated she was the charge nurse and was assigned to the Hall 200 Nurse Medication Cart. LVN D stated she was in the process of passing out medications and taking vitals and she had been dealing with a resident that was confused and wanted pain medications, and she tried to help the resident figure it out. LVN D stated the policy was that computer screens were supposed to be locked, and residents' personal information was supposed to be covered when left unattended. She stated she was supposed to lock the computer and flip over the list of vitals when she stepped away from them. She stated this was a HIPAA violation. She stated she was unaware she had left the computer screen unlocked and left residents' vital results exposed and was trained not to do so. She stated she was responsible for ensuring residents' privacy was respected. LVN D stated staff usually completed spot checks to ensure computer screens were locked and residents' personal information was kept private. She stated she had been in-serviced and trained in medication administration and to ensure the carts were locked and they maintained privacy. She stated a potential negative outcome was that someone could get a resident's private information and use it against them or it could cause residents' embarrassment. During an observation and interview on 05/19/26 at 1:20 PM it was revealed that the Hall 200 Nurse Medication Cart had a list of residents and their vital results on a sheet of paper in a clipboard lying faced-up on top of the medication cart with no staff present. During an interview on 5/21/26 at 11:30 AM, the DON stated the policy was that residents' health and care information was only shared with who was approved such as providers, the inter-disciplinary team, and relevant staff. The DON stated computer screens should have been locked, and all documents should have been locked up in the medication cart so that passersby did not see it anytime staff stepped away from them. She stated she was aware yesterday that staff left the computer screen unlocked and vitals exposed on top of the medication cart while unattended. The DON stated she did rounds and stood by medication carts to prompt staff and ensure they remembered to lock the screen and ensure privacy was maintained. She stated she had also educated staff on how important it was to ensure medication carts were locked up and privacy was maintained. The DON stated all new staff were trained for a minimum of 3 days in medication administration. She stated the first day the new staff shadowed nursing staff to observe and learn the routine and HIPAA requirements. On the second day, they helped take vitals and passed medications. She stated that on the third day, the new staff completed the medication administration process and was shadowed by a staff for training purposes. She stated they answered any additional questions and determined if the staff member was ready or if more training was needed. The DON stated staff were also in-serviced on medication administration periodically by herself or the ADON. The DON stated the staff that passed the medications were responsible for ensuring privacy was maintained but it was also everyone's responsibility to ensure privacy was maintained. The DON stated she expected staff to maintain privacy when carts were (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unattended. She stated a potential negative outcome was that someone not approved could get their information and their dignity and rights would be violated. During an interview on 5/21/26 at 1:10 PM, the ADM stated all screens should have been shut down and all paperwork should have been covered for privacy when staff walked away from the medication carts. The ADM stated she was not aware screens were unlocked and paperwork with residents' personal information was exposed on medication carts while unattended. The ADM stated nursing leadership did spot checks to ensure staff locked screens and had not exposed residents' records. The ADM stated the DON and the ADON in-serviced staff on privacy and medication cart privacy. The ADM stated herself and the leadership team were responsible for ensuring privacy was maintained. She stated she expected staff to lock screens and cover paperwork anytime they walked away from the carts, so others did not see it. The ADM stated a potential negative outcome was that there would be a breach of confidentiality and breach of HIPAA, and people could get residents' personal information. Record review of the facility policy, Resident Rights, amended July 13, 2017, revealed the following in part: As a resident of this nursing facility, you have the right to a dignified existence, self? determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. Privacy and Confidentiality. You have the right to personal privacy and confidentiality of your personal and medical records. You have the right to: -secure and confidential personal and medical records.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for 1 of 17 Residents (Resident #54) and 1 of 2 Shower rooms (Shower Room A) reviewed. The facility failed to store Resident #54's portable oxygen tank properly when not in use. The facility failed to ensure Lemon disinfectant spray bottle was not stored properly in Shower Room A. These failures could place residents at risk for poisoning or chemical burns and avoidable injuries related to improperly storing a portable oxygen tank. The findings included: Record review of Resident #54's face sheet, dated 05/21/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Wernicke's encephalopathy (brain damage) reduced mobility and chronic obstructive pulmonary disease (lung disease). Record review of Resident #54's quarterly MDS assessment, dated 03/26/26, revealed a BIMS score of 03, indicating Resident #54's cognition was severely impaired. Record review of Resident #54's order summary report, dated 05/21/26, revealed an order: Oxygen 2-4 LPM via nasal cannula to keep SpO2 greater than 90% as needed related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE with a start date of 08/07/25. During an initial tour observation on 05/19/26 at 10:35 AM in Resident #54's room revealed 1 portable oxygen tank free-standing and sitting up on a long dresser. Attempted interview on 05/19/26 at 10:37 AM with Resident #54 revealed he was not interview-able. During an observation on 05/20/26 at 7:39 AM in Resident #54's room revealed 1 portable oxygen tank free-standing and sitting up on a long dresser. Clothes were observed scattered on the long dresser around the portable oxygen tank. During an interview on 05/20/26 at 8:01 AM, LVN C stated she did not know why the portable oxygen tank was on the dresser in Resident #54's room. LVN C stated the portable oxygen tanks were supposed to be stored in the oxygen storage room with the racks. LVN C stated a potential negative outcome to the residents was that the portable oxygen tank could have gone through the wall if it fell over and it was full. During an observation on 05/20/26 at 1:10 PM of Shower Room A, 1 spray bottle labeled Lemon Disinfectant with a warning label Keep out of reach of children was stored hanging on the rail by the toilet. A small amount of liquid with bubbles was noted in the bottom of the spray bottle. During an interview on 05/20/26 at 1:13 PM, the DON stated she did not know why the Lemon Disinfectant spray was being stored in the shower room. The DON stated a potential negative outcome to the residents was that it could cause injury to the residents if it got on them or if ingested. During an interview on 05/21/26 at 12:26 PM, the DON stated if a portable oxygen tank was not in use, it should be stored in the oxygen room. The DON stated the staff were trained to never store the portable oxygen tanks free standing. The DON stated she did not know why the portable oxygen tank was being stored on the dresser in Resident #54's room. The DON stated a potential negative outcome to the residents was it could become like a missile if it fell over. During an interview on 05/21/26 at 12:46 PM, the ADM stated the portable oxygen tanks should always be stored in a cart, or a bag on the back of their wheelchair if they were in use. The ADM stated if a portable oxygen tank was not in use, it should be stored in the oxygen room with the holders. The ADM stated the staff were trained on proper storage of portable oxygen tanks and she did not know why this tank was stored improperly. The ADM stated a potential negative outcome to the residents was it could explode if it was knocked over. The ADM stated she expected the cleaning chemicals to be stored locked in carts or cleaning closets when not in use. The ADM stated she did not know why the cleaning spray was being stored in Shower Room A. The ADM stated a potential negative outcome to the residents was it could be harmful if they got ahold of it and possibly ingested or got the spray in their eyes. Record review of the facility's policy and procedure titled, Oxygen Storage, with a revised date of 07/18, reflected the following: Policy: It is the policy of this facility to ensure oxygen and all other gases are (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stored according to gas storage regulations. Procedure: All oxygen cylinders shall be stored in a locked, outside area.Cylinders will be physically supported, either in a stand, or rack, or chained to or strapped to the wall. Record review of the facility's policy and procedure titled, Safety Management. Subject: Hazardous Chemicals, undated, reflected the following: .Procedure:.8. Chemicals must be properly stored, labeled, maintained and handled according to manufacturer's guidelines.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure each resident received, and the facility provided food prepared in a form designed to meet individual needs for 2 of 2 meals (breakfast and lunch) observed for puree texture. The facility failed to provide pureed food in proper form for the breakfast and lunch meals observed on 05/20/26. This failure could place residents at risk of decreased food intake, choking and aspiration. The findings included: During an observation on 05/20/26 at 7:40 AM, the DM prepared puree eggs, cream of wheat and puree's sausage with gravy and provided a sample tray to the surveyor. The surveyor tasted the puree sausage with gravy, and it had small chunks of meat and was in a soup like form, meaning the sausage and gravy did not hold any shape. During an interview on 05/20/26 at 7:58 AM, the ADM stated she agreed that the sausage and gravy was not the correct consistency for the puree form. During an observation on 05/20/26 at 12:00 PM, the DM prepared puree chicken, mashed potatoes, bread and mixed vegetables and provided a sample tray to the surveyors. The surveyors tasted the puree mixed vegetables, and it had small chunks in it and was in a soup like form, meaning the mixed vegetables did not hold any shape. During an interview on 05/20/26 at 12:10 PM, the ADM stated she agreed that the mixed vegetables were not the correct consistency for the puree form. During an interview on 05/21/26 at 11:00 AM the DM stated she had been trained on puree form and to mix it good so there are no chunks of food. The DM stated the puree food should be a smooth consistency and be able to hold form. The DM stated she had a hard time getting the sausage and gravy and the mixed vegetables to hold form. The DM stated a potential negative outcome to the residents was they could choke on it. During an interview on 05/21/26 at 12:46 PM the ADM stated she expected the puree foods to be a safe and proper consistency every times it was sent out to the residents. The ADM stated the puree food should be smooth and be able to hold form. The ADM stated the DM had been trained on food consistency, but it was unknown when. The ADM stated she did not know why the puree foods were sent out when not in proper form. The ADM stated a potential negative outcome to the residents was a choking hazard. Record review of the facility's policy and procedure titled, Texture and consistency-Modified Diets, undated, reflected the following: Policy: Texture and consistency-modified diets will be individualized with modifications made by the speech-language pathologist and physician in conjunction with the registered dietician nutritionist or designee and director of food and nutrition services.Procedure: .5. The food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency as ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 19 residents (Residents #2, #4 and #26) reviewed for infection control. 1. CNA E failed to wear proper PPE (gown) when providing direct resident care for Resident #2 who was on EBP on 5/20/26. 2. CNA E failed to wear proper PPE (gown) when providing direct resident care between Residents #2 and #4 when Resident #2 was on EBP on 5/20/26. 3. CNA F failed to wear proper PPE (gown and gloves) when providing direct resident care for Resident #26 who was on EBP on 5/20/26. These failures could place residents at risk for the spread of infection and cross contamination.Findings included: 1. Record review of Resident #2's face sheet, dated 5/20/26, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: pressure ulcer of sacral region(base of spine), stage 4 (tissue loss where the skin, subcutaneous fat, and muscle are destroyed, leaving bone, tendon, or fascia exposed (connective tissue)), acute kidney failure (rapid decline in kidney function), urinary tract infections (bacterial infections in the kidneys, bladder, ureters, and urethra), ileostomy status (surgical procedure that creates a new way for digestive waste to leave the body by diverting it from the large intestine), pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere (three distinct but related species of bacteria), resistance to carbapenem (ability to resist treatment with carbapenem antibiotics), acquired absence of right foot, and acquired absence of left leg below knee. Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident's cognition was intact. Section - H - Bladder and Bowel revealed the resident had an ostomy (opening in the abdomen to allow waste or urine to exit the body). Section - M - Skin Conditions revealed the resident had a stage 4 pressure ulcer. Record review of Resident #2's undated care plan revealed: focus: The resident had a surgical wound to L BKA (left below the knee amputation), date initiated 2/17/25. Interventions: Use Enhanced Barrier Precautions, date initiated: 2/17/26. The resident had a Stage 4 pressure ulcer to the coccyx (final bone at the base of the spine), date initiated: 8/6/25, revision on: 12/31/25. Interventions: Use Enhanced Barrier Precautions, date initiated: 4/15/25. Record review of Resident #2's current Physician's Orders, dated 5/20/26, revealed an order with a start date of 5/5/25 for LLL (lower left leg) (surgical wound) - cleanse with NS (normal saline), pat dry with 4x4 gauze, apply collagen, cover with non-adherent dressing qod (every other day) and prn (as needed) one time a day every other day related to acquired absence of left leg below knee. There was also an order dated 5/19/26 which revealed that the resident had a central venous catheter to R (right) upper chest monitor site q (every) shift for bleeding, pain, redness, tenderness, swelling, & dislodgement. Document (-) Absent or (+) if present. Notify MD (medical director) & dialysis center every shift related to end stage renal disease. Additionally, there was an order dated 1/27/26 for colostomy care every shift related to ileostomy status, need for assistance with personal care. Further review revealed an order dated 3/31/26 for Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: dialysis port, wounds, and ostomy, colostomy every shift. Record review of Resident #4's face sheet, dated 5/20/26, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included: muscle wasting atrophy, not elsewhere classified, unspecified site (loss of muscle tissue), schizoaffective disorder, depressive type (mental health condition), systemic lupus erythematosus, unspecified (autoimmune disease), and personal history of transient ischemic attack and cerebral infarction without residual deficits (previous mini-stroke and localized stroke). Record review of Resident #4's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident's cognition was intact. (continued on next page)

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	676163	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesquite Post Acute Care	4510 27th St Lubbock, TX 79410

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's current Physician's Orders, dated 5/20/26, revealed there were no orders for Enhanced Barrier precautions. During an observation on 5/20/26 at 9:10 AM, CNA E was observed inside Residents #2 and #4's bedroom. CNA E assisted Resident #2 with dressing and then transferred Resident #2 from the bed to wheelchair. CNA E handed Resident #2 their belongings such as water cup, money, and grabber, etcetera. Then Resident #2 left the room. Then CNA E fixed Resident #2's bed and then she fixed Resident #4's bed. CNA E was not wearing a gown when she assisted Resident #2 with dressing, transferring, and handing her belongings, and when she fixed both beds in the room. Enhanced Barrier Precaution signage was posted on the outside of Resident #2 and #4's bedroom door. During an interview on 5/20/26 at 2:30 PM, CNA E stated she was trained on EBP and was supposed to wear PPE which included a gown, gloves, possibly shoe and hair covers depending on the situation for residents who were on EBP. She stated she must wear PPE when she touched the residents and provided care, or when she touched anything, the residents had contact with. She stated she was to remove the PPE before she exited the resident's room and disposed of the items in the biohazard bin. CNA E stated she also must wash or sanitize her hands before she entered, during care, and after she exited the resident's room. CNA E stated she did not believe she had to wear PPE if she went into the room just to talk to the residents who were on EBP. CNA E stated she was supposed to wear PPE when she touched residents' linens and changed their briefs when they were on EBP. CNA E stated she recalled she went into Residents #2 and #4's room and did not wear any PPE besides gloves when she helped Resident #2 get dressed and transferred to her wheelchair. CNA E stated she believed she was supposed to wear PPE when she fixed Resident #2's bed and helped her get ready and transferred her. CNA E stated she also fixed Resident #2 and #4's beds when she was in there. CNA E stated she did not wear any PPE besides gloves when she fixed Residents #2 and #4's linens and bedding today. CNA E stated she sanitized before she entered the room and after she exited the room and in between when she fixed their beds. CNA E stated she also changed gloves when she fixed their beds. CNA E stated she did not know where the gowns were as they were normally outside the resident rooms in the hallway in a container. CNA E stated she recalled there being a container filled with PPE in the hallway outside their door, but she had been off for the past two days, and this was her first day back to work. CNA E stated she knew there were some in the linen closet, but she was not thinking at the time when she helped the residents. She stated she was not aware she forgot to wear PPE when she provided direct care to Residents #2 and #4 prior to this interview. She stated the system that was in place to ensure she remembered to wear PPE for residents who were on EBP was the container filled with PPE that was placed outside their doors. CNA E stated she was trained on EBP and infection control through training videos she watched during onboarding when she was hired. She stated she was responsible for wearing PPE when she went into rooms and provided direct care for residents who were on EBP. She stated a potential negative outcome was that germs could be transferred on her body and clothing and then she could transfer that to other residents and it could keep spreading and someone could get sick. 2. Record review of Resident #26's face sheet, dated 5/20/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included: anoxic brain damage, not elsewhere classified, (brain damage due to loss of oxygen), major depressive disorder, recurrent severe without psychotic features (mental illness), muscle wasting atrophy, not elsewhere classified, unspecified site (loss of muscle tissue), chronic obstructive pulmonary disease, unspecified (lung disease that block airflow and made it hard to breathe), personal history of urinary tract infections (history of bacterial infections in the kidneys, bladder, ureters, and urethra), colostomy status (surgically created opening in the abdomen that connects the colon to the outside of the body that allows waste to bypass the rectum and collect in an external pouch), and acquired absence of right leg below knee. Record review of Resident #26's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident's cognition was intact. Section - H - Bladder and Bowel revealed the resident had in indwelling catheter and ostomy. Section - M - Skin (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conditions revealed the resident had a stage 3 pressure ulcer. Record review of Resident #26's undated care plan revealed: focus: The resident had an indwelling foley catheter, 18FR (French) 30cc, for diagnosis of neuromuscular dysfunction of the bladder, obstructive and reflux uropathy (disruption of the signals required to store and empty urine) , date initiated 2/15/25, revision on: 3/17/2025. Interventions: Use Enhanced Barrier Precautions, date initiated: 2/15/25. The resident had a Stage 3 pressure wound to the coccyx; resident prefers to perform her own wound care and is followed by wound provider outside of facility. Continuing education provided on infection control, date initiated: 2/17/25, revision on: 9/30/25. Interventions: Use Enhanced Barrier Precautions, date initiated: 3/17/25. Record review of Resident #26's current Physician's Orders, dated 5/20/26, revealed an order with a start date of 3/17/25 for a catheter type: 18 FR (French) #30ML - to closed urinary drainage system - diagnosis for use: Neuromuscular dysfunction of the bladder (disruption of the signals required to store and empty urine) . The was also an order dated 3/31/26 for colostomy care every shift related to colostomy status. Additionally, the was an order with a start date of 3/23/26 for Wound Care-(Right ischium (lower and back part of the hip bone)) (stage 3): Cleanse wound with WC/NS (wound care/normal saline), pat dry with gauze, apply MD compounded topical (medication compounded by a medical doctor) (APG+) (Alkyl Polyglucoside), cover with silicone Super absorbent dressing as needed for Right Ischium Wound. Further review revealed an order dated 3/17/25 for Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: wounds, indwelling catheter and colostomy every shift for catheter and wounds. During an observation and interview on 5/20/26 at 2:51 PM, CNA F was observed inside Resident #26's room combing Resident#26's hair while Resident #26 sat in their wheelchair. CNA F was not wearing a gown or gloves during this observation. Enhanced Barrier Precaution signage was posted on the outside of Resident #26's bedroom door. CNA F stepped into the hallway to speak with the surveyor. CNA F stated she was a floater and worked in all three halls. CNA F stated she was trained that she was supposed to wear gowns, gloves, and masks when she entered resident's room to provide patient care, touch their belongings, and touch anything else that may have had contact with resident's fluids for residents that had an infection and were on EBP. CNA F stated she was combing Resident #26's hair and was about to put two braids in her hair. CNA F stated she was not aware Resident #26 was on EBP which was why she had not worn any PPE during this encounter. She stated she could now see the EBP signage posted on the outside of Resident #26's door and stated she should have worn PPE when she combed the resident's hair. She stated she was in-serviced during morning report by nursing staff to ensure she was aware of which residents were on EBP, and there was usually a bin outside the room in the hallway filled with PPE but there was not one outside Resident #26's room today. She stated the last time she worked was Sunday (5/17/26) and she believed it could have changed since then because she noticed today the PPE was moved to a container that hung on the back of the resident's doors. She stated she was not in-serviced about that change when she came on shift today. CNA F stated she was last trained on EBP about a month ago during her onboarding training. She stated the charge nurse was responsible for ensuring staff remembered to wear PPE, however she was responsible for herself to wear PPE. CNA F stated a potential negative outcome was that she could catch AIDS (acquired immunodeficiency syndrome) or she could transfer an infection such as AIDS, syphilis, or any infection the resident had to others and they could get sick. During an interview on 5/21/26 at 11:30 AM, the DON stated the policy for EBP was that staff were to implement EBP with residents who were on EBP when they had contact with anything going in or outside of their bodies and when they were providing care. The DON stated staff were expected to wear gowns and gloves when they had close contact with those residents. The DON stated she expected staff to follow the EBP that was listed on the signage on resident's doors. The DON stated this included perineal care and handling their linens. The DON stated she had just learned that EBP required them to wear PPE when they changed linens. She stated they determined it was still close proximity with resident's belongings since the residents touched those things. The DON stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combing the resident's hair was considered direct contact with the patient and staff was to practice EBP during that task as well. The DON stated staff were to wash hands or use hand sanitizer before they entered, after they exited, and in-between tasks with the resident such as if they changed the resident. The DON stated staff should wear gloves when handling resident's cups to get them water if they were on EBP. She stated she had an infection control bulletin board, in-serviced staff, and there were signs on doors so that it did not get overlooked. The DON stated staff were expected to follow the EBP policy even when they were rushed to get tasks done. The DON stated PPE was hung on the inside of the residents' doors for staff to utilize. The DON stated they used to have PPE placed outside of the doors, but they felt there would have been too many PPE carts in the hallway, so they moved them to be hung on the inside of the doors. The DON stated they initially hung the PPE on the front of the resident room doors, but they felt it was not efficient and changed to hanging on the back of the doors. The DON stated there was a supply room filled with PPE and an additional supply center staff could get PPE from. The DON stated Resident #2 was on EBP for significant wounds and because they had a port for dialysis. The DON stated Resident #26 was on EBP for wounds and a catheter. The DON stated a potential negative outcome of not following EBP and infection control policy was that infection could be spread and could cause residents to get sick because they were at risk due to their health issues. During an interview on 5/21/26 at 1:10 PM, the ADM stated the policy for EBP was that staff were to wear the appropriate gown and gloves when they provided care to a resident that was on EBP. The ADM stated staff were also to complete hand hygiene before they entered and after they exited those rooms. She stated she was not aware staff did not wear PPE when they provided care for residents on EBP. The ADM stated the system to monitor this was ongoing in-services provided to staff on the EBP protocol, the signage, and spot checks completed by the nursing leadership as a team. The ADM stated she and nursing leadership were responsible for ensuring EBP were followed. The ADM stated Residents #2 and #26 were both on EBP. The ADM reviewed the EBP signage and stated EBP were required when staff changed linens and touched their personal items. The ADM stated a potential negative outcome of staff not following infection control and EBP policies was that there was an opportunity for infection control issues and cross contamination. Record review of the facility's undated sign posted outside Residents #2 and #26's doors, titled, Enhanced Barrier Precautions, revealed: EVERYONE MUST: Clean their hands, including before entering and when leaving the rooms. PROVIDERS AND STAFF MUST ALSO:Wear gloves and a gown for the following High-Contact Resident Care Activities .dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toiletingDevice care use: central line, urinary catheter, feeding tube, tracheostomy.Wound care: any skin opening requiring a dressing.Do not wear the same gown and gloves for the care of more than one person. Record review of the facility-provided policy titled, IPCP (Interprofessional Collaborative Practice) Standard and Transmission-Based Precautions- 483.80 Infection Control, revision dated April 2025, revealed in part: Policy:It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. In Long Term Care (LTC), it is appropriate to individualize decisions regarding resident placement (shared or private), balancing infection risks with the need for more than one occupant in the room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident. It is therefore appropriate to use the least restrictive approach possible that adequately protects the resident and others. Maintaining isolation longer than necessary may adversely affect psychosocial well-being. Where possible, the goal is to isolate the organism, not the resident. Transmission-Based Precautions are the second tier of basic infection control and used in addition to Standard Precautions for patients who are or may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Procedure:3. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities that provide opportunities for indirect transfer of MDROs (multidrug-resistant organism) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs).a. PPE: The use of gown and gloves for high-contact resident care activities is indicated when Contact Precautions do not otherwise apply, for nursing home residents with:i. Wounds and/or indwelling medical devices regardless of known MDRO infection or colonization.- Wounds include, but are not limited to chronic wounds, pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.- Generally, shorter-lasting wounds, such as skin tears or skin breaks covered by an adhesive bandage are not included.- Indwelling medical devices include, but are not limited to central lines,peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes, and tracheostomies.- Peripheral intravenous lines (not PICC lines) or lines used for hypodermoclysis (subcutaneous hydration/nutrition) are not included.c. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:i. Dressingii. Bathing/showeringiii. Transferringiv. Providing hygienev. Changing linensvi. Changing briefs or assisting with toiletingvii. Device care or use: central vascular line (including hemodialysis catheters), indwelling urinary catheter, feeding tube, tracheostomy/ventilator.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms for 4 (Rooms #407, 602, 604 and 611) of 48 semi-private rooms reviewed for physical environment. The facility failed to ensure resident Rooms #s 407, 602, 604 and 611 met the required minimum of 80 square feet per resident. This failure could place residents at risk of crowding and cause difficulty in providing resident care. Findings include: During an interview with the ADM during entrance conference on 05/19/26 at 9:08 AM it was revealed the facility would need the Texas Health and Human Services Form 3762 Room Size Waiver for Facilities for several rooms at the facility. The ADM stated the rooms were in the part of the facility that was not in use and awaiting renovations, but the rooms were still listed on their bed classification form. Record review of Texas Health and Human Services Form 3740 (Bed Classifications (Numbers and Location) dated 05/20/26 documented that room [ROOM NUMBER] was listed as a Title 18/19 bed classification semi-private rooms for two residents. rooms [ROOM NUMBER] were listed as Title 18 rooms. During an interview on 05/21/26 at 10:56 AM, the ADM stated the facility did not have a policy for the room size waiver. The ADM stated the facility followed state regulations for the room sizes. During an observation on 05/21/26 at 11:50 AM with the Maintenance Aide, room [ROOM NUMBER] was measured to be 141.81 Sq. Ft. The room was not occupied. During an observation on 05/21/26 at 11:53 AM with the Maintenance Aide, room [ROOM NUMBER] was measured at 155.04 Sq. Ft. The room was not occupied. During an observation on 05/21/26 at 11:55 AM with the Maintenance Aide, room [ROOM NUMBER] was measured at 151.59 Sq. Ft. The room was not occupied. During an observation on 05/21/26 at 11:58 AM with the Maintenance Aide, room [ROOM NUMBER] was measured at 155.1 Sq. Ft. The room was not occupied. During an interview on 05/21/26 at 12:46 PM with the ADM regarding the square footage for Rooms 407, 602, 604 and 611. When asked if she wanted to continue with the room size waiver she stated, Yes. The ADM stated Rooms 407, 602, 604, and 611 were still listed on their bed classification form. The ADM stated the facility did not have plans to open up the rooms in the near future and stated the long-term goals were to renovate and make sure all of the rooms were up to date. The ADM stated a potential negative outcome to the residents was not enough space to move around.