

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Windsor Arbor View		STREET ADDRESS, CITY, STATE, ZIP CODE 218 Baltic Edinburg, TX 78539	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 residents out of 8 (Resident #77, Resident #50, Resident #26) that were reviewed for safe environment. The facility failed to ensure bathroom sink water temperatures were between 100-110 degrees Fahrenheit in occupied rooms for Resident #77, Resident #50 and Resident #26. These failures could affect residents by placing them at risk for diminished quality of life due to the lack of a well-kept environment and water temperatures over 110 degrees Fahrenheit, placing residents at risk of being in an unsafe environment and at risk for burn injuries. The Findings Included: 1. Record review of Resident #77's face sheet dated 12/17/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included: Orthopedic Care Aftercare following Surgical Amputation, Dementia (a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life, caused by brain cell damage, not a normal part of aging), Depression, Muscle Wasting and Atrophy (thinning or loss of muscle mass), Type 2 Diabetes Mellitus (body either doesn't use insulin effectively or can't produce enough to manage blood sugar). Record review of Resident #77's Comprehensive MDS assessment, dated 11/03/2025 revealed a BIMS score of 15 indicated she was cognitively intact. She was independent of self-care. 2. Record review of Resident #50's face sheet dated 12/17/2025 reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included: Metabolic Encephalopathy (a change in how the brain works due to an underlying condition), Type 2 Diabetes Mellitus (body either doesn't use insulin effectively or can't produce enough to manage blood sugar), Anxiety, Dementia (a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life, caused by brain cell damage, not a normal part of aging), Depression, Need for Assistance with Personal Care. Record review of Resident #50's Comprehensive MDS assessment, dated 11/12/2025 revealed a BIMS score of 05 indicated that Resident #50 was severely cognitively impaired. She required maximal assistance for toileting hygiene and was dependent on staff for mobility. 3. Record review of Resident #26's admission Record dated 12/17/25 reflected a [AGE] year-old female with an admission date of 07/17/25. Her diagnoses included Type 2 Diabetes Mellitus without complications (body either doesn't use insulin effectively or can't produce enough to manage blood sugar), Essential Primary Hypertension (high blood pressure) and Hypothyroidism (thyroid gland doesn't make enough thyroid hormones to meet your body's needs). (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26's admission Quarterly MDS assessment dated [DATE] reflected a BIMS score of 10, which indicated she had moderate cognition impairment. Section GG: Functional Abilities revealed her functional limitation in range of motion was coded as no impairment in upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). Personal hygiene: Score: 04 (supervision or touching assistance) has the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excluding baths, showers and oral hygiene). During an observation on 12/15/25 at 10:49 a.m. the hot water faucet in Resident #26's bathroom was not warming up after a minute of running the water. During an observation on 12/16/2025 at 3:30 p.m. with the Maintenance Director and using the thermometer the bathrooms sink hot water temperatures were: Resident #77's and Resident #50's bathroom sinks hot water temperatures were 115 degrees Fahrenheit. During an observation on 12/16/2025 at 3:41 p.m. with the Maintenance Director and using the thermometer , Resident #26's bathroom hot water faucet sink temperature was at 81 degrees Fahrenheit. In an interview on 12/15/2025 at 9:59 a.m. with Resident #77, she stated that she does use the restroom sink and she has not been burned. She stated that she adjusted the water temperature before she used it. In an interview on 12/15/25 at 11:01 a.m. Resident #26 stated when she had opened the hot water faucet it was not warm or hot. She stated she would like to have the option to use warm water. Resident #26 stated she did not tell any of the staff about it because she thought they would not be able to fix it. In an interview on 12/15/2025 at 3:30 p.m. with the Maintenance Director, he stated that he checks the water temperatures at least two to three rooms in each hall every day and the last time he checked them was yesterday (12/14/2025). The Maintenance Director stated that he documented the temperature readings on a paper daily and then entered it in TELS at the end of the week. He stated if they were not within range, that he would notify the Administrator right away and adjust the temperature. The Maintenance Director stated the hot water temperature should not be over 110 degrees Fahrenheit. The Maintenance Director stated that the negative outcome of the water temperature being too hot in the resident's restroom was that the residents could get burned. In an interview on 12/17/25 at 3:15 p.m., the Administrator stated that the Maintenance Director randomly checked the water temperatures daily and enters the temperatures weekly in TELS. She stated that each hall shares the same boiler. She stated that the ambassadors, the management team, also check the water with their hands. If it felt too hot, they notify the Maintenance Director so he can check it with the thermometer. She stated the hot water should not be over 112 degrees Fahrenheit. She stated that if the water temperature was out of range either too hot or too cold, then the concern would be entered into TELS. She would also be notified by the Maintenance Director. They will then contact a plumber. She stated the negative outcome of the hot water being too hot was that the residents could get burned. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the Water Temperature TELS Logbook documentation for the week of 12/10/2025-12/17/2025 revealed minimal variation of temperature between 89 to 110 degrees Fahrenheit. Review of facility's incidents and accidents logs dated 10/2025, 11/2025, and 12/2025 did not reveal any injuries to residents due to hot water. Review of the facility's Grievance logs dated 10/2025, 11/2025, and 12/2025 did not reveal any complaints of water temperature being too hot. Review of the facility's Instructions Direct Supply TELS provided the following information: 1. Ensure patient room water temperatures are between 100 degrees and 110 degrees Fahrenheit or as specified by state requirement). Texas 100-110 degrees Fahrenheit 5. Common area bathrooms, public bathrooms and any other areas having sinks should be checked and recorded as well. Record results in the water temperature log 1. Note any discrepancies 2. Adjust water heater setting as required 3. Retest as necessary Review of the facility's Grievance logs dated 10/2025, 11/2025, and 12/2025 did not reveal any complaints of water temperature being too hot.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish 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 16 residents (Resident #29, Resident #117, and Resident #9) observed for infection control issues in that: 1. LVN H did not put on PPE when she entered Resident #29's room who was on contact precautions. 2. The facility failed to ensure Resident #117's breathing mask for his nebulizer (a medical device that turns liquid medicine into mist that could be inhaled through a face mask) was properly stored when not in use on 12/15/2025. 3. CNA A failed to hand sanitize before entering and after exiting Resident #9's room. Resident #9 was on Enhanced Barrier Precautions. These deficient practices could place residents at-risk for infection due to improper infection control practices and respiratory infection. The findings included: 1. Record review of Resident #29's face sheet dated 12/17/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with an original admit date of 02/13/2024. Resident #29 had diagnoses which included the following: Metabolic Encephalopathy (a change in how the brain works due to an underlying condition), Type 2 Diabetes Mellitus (body either doesn't use insulin effectively or can't produce enough to manage blood sugar), Muscle Wasting and Atrophy (thinning or loss of muscle mass), Depression, Hemiplegia (paralysis or weakness of one side of the body), and Gastro-Esophageal Reflux Disease (a condition in which the stomach contents leak backwards from the stomach into the esophagus). Record review of Resident #29's Comprehensive MDS assessment, dated 12/01/2025, reflected that the resident had a BIMS score of 12 which indicates moderate cognitively impaired. Record review of the Physician Order Summary reflected Resident #29 had Contact Isolation every shift for ESBL to urine. Start Date: 12/15/25. Record review of the most recent Care Plan on 12/17/25 for Resident #29 reflected the resident had an infection of the (UTI/ESBL) Date Initiated: 12/15/2025. Interventions: Give antibiotic therapy as ordered (Meropenem until 12/22/2025) Date Initiated: 12/15/2025. Maintain Contact Isolation .Date initiated 12/15/2025. Observation on 12/15/2025 at 2:45 p.m. revealed LVN H entered Resident #29's room without donning a gown and gloves. A red contact precaution sign was observed above the room number with the following instructions: wear gown to enter the room, wear gloves when entering the room, and discard gowns in the room. In an interview on 12/15/25 at 2:50 p.m., LVN H stated she was aware that Resident #29 was on contact precautions due to ESBL to the urine. She stated that PPE was to be used when entering the room. She stated that contact precautions required staff to sanitize, wear a gown, and gloves prior to going into the room. LVN H stated that it slipped her mind and she forgot to put PPE on prior to going into the room. She stated that if they did not follow the instructions on the precaution signs located outside of resident rooms, they could spread infection. LVN H stated that the last infection control in-service she attended was a week ago. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/15/2025 at 2:55 p.m. with Resident #29 states she was aware that she was on isolation due to a urine infection. She stated that today was the first day. She stated that the staff had been going into her room wearing PPE, with the exception of LVN H. 2. Record review of Resident #117's face sheet dated 12/16/2025 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #117 had diagnoses which included the following: Acute Respiratory Failure with Hypoxia (a condition where the lungs cant get enough oxygen into the blood), Acute Pulmonary Edema (excess fluid buildup in the lungs air sacs), Gastrostomy (a tube inserted through the wall of the abdomen directly into the stomach), Dementia (a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life, caused by brain cell damage, not a normal part of aging), Alzheimer's, and Heart Failure (the heart cant's pump enough oxygen-rich blood for the body's needs, causing fluid backup and symptoms like shortness of breath, fatigue, and swelling). Record review of Resident #117's MDS assessment, dated 12/12/2025, reflected that the resident had a BIMS score of 0 which indicated he was severely cognitively impaired. Record review of the Physician Order reflected Resident #117 had Ipratropium-Albuterol Inhalation solution three times a day. Start Date: 12/12/2025. Record review of the most recent Care Plan on 12/17/25 for Resident #117 reflected the resident had altered respiratory status/difficulty breathing r/t Pulmonary Edema, acute respiratory failure Date Initiated: 12/14/2025. Interventions: Administer medication as ordered. Date Initiated: 12/14/2025. Observation on 12/15/2025 at 9:15 a.m. revealed Resident #117 was in his bed, with eyes closed. A nebulizer machine was noted on the resident's side table with a breathing mask connected to it. The breathing mask was not bagged. In an interview on 12/15/2025 at 9:25 a.m., LVN M confirmed that the breathing mask was not bagged. She stated that she used it earlier today, 12/15/25. LVN M stated she was going to come back and place it in a bag but forgot. She stated Resident #117 had breathing treatments that were scheduled. She stated that the mask should be bagged when not in use to ensure cleanliness. LVN M stated that it was important for infection control and hygiene as well. She stated she would get another mask and make sure it was inside the plastic bag to prevent any respiratory infection. She stated she had in service on respiratory care and infection control about 2 weeks ago. In an interview on 12/15/2025 at 9:43 a.m., ADON L stated the breathing mask was supposed to be in a bag when the resident was not using it to prevent cross contamination and worsening of any respiratory issues. She stated that this was the nurse's responsibility. She stated that she replaced the mask and placed it in a bag. She stated the bag should be labeled with the resident's name, room number, and date. ADON L stated that the negative outcome of not having the breathing mask in a bag would be respiratory infection. She stated that she conducted an in-service a couple months ago as well as a respiratory therapist. She stated that she goes and checks that masks are bagged but that she had not gotten to Resident #117's room. 3. Record review of Resident #9's admission Record dated 12/17/25 reflected an [AGE] year-old male with an admission date of 07/17/25. His diagnoses included Type 2 Diabetes Mellitus without complications (body either doesn't use insulin effectively or can't produce enough to manage blood sugar), Chronic Obstructive Pulmonary Disease, Unspecified (difficulty breathing due to airflow (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obstruction), and Acquired Absence of Left Upper Limb, Unspecified Level. Record review of Resident #9's admission MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated his cognition was intact. Record review of Resident #9's most recent care plan assessment reflected Resident has the need for Enhanced Barrier Precautions due to wound. Resident is at risk of infection. Interventions reflected; Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of precautionary measures. Observation on 12/15/25 at 9:58 a.m. revealed CNA A entered Resident #9's room without hand sanitizing or washing hands. It was also observed she exited Resident #9's room without hand sanitizing or washing hands. Observation on 12/15/25 at 9:58 a.m. revealed a sign placed on the outside of Resident #9's room titled Enhanced Barrier Precautions; Everyone must: Clean their hands, including before entering and leaving the room. In an interview on 12/15/25 at 9:59 a.m. CNA A stated she knew she was supposed to hand sanitize before entering Resident #9's room as well as after leaving but forgot to do so. She stated she receives in-services on infection control frequently and stated she had received it about 2 weeks ago. CNA A stated if she did not practice hand sanitizing like they told her to do, she could contaminate one resident to another if they have an illness or bacteria. In an interview on 12/16/2025 at 10:55 a.m. CNA I, stated that when there was a contact precaution sign up, PPE was required before going into the room. The required PPE would be a gown and gloves. She stated the last infection control in-service she attended was last week, but they do have them frequently. She stated they went over hand hygiene before entering rooms and when exiting rooms. In an interview on 12/16/2025 at 11:14 a.m. with CNA J, she stated she was familiar with Resident #29. She stated that she was on contact precautions and staff had to sanitize and put on PPE before entering the room. She stated that the last infection control in-service she attended was last week. She said they went over the posted signs. She said if a resident had a yellow EBP sign, they must wear gowns and gloves while providing care. If a resident had a red sign posted for contact precautions, they must wear a gown and gloves whenever entering the room. She said they must sanitize their hands before and after entering and exiting all rooms. She stated they must remove PPE before coming out of the rooms and wash hands or sanitize. In an interview on 12/16/2025 at 4:53 p.m. with LVN K, she stated that infection control in-services were conducted at least three times a month; the most recent one was approximately a week ago. She stated they went over handwashing. She stated they also had in-service for respiratory care. LVN K stated that it was the nurse's responsibility for placing the breathing masks in a bag when not in use. She stated that the bag would be labeled with the resident's name, date, and room number before leaving the room. LVN K stated this was important for infection control, and so that the mask does not touch the floor. She stated that for residents who were on contact precautions, staff must wear a gown and gloves before going into the room. She was to remove PPE before leaving the room and wash hands before exiting the room. In an interview on 12/16/25 at 3:25 pm ADON L stated residents who have any opening in their body (continued on next page)		

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident #44) reviewed for dignity. The facility failed to ensure CNA A did not stand while assisting Resident #44 with lunch on 12/15/25. This failure could place the residents at risk of not having the right to a dignified existence maintained. Findings included: Record review of Resident #44's admission record dated 12/15/25 reflected an [AGE] year-old male with an admit date of 01/18/20. His relevant diagnoses included vascular dementia (a decline in thinking skills caused by conditions damaging blood vessels, reducing blood flow and oxygen to the brain, often after strokes or mini-strokes), heart failure (the heart can't pump enough oxygen-rich blood for the body's needs, causing fluid backup and symptoms like shortness of breath, fatigue, and swelling), lack of coordination, and dysphagia (difficulty swallowing). Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated his cognition was severely impaired. His functional ability for eating (the ability to use utensils to bring food and/or liquid to mouth and swallow food and/or liquid once the meal is placed before the resident) was substantial/maximal (assist-helper does more than half the effort. Helper lifts or hold trunk or limbs and provide more than half the effort). Record review of Resident #44's quarterly care plan dated 08/14/25 reflected a focus of [Resident #44 has an ADL self-care performance deficit (date initiated 01/18/20 and revised 05/04/20) His interventions in part included Eating: the resident requires supervision assistance by (1) staff to eat (date 08/10/21 and revised on 08/10/21). During an observation on 12/15/25 at 12:35 pm, CNA A was observed as she walked into Resident #44's room to assist him with his lunch meal. CNA A stood on his left side the entire time she fed him. After Resident #44 was done eating, she was observed as she removed his lunch plate from his bedside table. In an interview on 12/15/25 at 12:40 am, Resident #44 said he was glad CNA A had assisted him with his lunch tray. In an interview on 12/15/25 at 12:45 pm, CNA A said the facility's protocol when assisting a resident with their meals was for the CNA to be sitting next at their level while feeding them. CNA A said the reason she had forgotten to get a chair and sit while she fed Resident #44 was because she had rushed to get to his room. She said a negative outcome for her not sitting while she fed Resident #44 was that maybe Resident #44 felt rushed when eating. In an interview on 12/16/25 at 2:36 pm, ADON B said Resident #44 required assistance with all his meals. She said CNAs and/or nursing staff were required to sit at the resident's level when feeding them. She said a negative outcome for Resident #44 not fed by a CNA who was sitting at his level would be a dignity issue. She said CNAs were in-serviced to sit while feeding resident in their rooms or in the dining room. In an interview on 12/16/25 at 2:46 pm., the DON said residents that required assistance with their feeding were fed by CNAs. She said, should be sitting next to the resident's bed. The DON said a negative outcome for a resident who was fed by a CNA while standing was a dignity issue and they might feel the CNA was rushing them. Record review of the facility's Promoting/Maintaining Resident Dignity During Mealtimes, dated 01/13/23 reflected: Policy: It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. Policy Explanation and Compliance Guidelines: 5. All staff will be seated, if possible, while feeding a resident.		

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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 observations, interviews, and record reviews, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for two of eight residents (Resident #44 and Resident #9) reviewed for accidents and hazards. 1. RN G failed to reposition Resident #9 using two employees as required by his care plan. 2. The facility left meal tray within reach for Resident #44 who required assistance with feeding allowing resident to reach drinks on tray. These failures place residents who require assistance with feeding and repositioning at risk of accidents and possible injuries. The findings included: The findings included: 1. Record review of Resident #9's Face Sheet dated 12/16/25 revealed an [AGE] year-old male was admitted to the facility on [DATE] with the following diagnoses: vascular dementia (a cognitive decline from brain damage due to reduced blood flow, often from strokes or tiny vessel issues, affecting thinking, memory, judgment, and walking), acquired absence of left upper limb (someone lost their left arm or part of it after birth). Record review of Resident #9's Care Plan, dated 6/5/25, documented Bed Mobility: Resident #9 required substantial/maximal assistance by two staff due to impaired mobility. Resident #9's quarterly MDS resident assessment, dated 12/2/25, documented Resident #9 needed partial/moderate assistance with roll left and right when lying on back. During a wound care observation on 12/16/2025 at 10:00am RN G failed to reposition Resident #9 using two employees as required by his care plan. WCN was washing his hands while RN G was repositioning Resident. During an interview on 12/16/25 at 10:30am, RN G said that he did not know Resident #9 was a two person assist. RN G said that he thought he was a one person assist, and he did not check the care plan. RN G said he was just assisting with the wound care. RN G said that the WCN should have checked the care plan. RN G said that if he did not follow the care plan, the resident or herself could be harmed. During an interview on 12/16/25 at 10:40am, WCN said that all staff could check the plan of care of each resident in the Point Click Care system (electronic health record). WCN said that he forgot to review the care plan before the wound care procedure. WCN said that he was worried about the wound care observation and that he forgot. WCN said that by not following the plan of care residents or staff could get injured. During an interview on 12/17/25 at 2:32pm, the DON said staff should follow the plan of care of each resident to do the proper repositioning. The DON said that both the resident and the staff could get injured if they failed to follow the plan of care. DON said that the facility did not have a policy for accidents and incidents. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Windsor Arbor View		STREET ADDRESS, CITY, STATE, ZIP CODE 218 Baltic Edinburg, TX 78539	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #44's admission record dated 12/15/25 reflected an [AGE] year-old male with an admit date of 01/18/20. His relevant diagnoses included vascular dementia (a decline in thinking skills caused by conditions damaging blood vessels, reducing blood flow and oxygen to the brain, often after strokes or mini-strokes), heart failure (the heart can't pump enough oxygen-rich blood for the body's needs, causing fluid backup and symptoms like shortness of breath, fatigue, and swelling), lack of coordination, and dysphagia (difficulty swallowing). Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated his cognition was severely impaired. His functional ability for eating (the ability to use utensils to bring food and/or liquid to mouth and swallow food and/or liquid once the meal is placed before the resident) was substantial/maximal (assist-helper does more than half the effort. Helper lifts or hold truck or limbs and provide more than half the effort). Record review of Resident #44's quarterly care plan dated 08/14/25 reflected a focus of [Resident #44 has an ADL self-care performance deficit (date initiated 01/18/20 and revised 05/04/20) His interventions in part included Eating: the resident requires supervision assistance by (1) staff to eat (date 08/10/21 and revised on 08/10/21). In an observation and interview on 12/15/25 at 8:55 am, Resident #44 was observed sitting upright in his hospital bed with his breakfast tray positioned directly in front of him and within reach. Resident #44 had spilled coffee on his breakfast plate; and tray and some had spilled down to his bed sheet (left side) closer to the bed rail and away from him. Resident #44 said he attempted to reach for the coffee cup but dropped it. He said he had not gotten burned because the tray had been sitting at his bedside table for a while before he reached out for it (not able to say how long) and the coffee was already cold. Resident #44's clothing was dry. Resident #44 said he did not like to be fed because he felt he could feed himself. Surveyor was not able to take the temperature of the breakfast plate because it was soaked in coffee. In an observation and interview on 12/15/25 at 8:58 am, CNA A walked into Resident #44's room and said she was going in to assist in feeding him. She noticed Resident #44 had spilled coffee on his breakfast plate, tray, and bed sheet and quickly asked if he had burned himself. Resident #44 replied no, the coffee was cold and she immediately removed his breakfast tray. She was observed as she checked his arms and called out for the nurse. An observation on 12/15/25 at 9:03 am, revealed LVN C was observed as he walked into Resident #44's room and closed the door. In an interview on 12/15/25 at 9:20 am, LVN C said Resident #44 had been assessed and no injuries were noted. In an interview on 12/15/25 at 9:24 am, CNA A said Resident #44 required assistance with all his meals. She said Resident #44 at times refused to be fed because he thought he could still feed himself. She said the facility's protocol for residents who needed assistance with their meals was that only CNAs could deliver the meal tray, and they must stay with the resident to assist in feeding them. She said CNAs were not allowed to deliver meal trays and leave them in the resident's room unattended. CNA A said she had not delivered Resident #44's breakfast tray and had no idea who had delivered it. CNA A said she had been in-serviced in ADLs which included assisting residents with feeding. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's change in condition communication form dated 12/15/25 at 9:30 am, authored by LVN C, reflected a change in condition due to Resident spilled his coffee on himself during breakfast. Resident was assessed for possible burn on skin due to coffee spill. No redness, swelling or blistering noted on abdomen area or legs. Resident stated that coffee was not hot and that he did not have any pain. will continue to monitor. no injury sustained. Record review of Resident #44's progress note dated 12/1/25 at 2:43 pm, authored by LVN C, reflected Resident had an accident and spilled his coffee on himself. No burn marks, no redness, no swelling noted. Resident stated that he had no pain. Resident stated that coffee was not hot. Notified NP NNO given. In an interview on 12/16/25 at 2:27 pm, LVN D said after the meal cart had been delivered to the assigned hall, it was the responsibility of the charge nurse to check each meal tray to ensure it matched the resident's prescribed diet, including correct texture, liquid consistency, and any food allergies. She said once she confirmed the meal tray was correct, she would initial the meal ticket. She would then handover the tray to the staff that were helping in passing out trays. She said they first served those residents that were able to eat on their own. LVN D said the meal trays that were for residents that needed assistance could only be delivered by CNAs. She said whenever a CNA delivered a meal tray, that meant he/she was ready to assist the resident with their meal. LVN D said CNAs were not allowed to leave a meal tray in a resident's room unattended. She said the nursing staff and CNAs were regularly in-serviced on the topics of ADLs and assisting residents with their meals. In an interview on 12/16/25 at 2:36 pm, ADON E it was the responsibility of the dietary aides to deliver the meal carts to their assigned halls. She said once the meal carts were at their assigned hall, it was the responsibility of the charge nurse to check each tray to ensure the diet and liquid consistency matched the resident's order. ADON E said staff knew if the meal ticket had the charge nurse initials, it was ready for distribution. ADON E said aside from CNAs, the facility's management team also assisted in distributing meal trays. She said the management team were only allowed to distribute meal trays to residents that were able to eat on their own and were not allowed to assist in feeding. ADON E said residents that were able to eat on their own were first to receive their meal trays. She said resident's that required assistance to eat had their trays delivered by CNAs. She said that meal trays were only delivered when a CNA was available to assist, since trays were not to be left unattended in residents rooms. ADON E was not able to say if there were any negative outcomes to Resident #44 having his meal tray within reach/unattended. In an interview on 12/16/25 at 2:46 pm, the DON said aside from CNAs, management staff also assisted in distributing meal trays to residents who ate in their rooms. She said management staff were only allowed to distribute meal trays to residents that were able to eat on their own. The DON said residents who required assistance had their meal trays delivered only by CNAs. She said that meal trays were only delivered when a CNA was available to assist, since trays were not to be left unattended in residents rooms. The DON said Resident #44 had not sustained any injuries when he spilled his coffee. The DON said a negative outcome for leaving a meal tray unattended and within reach could be the resident might reach for it and spill the liquids. The DON said the facility did not have a supervision policy.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice for 1 of 6 residents reviewed for intravenous fluids. (Resident #96) The facility failed on 12/15/2025 to ensure the dressing on Resident #96's peripheral intravenous line (a short flexible tube inserted into the vein to administer fluids and medications) was dated and initialed. This failure could place residents at risk of not receiving the appropriate IV care and services. The findings included: Record review of Resident #96's admission record dated 12/15/25 revealed a [AGE] year-old female with diagnosis of Pneumonia (is a lung infection that inflames the air sacs, causing them to fill with fluid or pus, leading to cough, fever, chills, and difficulty breathing). Chronic Obstructive Pulmonary Disease (is a progressive lung disease that blocks airflow, making it hard to breathe, and includes conditions like emphysema and chronic bronchitis). Record review of Resident #96's care plan dated 8/29/25 revealed: Resident is on IV medications r/t pneumonia. Record review of Resident #96's quarterly MDS assessment dated [DATE] revealed Resident #96's BIMS score was a 7 which indicated severe cognitive impairment. Section O - Special Treatments, Procedures, and Programs revealed Resident #96 was not marked for receiving IV medications. Record review of Resident #96's Order Summary Report dated 12/15/2025 revealed Resident #96 had an order for Sodium Chloride Intravenous Solution. 0.9% (sodium chloride). Use 2 liter intravenously every shift for hydration for 2 days infuse at 60 mL/hr x 2 liters. Start date 12/13/2025. During an observation on 12/15/25 at 9:25 a.m. Resident #96 was in her room sitting in her wheelchair. She had a peripheral intravenous lock covered with a transparent dressing with no date and no initials on her right hand. There were no signs or symptoms of infection or infiltration noted at the IV site. During an interview on 12/15/25 at 9:30 a.m., LVN F stated she was the nurse for Resident #96. She stated that the nurse who initiated the IV was responsible for labeling the dressing with the date of placement and initials. LVN F stated that it was important to label the IV site to know when the IV was placed or the last time it was changed. She stated that if the IV was not changed within the ordered time, then it could cause an infection. She stated that the last time she had checked the resident's IV site was this morning, at the beginning of her shift. LVN F stated that the IV site should be checked at every shift. The site was to be checked for any signs of infection, and the date and signature on the dressing. She stated she could not recall when the last training she had received on IV administration was. LVN F confirmed the resident had a peripheral IV lock on her right hand covered with a transparent dressing that was not labeled or dated. In an interview on 12/17/25 at 3:10 p.m., the DON stated she did not know why the dressing label had not been dated and initialed. The DON stated that the LVN F inserted the IV should have dated and initialed the dressing that was over the IV site. The DON stated that labeling the insertion site dressing was taught in nursing school and every nurse should have known to label it. She stated that the negative outcome of not labeling the dressing was that it could go over the recommended standard time of every 72 hours and could cause infection. During an interview on 12/17/25 at 4:00 p.m., the DON stated that she could not find a policy on IVs.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 2 of 26 residents (Resident #43 and Resident #54) reviewed for effective pest control. The facility failed to ensure Residents #43 and #54's room was free of pests. These failures could place residents at risk of exposure to bugs and bug bites. Findings included: Observation on 12/15/25 from 9:00 AM-9:30 AM revealed Resident #54's and Resident #43's room had one live cockroach next to floor mat. Record review of the facility's Pest Control log revealed 4 times cockroaches had been reported since October 2025. Pest control had treated for cockroaches every month. The last visit was on 11/15/25. In an interview on 12/16/25 at 5:30 PM the Maintenance Director stated their pest control company treated the whole facility and any rooms that were identified by staff or residents as having live bugs. The pest control company also sealed up any openings they discovered during their treatments. He stated the residents deserved to have a bug and rodent free facility for their overall health. He stated he did not know of a policy for pest control other than if they were required to have a pest control program. He stated that the pest control program comes every month. During an interview on 12/17/2025 at 3:20 p.m., ADM stated they have a pest control vendor entering the facility monthly and as needed. The staff do rounds every morning to check the environment and would report any concerns they found. If there were any concerns, we do a deep clean in that room. She stated staff documents it in the pest control sighting logbook. She stated that they do not have a pest control policy. Record review of Pest Control Invoice, dated 11/15/2025, revealed the following services, Regular Pest Service and Flying Insect Program. Under General Comments/Instructions: Talked to contact, look over sighting log and inspected and treated rooms 502, 618, 612, 604, 404, 406 and 603 for Roaches. Interior . Inspected and treated all common areas, kitchen, dining, laundry, employees' area and hallways checked and changed glue borders as needed. Exterior .Inspected and treated perimeter of building and replaced baits in rodent bait stations.		