STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676183	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Health Care & Rehabilitation Center	220 E Ash Street Huntington, TX 75949

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident's physician when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 6 residents (Resident #52) reviewed for notification of changes in that: The facility did not notify Resident #52's physician for a significant change in weight. (weight loss of 25.8 pounds in 30 days.) This deficient practice could place residents at risk of not having their physician notified of changes resulting in a delay in continuity of care.The findings were: Record review of Resident #52's face sheet, dated 7/16/2025, revealed Resident #52 admitted to the facility on [DATE] with diagnoses that included cerebral palsy (a group of conditions that affect movement and posture), dysphagia (A condition with difficulty in swallowing food or liquid. This may interfere in a person's ability to eat and drink), and lack of coordination. Record review of Resident #52's quarterly MDS dated [DATE] revealed Resident #52 was rarely or never understood and was moderately impaired for daily decision making. Record review of the same document, revealed the following item: Section GG, Item GG130 Self Care.Review of this item revealed Resident #52 required moderate assistance with eating and substantial assistance with toileting, bathing and dressing. Record review of the weights tab in the electronic medical record for Resident #52 indicated: 6/1/25 weight 137.0 lbs. 6/7/25 weight 182.9 lbs. gain of 45.9 lbs. 7/14/25 weight 157.1 lbs. loss of 25.8 lbs. Record review of Resident #52's care plan, dated 7/16/25 revealed the following focus area initiated on 8/28/24: The resident is resistive to care, Refused meal on 5/19/25 Record review of Resident #52's Progress Notes, dated 6/1/25 thru 7/16/25 revealed no documentation indicating that the resident's primary care physician was notified of any significant weight changes. During an interview on 7/16/25 at 12:15 pm with the DON, she said she was currently in charge of monitoring resident weight variances. She stated the previous assistant director of nursing was responsible for monitoring weights and following up on any changes, but she was relieved of her duties last week. The DON stated she took over monitoring residents' weights this week. She said the CNAs on each hall were responsible for weighing residents at the first of the month. She said a resident list of who needed to be weighed was given to the CNAs. She said the resident weights were turned into the charge nurse and the charge nurse entered the data into the resident's Electronic Medical Record (EMR). She said the EMR system would alert the nurse to any weight variances and the residents that had a weight variance were placed on a list for reweight. She said that if there was a variance after the reweight, the ADON that oversaw the weight program was responsible for contacting the doctor, resident representative, and the dietician. She said notifications were documented in the nurse's progress note. She stated she was not aware of Resident #52's weight variance and that he would be weighed again today. She stated a possible reason for the variance could be related to the weight of the resident's wheelchair not being subtracted from the weight in combination with recent hospitalizations that included intravenous fluid administration. She stated that she expected the charge nurse to document weights timely, and for reweights to be performed the next day. She stated that the doctor should be notified after the reweigh confirms a variance as well as the responsible party and dietician. She said the nurse should document notifications in the progress notes. She said if the physician was not notified it could result in the resident not receiving interventions needed. She said she expected the charge nurse to recognize when a resident required a reweigh and that variances were reported to the physician. She stated that moving forward she would be performing the weekly audits of resident weights. Resident # 52 was reweighed on 7/16/2025 with a weight of 157.0 lbs. In an interview on 07/16/25 at 3:15 pm the Administrator stated that the DON was now responsible for monitoring resident's weights and ensuring that monthly and weekly weights were completed. He stated the ADON that was responsible for monitoring resident weights was relieved of her duties the previous week. He stated the DON would be reviewing all resident weights and following the facility's policy and procedure on the facility weight system. The Administrator expected the nursing staff to follow the facility policy on weighing residents and notifying the primary care physician and dietician when needed. He said if the physician was not notified of weight variances the residents may not receive orders and evaluations needed to address potential problems. The former ADON was not available for interview. Record review of Nursing Policy and Procedure for Weight System dated 9/2022 indicated .3. Any resident with a significant weight loss will be reweighed. 5. weight variances will be reviewed at the weekly. 7. The Director of Nursing/Designee will ensure that the Physician, Responsible Party and the Dietician will be notified in a timely manner and documented in the

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to complete a comprehensive MDS assessment within 14 days after a significant change in the resident's mental or physical condition for 1 of 4 residents (Resident #6) reviewed for assessments. The facility failed to reassess Resident #6 following a hospice admission (specific care for the sick or terminally ill) on 03/24/25.This failure could place residents at risk for not having their individual needs met due to inaccurate assessments.Findings included:Record review of a facility face sheet dated 7/16/25 for Resident #6 indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Record review of a diagnosis report dated 7/16/25 for Resident #6 indicated her primary diagnosis was senile degeneration of brain (a neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior).Record review of a comprehensive MDS assessment dated [DATE] for Resident #6 indicated a BIMS score of 06, indicating severely impaired cognition. She was receiving hospice services as a resident in the facility. Record review of a physician's order summary report dated 7/15/25 for Resident #6 indicated she had the following order dated 3/24/25: .Admit to [name of hospice provider] hospice services .Record review of a comprehensive care plan dated 3/12/25 for Resident #6 indicated the care plan did not address hospice services.Record review of an electronic medical record for Resident #6 indicated the MDS tab in her chart did not indicate a significant change MDS done within 14 days after admission to hospice services.During an interview on 7/16/25 at 3:08 pm the MDS coordinator said she must have overlooked the significant change MDS after Resident #6's hospice admission. She said residents might miss out on orders, treatments and care if the MDS assessment was not done accurately or timely. She said she would ensure significant change MDS assessments were done timely going forward. During an interview on 7/16/25 at 3:15 pm the DON said if an MDS was not completed timely and accurately, residents may not receive appropriate care. She said going forward, she would ensure significant change MDS assessments were completed timely. During an interview on 7/16/25 at 3:25 pm the Administrator said if MDS assessments were not completed appropriately, residents may not receive appropriate care. He said going forward, he expected the MDS coordinator to complete MDS assessments appropriately.Record review of a facility policy titled Resident Assessments dated November 2019 read: .A significant change in status assessment (SCSA) is completed within 14 days of the interdisciplinary team determining that the resident meets the guidelines for major improvement or decline . and .A SCSA is required when a resident: a. enrolls in a hospice program .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to refer 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 of condition for 1 of 4 Residents (Resident #6) reviewed for PASRR (Preadmission Screening and Resident Review Services).The facility failed to ensure Resident #6 had a new level 1 PASSR completed with a new diagnosis of psychotic disorder with delusions (a mental disorder in which a person has delusions, but with no accompanying prominent hallucinations, thought disorder, mood disorder, or significant flattening of affect) and major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and a range of emotional and physical problems).These failures could place residents at risk of not receiving the needed PASSR services to meet their individual needs and could result in a decreased quality of life. The findings included:Record review of a facility face sheet dated 7/16/25 for Resident #6 indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Record review of a diagnosis report dated 7/16/25 for Resident #6 indicated her primary diagnosis was senile degeneration of brain (a neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior). She had diagnoses of psychotic disorder with delusions and major depressive disorder added on 9/9/24.Record review of a comprehensive MDS assessment dated [DATE] for Resident #6 indicated a BIMS score of 06, indicating severely impaired cognition. Record review of a PASSR level I form completed on 6/21/24 for Resident #6 indicated the level I screening was negative for mental illness.During an interview on 7/16/25 at 11:43 am the MDS coordinator said she was responsible for PASSR. She said she did not have a new level I completed when Resident #6 had 2 new diagnoses added on 9/9/24 because she did not know she needed to do that. She said residents could possibly miss out on services they qualify for if PASSR evaluations were not done appropriately.During an interview on 7/16/25 at 3:15 pm the DON said the MDS coordinator was responsible for PASSR, but she (DON) provided oversight. She said going forward she would ensure the Local Authority was notified when a resident received a new psychiatric diagnosis. She said residents could miss out on services if PASSR evaluations were not completed appropriately.During an interview on 7/16/25 at 3:25 pm the Administrator said if PASSR evaluations were not done appropriately, residents could miss out on services and may not receive appropriate care. He said going forward, he expected his staff to have appropriate PASSR evaluations completed. A facility policy for PASRR was requested from Administrator on 7/16/25 at 10:00 am, but none was provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 of 4 residents (Resident #21) reviewed for PASRR Level I screenings. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #21. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnoses (bipolar disorder) were present upon Resident #21's admission date on 9/27/2024. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs.Findings included: Record review of an admission Record for Resident #21 dated 7/16/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old.Record review of active physician orders for Resident #21 dated 7/16/2025 indicated she had diagnoses of bipolar disorder (a mental illness that causes extreme shifts in mood), type 2 diabetes, and dementia (a decline in mental ability that can interfere with daily life).Record review of a Quarterly MDS Assessment for Resident #21 dated 5/19/2025 indicated she did not have any impairments in thinking with a BIMS score of 14. She had active diagnoses in the look back period of 7 days that included bipolar disorder. Record review of a care plan for Resident #21 dated 10/17/2024 indicated she had a mood problem related to bipolar and depression with interventions to administer medications for targeted behaviors and side effects.Record review of a PASRR Level 1 Screening (PL1) dated 10/1/24 for Resident #21 indicated she was negative for mental illness.During an interview on 7/16/2025 at 11:41 AM, the MDS Coordinator said she had been employed at the facility for 9 years and was responsible for all thing related to PASRR in the facility. She said Resident #21 admitted to the facility 9/27/2024 and had a diagnosis of bipolar on admission. She said she entered the PL1 dated 10/1/2024 and it was negative for mental illness, and it should have been positive. She said she would update the information and get a new PL1 entered so the local authority could come out and complete an evaluation for Resident #21. She said she would audit the other residents in the facility to ensure everyone's information was accurate. She said residents could be at risk of not getting the help and miss services if information was not correct.During an interview on 7/16/2025 at 3:45 PM, the DON said the MDS coordinator was responsible for ensuring accuracy of PASRR and a PASRR Level 1 screening should be completed before admission to the facility. She said the MDS Coordinator should review all diagnoses to ensure the PL1 was correct. She said going forward she along with the MDS Coordinator would be reviewing them before admission and complete an audit of all residents. She said if the PL1 was not accurate, residents could miss services, and they might not be able to provide proper care for them. During an interview on 7/16/2025 at 3:25 PM, the Administrator said the MDS Coordinator was responsible for all things PASRR. He said if the PASSR screenings were not accurate then residents may not receive appropriate care and services. He said the facility did not have a policy related to PASRR.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to review and revise the comprehensive care plan after each assessment for 1 of 4 (Resident #6) residents reviewed for care plan revisions.The facility failed to update Resident #6's care plans for hospice status.These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs.Findings included:Record review of a facility face sheet dated 7/16/25 for Resident #6 indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Record review of a diagnosis report dated 7/16/25 for Resident #6 indicated her primary diagnosis was senile degeneration of brain (a neurological disorder that is tied to cognitive decline, memory impairment, and changes in behavior).Record review of a comprehensive MDS assessment dated [DATE] for Resident #6 indicated a BIMS score of 06, indicating severely impaired cognition. She was receiving hospice services as a resident in the facility. Record review of a physician's order summary report dated 7/15/25 for Resident #6 indicated she had the following order dated 3/24/25: .Admit to [name of hospice provider] hospice services . Record review of a comprehensive care plan dated 3/12/25 for Resident #6 indicated the care plan did not address hospice services. The care plan was not updated after the comprehensive MDS assessment dated [DATE] to reflect hospice status.During an interview on 7/16/25 at 3:08 pm the MDS coordinator said she was responsible for care plan updates. She said care plans should be updated after each MDS assessment. She said she must have just overlooked this care plan update for Resident #6. She said residents could miss out on care needed if care plans were not updated appropriately. She said she would ensure all care plan updates were done timely and correctly in the future.During an interview on 7/16/25 at 3:15 pm the DON said if care plans were not updated appropriately, residents may not receive appropriate care. She said going forward, she would ensure the MDS coordinator appropriately updated the care plans to include relevant information. During an interview on 7/16/25 at 3:25 pm the Administrator said if care plans were not updated as required, residents may not receive appropriate care. He said going forward, he would expect his staff to include needed information in the residents' care plans. Record review of a facility policy titled Care Plan - Resident dated 7/2018 read: .Individualize care to ensure the care plan is person centered for the unique needs of the resident. and .the care plan must be reviewed and revised (updated) at least every 90 days. and .all residents receiving either Hospice or Dialysis are to have care plans developed in conjunction with these organizations.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 2 of 8 residents (Resident #9 and Resident #20) reviewed for quality of care.1.The facility failed to remove worn and damaged mechanical lift slings from service for Resident #9 on 7/15/2025 and 7/16/2025.2. The facility failed to ensure a bottle of peri-wash was not left in Resident #20's room on 7/15/25.This failure could place residents at risk of injuries due to environmental hazards. Findings included: 1.Record review of Resident #9's facility face sheet dated 7/16/2025 revealed he was a [AGE] year-old male that admitted to the facility on [DATE]. Record review of Resident #9's physician's consolidated orders dated 7/16/2025 revealed Resident #9 had a primary diagnosis of sepsis (infection in the body) and used a mechanical lift for all transfers. Record review of Resident #9's comprehensive care plan dated 7/15/2025 revealed Resident #9 had an ADL self-care performance deficit and required 2 staff to move between surfaces. Record review of Resident #9's Quarterly MDS assessment dated [DATE] revealed Resident #9 had a BIMS of 15 indicating intact cognition and was dependent of 2 or more staff for transfers. During an observation and interview on 7/15/2025 at 10:37 am Resident #9's lift sling under him had faded loops. He said the staff used a lift daily for him to transfer and the slings vary but mostly the loops were faded. During an observation on 7/16/2025 at 8:30 am Resident #9 was up in his wheelchair and the lift sling under him had faded loops. During an interview on 7/16/2025 at 8:46 am CNA C said that Resident #9 required a mechanical lift for transfers and before transfers the slings were to be inspected for holes, tears and frays but was not sure about the coloring or fading of the loops and fabric. She said that a sling used that was worn or old could cause resident injury. During an interview on 7/16/2025 at 11:18 am the Housekeeping Supervisor said she had been working in laundry and the lift slings were washed on regular cycle with no bleach and then dried. She said she had not been told to launder them any other way and there was no system for inspection before they returned to the hallway for staff to use. She said she could see how drying them could affect the fabric and if they were not cared for properly residents could become injured. During an interview on 7/16/2025 at 11:25 am the DON said that the lift slings should only be hung to dry, and the aides were to inspect them for fraying or faded colors before using. She said she was responsible for all things nursing and staff had been trained on hire and as needed on proper inspection of slings. She said she expected all nursing staff that used the slings to inspect them before use and not use any that were worn. She said using worn or faded slings could cause resident injury. During an interview on 07/16/2025 at 3:11 PM the Administrator said the CNAs had been trained on inspecting the lift slings for tears, fraying, and discoloring before using them. He said the sling pads should be washed and hung to dry to prevent damaging the sling fabric. He said worn and discolored slings could cause accidents and injuries and expected all slings to be kept in good repair. Record review of a facility policy titled Lifting and Movement of Resident-Safe dated 8/2022 indicated, .this home uses appropriate techniques and devices to lift and move residents . 2. Record review of a facility face sheet dated 7/16/25 for Resident #20 indicated she was an [AGE] year-old female admitted to the facility on [DATE].Record review of a diagnosis report dated 7/16/25 for Resident #20 indicated her primary diagnosis was senile degeneration of the brain (memory loss). Record review of a comprehensive MDS assessment dated [DATE] for Resident #20 indicated she was unable to complete the BIMS assessment and had severely impaired cognition. Record review of a comprehensive care plan dated 6/9/25 for Resident #20 indicated she had impaired cognitive function/dementia or impaired thought processes related to diagnosis including senile degeneration of the brain and Alzheimer's disease. During an observation on 7/15/25 at 10:37 am a bottle of peri-cleanse wash was observed in a tray table in Resident #20's room. The peri-wash bottle label said, keep out of reach of children. During an interview on 7/16/25 at 3:04 pm CNA B said she was unsure how the peri-wash got left in the resident room and said it should not be in there due to possible wandering residents and the cognitive status of the residents on the secured unit. She said it was a safety issue. During an interview on 7/16/25 at 3:15 pm the DON said if peri-wash was left in residents' rooms, especially in the secured unit, residents could possibly drink it, and it could cause harm. She said she would ensure staff knew not to leave it in residents' rooms going forward. During an interview on 7/16/25 at 3:25 pm the Administrator said the peri-wash should not be left in residents' rooms due to the risk of residents possibly consuming it and getting sick. He said administrative staff already did Scout rounds to check for things in residents' rooms that needed to be addressed. He said

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences for 1 resident (Resident #57) out of 2 residents observed for respiratory therapy.The facility failed to obtain physician orders for Resident #57's Bipap settings he used each night at the facility since his admission on [DATE].This failure could place residents who reside at the facility at risk for inaccurate care and communication of health conditions to other providers.Record review of Resident #57's electronic medical record and face sheet dated 7/16/2025 reflected he was admitted to the facility on [DATE]. His diagnoses included: cellulitis (bacterial infection of the skin and the deeper tissues beneath the skin), obstructive sleep apnea (sleep disorder where breathing repeatedly stops and starts during sleep due to a blockage of the upper airway), nonrheumatic mitral valve insufficiency (mitral valve in the heart does not close properly). Record review of Resident #57's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored a 14/15 on his BIMS which signified he was cognitively intact. He could ambulate independently with a walker. Resident #57 required supervision or touching assistance from staff with his ADLs. He was continent of bowel and occasionally incontinent of bladder. Resident #57's Bipap (non-invasive ventilation that helps people breathe easier) machine was present upon admission.Record review of Resident #57's comprehensive care plan date initiated 6/10/2025 indicated Enablers at this time. With interventions that included: Bipap at bedtime due to sleep apnea.Record review of Resident #57's Order Summer Report, Active as of: 7/16/2025 indicated a physician's order for bipap to be used at bedtime and as needed while sleeping. The physicians order did not indicate what the bipap settings were to be. Record review of Resident #57's medication administration record for July 2025 reflected: bipap to be used at bedtime and as needed while sleeping and was signed as administered twice daily from 7/1/25 through 7/16/25. During an observation on 7/15/2025 at 11:04 am, Resident #57 was in his room lying in his recliner with a Bipap machine on his bedside nightstand with the connected tubing and mask in a plastic bag hanging from the top drawer.During an interview on 7/15/2025 at 11:04 am with Resident #57, he stated he used the Bipap at night and brought it with him from home. He stated he needed the Bipap at night for extra oxygen and he used it every night. He stated he would put the Bipap mask on himself and all he did was turn on the machine. He said he did not know what the settings on the machine should be, but the nurse would know. During an interview on 7/16/2025 at 9:40 am LVN H, who was the charge nurse for Resident #57, said Resident #57 had a Bipap and used it every night. When asked what the setting were supposed to be she said she would look in the computer and see what the order was. LVN H then said she did not see the settings in the physician's order and would ask the DON where she could find what the settings were supposed to be. When LVN H was asked how she knew if the settings were correct, she said she did not know. During an interview on 7/16/2025 at 9:43 am the DON stated Resident #57 needed a physician's order for his Bipap settings and she did not know why it was not obtained when he was admitted . She stated without a physician's order, the treatment could be given at the wrong setting or time and cause discomfort or respiratory distress. During an interview on 7/16/2025 at 3:30 pm the Administrator said it was the charge nurse's responsibility to make sure bipap settings were entered into the system. He said the potential hazard of not obtaining a physician's order for the bipap settings would be for the resident to have respiratory distress. Review of the facility policy and procedure titled BiPap/CPAP dated August 2022 indicated it is the policy of this home that Bi-level Positive Airway Pressure (BiPap) and/or Continuous Positive Airway (CPAP) will be set up by a respiratory therapist with a physicians order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing and administering for all drugs and biologicals to meet the needs of each resident for 1 of 12 months (May 2025).The facility failed to have a licensed pharmacist, 2 facility staff witnesses and sign the drug destruction log during drug destruction occurrence May 22, 2025.These failures could place residents at risk for misappropriation and drug diversion.Findings include:Record review of a Drug Destruction record, dated 5/22/25, indicated the attached sheets which contained the controlled substances were initialed only by the consultant pharmacist and contained no witness signatures.During an interview on 7/16/25 at 3:15 PM, the DON said if drugs were not destroyed appropriately and did not have the required witnesses, a drug diversion could happen. She said going forward, she would ensure the witnesses signed the attached sheets appropriately. Record review of the facility's policy titled Medication - Discontinued Medication / Destruction of Drugs, dated 8/2022, read: . It is the policy of this home to ensure that drugs are destroyed in accordance with Federal Regulations .the consultant pharmacist will arrange for the proper witnesses to be present for the destruction, and will destroy the medications

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 residents (Resident #23) reviewed for storage of medications and for 1 of 4 medication carts (Nurse Cart L) reviewed for pharmacy services.1. The facility failed to ensure Resident #23's 10 ml sterile normal saline prefilled syringe and intravenous site dressing were not kept at the bedside and was unable to be accessed by unauthorized personnel or residents on 07/15/25. 2.The facility failed to ensure expired Tresiba (insulin degludec) for Resident #30 was not on the nurse medication cart on 7/16/25. This failure could place residents at risk of unauthorized use of medication, accidental contaminations/use of an unprescribed medication, and adverse effects of medications. Findings include: 1.Record review of Resident #23's face sheet, dated 07/15/2025, indicated an [AGE] year-old female who was admitted to the facility on [DATE]. with diagnosis which included overactive bladder (bladder contracts with urgency to urinate), urinary tract infection (Infection of the urinary system) and chronic pain. Record review of Resident #23's quarterly MDS, dated [DATE], indicated Resident #23 had a BIMS score of 13, which indicated she was cognitively intact. Record review of Resident #23's physician order summary, dated 7/16/2025, indicated an order, dated 7/12/2025, to discontinue midline intravenous catheter (a venous device for infusion of intravenous antibiotics and/or fluids).During an observation and interview on 7/15/2025 at 10:40 AM, Resident #23 was observed leaving her room going to the shower. On the bedside table was a prefilled 10 ml syringe of sterile normal saline solution for intravenous use and a package containing a transparent dressing for covering an intravenous insertion site.During an observation and interview on 7/15/2025 at 1:30 PM, LVN A said the saline was left at the bedside to flush and change the site dressing of Resident #23's intra venous catheter which was currently discontinued. The dressing and 10ml of normal saline were removed from the bedside table. LVN A said all medications and dressings should be keep in a locked compartment to prevent contamination. LVN A said no medications should ever be left at the bedside and residents or visitors could tamper with and contaminate medications left at the bedside.During an interview on 07/16/2025 at 2:00 PM, the DON said she was responsible for ensuring all medications were stored in locked compartments and expected all medication to be stored in locked compartments of the medication room or medication carts. She said leaving medications at the bedside put the residents at risk for others tampering or contamination of the medications. During an interview on 7/16/2025 at 2:30 PM, the Administrator said he expected all medications should be stored in locked compartments of the medication room or medication carts. He said leaving medications at the bedside put the residents at risk for others tampering or contamination of the medications. 2.Record review of Resident #30's facility face sheet, dated 7/16/25, indicated an [AGE] year-old male who was admitted to the facility on [DATE].Record review of Resident #30's physician's order summary report, dated 7/16/25, indicated his primary diagnosis was diabetes mellitus with diabetic neuropathy (a condition characterized by nerve damage due to prolonged high blood sugar levels).Record review of Resident #30's quarterly MDS assessment dated [DATE] indicated a BIMS score of 15, which indicated intact cognition. He received daily insulin injections. Record review of Resident #30's comprehensive care plan, dated 6/10/25, indicated he had diabetes mellitus and interventions to administer medications as ordered. Record review of Resident #30's physician's order summary report, dated 7/16/25, indicated he had the following physicians order, dated 2/22/25: .Tresiba FlexTouch Subcutaneous Solution Pen-Injector 200 Unit/ml (Insulin Degludec) Inject 12 unit subcutaneously one time a day for diabetes During an observation of a nurse medication cart on 7/16/25 at 12:12 PM revealed a Tresiba injection pen for Resident #30, expiration date of the medication was 12/31/24. The pen was labeled as opened on 7/2/25.During an interview on 7/16/25 at 3:15 PM, the DON said if expired medications were not removed from the medication carts appropriately, residents could be at risk of not receiving an effective dose or could possibly be harmed. She said she and the ADON would check the carts monthly. She said going forward, she would ensure all medications were checked appropriately and discarded when necessary.During an interview on 7/16/25 at 3:25 PM, the Administrator said the nursing staff should have caught the expiration date on the insulin when she put it on the cart. He said a resident may not get the appropriate dose or potency or it may even cause illness if a resident received expired medications. He said he would be providing in-services to all nursing staff to ensure they properly checked

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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 service safety in 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure food stored the kitchen refrigerator was labeled, dated and not expired. 2. The facility failed to ensure food stored in the kitchen dry storage area was labeled, dated, and not expired. These deficient practices could place residents at risk for foodborne illness.During an observation on 7/15/2025 at 10:15 AM revealed the following: #2 refrigerator contained (2) 46-ounce containers of opened and undated thickened lemon water. #3 refrigerator contained (2) pies with a graham cracker crust and unknown white filling that was opened, unlabeled and undated. #4 Freezer contained (5) bags of French fries that were unlabeled and undated. #5 freezer contained (2) cases of frozen egg products on the bottom shelf which were stored below meat products. The Dry storage area contained (5) 1.5-pound bags of crispy onions with no received date. During an interview on 7/16/2025 at 3:16 PM the DM said she had worked at the facility for about 1 1/2 months. She said she was responsible for checking for expired foods since she did not have a reliable person at that time. She said the cooks also knew they were supposed to label and date foods that were opened with an open and use by date. She said she overlooked the nectar thick liquids in refrigerator #2. She said the French fries were in freezer #4 since before her employment and she was trying to get them used up because she did not know how long they had been there. She said an unknowledgeable and untrained employee did not label and date the 2 pies in refrigerator #3. She said she was responsible for training staff, but she had not been employed very long and had not had time to train all staff on all things yet. She said the residents could get a potential food borne illness outbreak by consuming expired foods. During an interview on 7/16/2025 at 3:35 PM, the Administrator said all dietary staff should be checking for expired foods in the kitchen. He said the DM should be checking for expired food on days she checked the truck in, at the least but said it should be happening daily. He said food borne illnesses was the potential hazard to the resident. Record review of the facility's policy titled Food Receiving and Storage, dated October 2017, indicated: Foods shall be received and stored in a manner that complies with safe food handling practices. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) . 13. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption for 1 of 2 resident personal refrigerators (Resident #57) reviewed for food safety. 1. The facility failed to ensure the refrigerator for Resident #57 was clean and contained food items that were labeled and dated. 2. The facility failed to ensure the refrigerator for Resident #57 did not contain expired milk or expired whipped cream. These failures could place residents at risk for food borne illnesses.Findings included: Record review of Resident #57's electronic medical record and face sheet, dated 7/16/2025, reflected a [AGE] year-old male resident who was admitted to the facility on [DATE]. His diagnoses included: cellulitis (bacterial infection of the skin and the deeper tissues beneath the skin), obstructive sleep apnea (sleep disorder where breathing repeatedly stops and starts during sleep due to a blockage of the upper airway) and nonrheumatic mitral valve insufficiency (mitral valve in the heart does not close properly).Record review of Resident #57's quarterly MDS assessment, dated 6/23/2025, reflected he could understand others and be understood. He scored a 14/15 on his BIMS, which signified he was cognitively intact. Resident #57 could ambulate independently with a walker. Resident #57 required supervision or touching assistance from staff with his ADLs. He was continent of bowel and occasionally incontinent of bladder. Record review of Resident #57's comprehensive care plan, date initiated 3/8/2025 and revised on 3/21/2025, indicated Hyperlipidemia (high cholesterol) With interventions that included: Assure proper diet, document meal consumption.During an observation and interview on 7/15/2025 at 11:04 AM, Resident #57 said his personal fridge was usually cleaned by the staff when it needed it. Resident #57 said he got items out of the fridge himself. Resident #57 said he did not know the 1/2 gallon of milk was expired since 6/19/2025 or that the can of 13-ounce whipped cream had expired on 6/5/2025. During an interview on 7/15/2025 at 11:16 AM, CNA F said she took care of resident's personal refrigerators and checked for expired foods about once a week. She said it had been about 2 weeks since she cleaned out the fridge in Resident #57's room. She said she did not check the milk or the whipped cream to see if they were expired. She said she just forgot to check for expired food items. During an interview on 7/16/2025 at 3:25 PM, the DON said housekeeping was responsible for keeping residents' personal refrigerators clean. She said residents could get sick by consuming expired foods. During an interview on 7/16/2025 at 3:33 PM, the Administrator said housekeeping should be checking residents' refrigerators daily for temperatures, cleanliness, and for expired food. He said the potential hazard would be food borne illnesses that could lead to a variety of issues. During an interview on 7/16/2025 at 3:38 PM, Housekeeper K said she did not think they were allowed to touch any of the food inside the residents personal refrigerator, so she just checked the temperature and recorded it on the temperature logs. She said she cleaned Resident 57's room but not the inside of the fridge because she did not think they were allowed to touch the food. She said a resident could get food poisoning from consuming expired or molded food. During an interview on 7/16/2025 at 3:45 PM, the Housekeeping Supervisor said it was the housekeeper's responsibility to clean out residents' personal refrigerators. She said expired items were missed probably because the staff did not open the refrigerators like they were supposed to do. She said the potential hazard to the resident was food borne illness by consuming expired food. During an interview on 7/16/2025 at 3:51 PM, Housekeeper L said she had been doing housekeeping since January 2025. She said they looked at personal fridges daily and cleaned them as needed. She said food poisoning was the potential hazard to the resident by consuming expired foods. Record review of the facility's policy titled Refrigerator-Personal, dated August 2022, indicated: it is the policy of this home that resident's refrigerators will be checked weekly for cleanliness and remaining sanitary. 1. The Housekeeping Supervisor/designee will monitor resident's refrigerator weekly. 3. Clean and remove expired food as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews 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 2 of 8 residents (Resident #3 and Resident #14) and 3 of 7 staff (CNA D, CNA E and LVN G) reviewed for infection control. 1. The facility failed to ensure CNA D followed EBP (enhanced barrier precautions) for Resident #3 when providing care on 7/15/2025. 2. The facility failed to ensure the ice cooler's scoop compartment on hall 400 did not contain a towel with a black substance on 7/15/2025. 3. The facility failed to ensure LVN G washed or sanitized her hands during administration of IV medications to Resident #14 on 7/16/2025.Findings include: 1. Record review of Resident #3's facility face sheet, dated 7/16/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE].Record review of Resident #3's physician's consolidated orders, dated 7/16/2025, revealed Resident #3 had a primary diagnosis of sepsis (an infection in the blood) and required foley catheter care every shift. There was no order for EBP.Record review of Resident 3's comprehensive care plan, dated 6/25/2025, revealed Resident #3 had a foley catheter and was to show no signs or symptoms of a urinary infection. No intervention for EBP was listed.Record review of Resident #3's Annual MDS assessment, dated 6/13/2025, revealed Resident #3 had a BIMS of 07, which indicated moderately impaired cognition. Resident #3 had an indwelling catheter. During an observation on 07/15/2025 at 10:08 AM revealed Resident #3's door name had a red dot beside it. He was lying in bed and sat up on the side of the bed. Resident #3 had a catheter in place. CNA D came in to Resident #3's room and assisted him to his wheelchair. CNA D handled Resident #3's catheter bag without any PPE. She then reapplied his linen to his bed without gloves or other PPE. CNA D left Resident #3's room with a soiled linen bag without performing hand hygiene. There was not any PPE observed in the room or outside in the hallway.During an interview on 7/15/2025 at 10:10 AM, CNA D said she received training on infection control and EBP. She said Resident #3 required EBP and that was why he had a red dot by his name outside the door. She said with EBP she should have put on was a gown and gloves before providing any care and she should have washed her hands before leaving the room. She said by not following the infection control measures infections could spread.Record review of a Certified Nurse Aide Proficiency Evaluation Tool, dated 11/01/2024, revealed CNA D demonstrated satisfaction training for infection control.2. During an observation on 7/15/2025 at 10:54 AM, in the hallway of hall 400 was an ice cooler. The cooler had a compartment that had an ice scoop with a white towel inside that had a black substance on it along with the inside of the compartment.During an observation and interview on 7/15/2025 at 3:22 PM, CNA E was on hall 400 and said she was assigned to that hall (400) that day and had been working at the facility for a year. She said the nurse aides were responsible for passing ice to the residents about 2-3 times a day. She said they kept ice in a cooler on the halls and the ice scoop was kept in a tray by the cooler. She looked inside the ice scoop compartment and said the towel was dirty and the tray needed to be cleaned. She said they normally placed the scoop on a towel, and she guessed she never looked inside of the scoop compartment to see if it was dirty or not. She said residents could get sick if the scoop was dirty and they drank dirty ice water. She said there was dirt, and it definitely needed to be cleaned. CNA F was present on the hall and heard the conversation and took the cooler off of the hall.During an interview on 7/15/2025 at 3:31 PM, CNA F said the ice coolers were supposed to be taken to the kitchen once a week and the kitchen staff cleaned the coolers for them. She said she observed the compartment when she removed it from the hall, and it was dirty. She said they did not normally place a towel in the ice scoop compartment. She said using a towel could hold moisture and create germs and residents could get sick. 3. Record review of Resident #14's admission Record, dated 7/16/2025, indicated a [AGE] year-old male resident who was admitted to the facility on [DATE].Record review of Resident #14's active physician orders, dated 7/16/2025, indicated he had diagnoses of Parkinson's disease (a condition that affects the brain and spinal cord), UTI (an infection that affects the urinary system), dementia (a decline in thinking abilities such as memory that can interfere with daily life), and pneumonia (infection in the lungs). An order dated 7/14/2025 for meropenem intravenous solution (antibiotic) one gram every 8 hours related to pneumonia with a start date of 7/15/2025.Record review of Resident #14's MDS Assessments indicated he was admitted to the facility on [DATE] and only had an Entry Assessment.Record review of Resident #14's care plan indicated it was still in progress. During an

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 1 of 4 resident hallways (Hallway 100) and the main dining room reviewed for environmental concerns. 1. The facility failed to ensure rooms 101, 103, 106, and 107 did not have soiled floors on 7/15/2025 and 7/16/2025. 2. The facility failed to ensure the floors on 100 hallway did not have soiled floors on 7/15/2025 and 7/16/2025. 3. The facility failed to ensure the dining room did not have soiled floors on 7/15/2025 and 7/16/2025. These failures could place residents at risk of a diminished quality of life. Findings include: During multiple observations on 7/15/2025 from 4:02 PM to 4:21 PM and on 7/16/2025 from 9:00 AM to 9:15 AM; rooms 101, 103, 106 and 107 the 100 hallway and main dining room were observed with black residue on the floor tiles in the rooms and bathrooms and floors were sticky. There was a buildup of thick black residue at the base boards and around furniture. During an interview on 7/16/2025 at 10:08 AM, Housekeeper L said she swept and mopped the floors, but the facility no longer had a floor technician to deep clean the tiles. She said the cleaning solutions they used would not breakdown the black buildup and the tiles needed to be stripped and waxed. She said the floors being dirty could affect the residents' well-being. During an interview on 7/16/2025 at 11:18 AM, the Housekeeping Supervisor said she oversaw the cleaning of her staff and tried to buff the floors to make them cleaner, but it did not work. She said she was not capable of stripping and waxing the floor tiles and the facility no longer had a floor technician to do so. She said the floors not being clean could make the residents upset about the environment. During an interview on 07/16/2025 at 3:19 PM, the Administrator said the housekeeping supervisor was responsible for maintaining the facility environment and floors. He said they no longer had a floor technician and have not had any luck finding a new one. He said floors that were not maintained in a clean manner could affect residents' quality of life and he expected the floors and environment to be clean. Record review of the facility's policy titled Homelike Environment, dated February 2021, indicated .residents are provided a safe, clean, comfortable, and homelike environment