STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676225	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell County Nursing and Rehabilitation Center	971 W I 20 Colorado City, TX 79512

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record reviews, the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promoted the maintenance or enhancement of their quality of life, recognizing each resident's individuality and the facility failed to protect and promote the rights of 7 of 20 confidential residents reviewed for resident rights. The facility failed to ensure staff were not on their personal cell phones while providing care, which included assisting residents with their showers. This failure could place residents at risk for a diminished quality of life and loss of dignity and self-worth.Findings include: Interview at an undisclosed date and time revealed seven confidential residents stated the use of cell phones by CNAs while performing care made them feel ignored, not a priority, embarrassed, concerned the CNA could make a mistake due to distraction by the cell phone conversation, and, most of all, their privacy was violated. The seven confidential residents stated the use of cell phones by CNAs occurred on every shift. Confidential residents also stated staff utilized their cell phones while feeding residents during meals; residents stated the use of the cell phones while feeding residents forced those residents to have significant wait times between bites. The seven confidential residents stated they did not know the names of the CNAs who utilized their cell phones while performing care. The confidential residents stated cell phone usage of the CNAs while performing care happened in the facility often, they said every CNA in the facility utilized their cell phone while performing care. During an interview on 04/28/26 at 2:15pm, the DON stated residents should be provided with privacy during resident care; the staff's attention should be 100% on the Resident. She stated all staff were trained in privacy, resident rights, dignity, and cell phone usage during orientation and through continuous education by department heads and the DON. She stated staff were monitored by sporadic rounds completed by the DON and the ADON. She stated cell phones should never be used in patient care areas, cell phones should not be utilized anywhere Residents were visible. She stated the potential negative outcome could be feeling ignored and loss of dignity. During an interview on 4/28/2026 at 3:33pm, the ADM stated staff should only be focused on Residents while performing care. The ADM stated all staff were trained on resident rights, dignity, and cell phone usage during the on boarding process and in-services. She stated cell phones should only be used during breaks; personal calls were not allowed while staff were on the clock. She stated cell phones should be kept in the breakroom. Staff were monitored for cell phone use by rounding completed by the ADM and the DON. The ADM stated the potential negative outcome for Residents, if staff used their cell phones while performing care, was Residents could feel ignored. Record review of the facility's policy dated October 2025 titled Resident Rights revealed the following: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and ImplementationFederal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:a dignified existence to be treated with respect, kindness, and dignityt. privacy and confidentiality

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to participate in the development and implementation of his or her person-centered plan of care for 13 of 13 residents (Residents #1, #2, #20 and 10 confidential residents) reviewed for comprehensive care plans.The facility failed to record any documentation inviting Resident #1 or their representative to the care plan meetings. The facility failed to record any documentation inviting Resident #2 or their representative to the care plan meetings. The facility failed to record any documentation inviting Resident #20 or their representative to the care plan meetings. The facility failed to ensure 10 confidential residents of the facility were provided with prior notice to participate in their care plan meetings. These failures could place residents at risk of not being involved in their plan of care and having their needs met. The findings include:1. Record review of Resident #1's facesheet dated 2/5/2026 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Fracture of right femur, anemia (low levels of red blood cells), pneumonia (infection that inflames the air sacs in lung), hypertension (blood forcefully pushes against artery walls), acute diastolic congestive heart failure (left ventricle becomes stiff and cannot fill properly with blood), macular corneal dystrophy (progressive genetic eye disease), history of cerebral infarction (blockage in a brain blood vessel), and history of falling. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 had minimal difficulty with hearing, impaired vision and has corrective lenses. Resident #1's BIMS score was 11/15 (moderate cognitive impairment). Resident #1 had functional limitation in range of motion to one side lower extremity. Uses walker and wheelchair for mobility. Resident #1 required limited to moderate assistance for ADL's, she was continent of bladder and bowel. The active diagnosis listed was fractures and other multiple trauma. Resident #1 received PRN pain medication, rates pain 5/10. Resident #1was 62 inches, 145 pounds and received a mechanically altered therapeutic diet. Resident #1 required surgical wound care, applications of nonsurgical dressings other than to feet, and application of dressings to feet. Resident #1 is took an antibiotic, opioid, and antiplatelet. Resident #1 received Occupational Therapy and Physical Therapy. Resident #1's overall goal was to be discharged to the community. There was an active discharge plan already occurring for the resident to return to the community. Record review of Resident #1's care plan initiated on 2/17/2026 addressed Resident #1's triggered concern areas from the admission MDS dated [DATE], but did not reveal any documentation of a IDT or care plan meeting. Record review of Resident #1's progress notes and assessments did not reveal any documentation of an IDT or care plan meeting between the dates 2/5/2026 through 4/28/2026. During an interview on 4/27/2026 at 9:26 AM with Resident #1 on whether she had participated in a care plan/IDT meeting to discuss her care and discharge plans. Resident #1 voiced she did not think so. During an interview on 4/28/2026 at 9:30 AM with Resident #1 and a family member revealed the facility communicated with the family member for any updates or orders. The family member voiced that he had probably talked to everyone individually, but not as part of a care plan/IDT meeting.2. Record review of Resident #2's facesheet dated 4/25/2026 revealed a [AGE] year-old male who was admitted to the facility on [DATE], with a readmission on [DATE]. Resident #2 had diagnoses which included: Dementia (progressive decline in cognitive function), altered mental status (sudden or gradual change in brain function), chronic viral hepatitis C (long-lasting liver infection), hyperlipidemia (high levels of fatty or waxy compounds in the blood), depressive disorder (mental illness causing persistent sadness), post-traumatic stress disorder (mental health condition triggered by experiencing or witnessing a terrifying event), polyneuropathy (damage to multiple nerves causing numbness, tingling, or muscle weakness), osteoporosis (bone disease where density decreases), urethral fistula (abnormal connection between the urethra and skin or other organ), and traumatic brain injury (sudden bump, (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blow, jolt that disrupts normal brain function). Record review of Resident #2' Quarterly MDS, dated [DATE], revealed Resident #2 had impaired vision and had corrective lenses. Resident #2's BIMS score was 5/15 (severe cognitive impairment). Resident #2 used a wheelchair for mobility. Resident #2 required extensive assistance for ADL's. Resident #2 was frequently incontinent of bladder and had an ostomy for bowel. Active diagnosis was non-traumatic brain dysfunction. Resident #2 received scheduled and prn pain medication. Resident #2 had two falls with no injury and one fall with injury (except major) since the previous assessment. Resident #2 was 72 inches, 146 pounds and received mechanically altered therapeutic diet. Resident #2 had skin tears and moisture associated skin damage with applications of nonsurgical dressings and applications of ointments/medications other than to feet. Resident #2 took an antidepressant and antibiotic. Resident #2 did not wish to return to the community. Record review of Resident #2's care plan initiated on 10/27/2025 addressed Resident #2's triggered concern areas from the Quarterly MDS dated [DATE], but did not reveal any documentation of a IDT or care plan meeting. Record review of Resident #2's progress notes and assessments did not reveal any documentation of a IDT or care plan meeting between the dates 2/26/2026 through 4/28/2026. During a phone interview on 4/27/26 at 1:10 PM with Resident #2's family member it was revealed the facility was good to contact him for any changes. The family member stated he had not been invited or had he attended any care plan/IDT meeting regarding Resident #2's care. 3. Record review of Resident #20's facesheet dated 1/19/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE], with a readmission on [DATE]. Resident #20 had diagnoses which included: Dementia (progressive decline in cognitive function), acute kidney failure (rapid often reversible loss of kidney function), acquired absence of specified parts of digestive tract (refers to the partial or complete surgical removal of digestive organs), cholecystitis (gallbladder inflammation), atrial fibrillation (rapid, irregular and, disorganized heartbeat from the hearts upper chambers), arthritis (inflammation or degeneration of joints), type 2 diabetes mellitus (chronic condition where the body resists insulin or fails to produce enough causing high blood sugar), insomnia (difficulty falling or staying asleep), depressive disorder (mental illness causing persistent sadness), hypertension (blood forcefully pushes against artery walls), and gastro-esophageal reflux disease (stomach acid frequently flows back into the esophagus causing discomfort). Record review of Resident #20's Quarterly MDS, dated [DATE], revealed Resident #20 had impaired vision and had corrective lenes. Resident #20 had a BIMS score of 6/15 (severe cognitive impairment). Resident #20 used a wheelchair for mobility. Resident #20 required extensive assistance for ADL's. Resident #20 was incontinent of bladder and bowel. Resident #20 ?s active diagnosis was medically complex conditions. Resident #20 received scheduled pain medication. Resident #20 was 60 inches, 135 pounds, and received a mechanically altered therapeutic diet. Resident #20 had moisture associated skin damage with applications of nonsurgical dressings. Resident #20 took seven days of insulin injections and took an antidepressant. Resident #20 did not wish to return to the community. Record review of Resident #20's's care plan initiated on 9/4/2025, addressed Resident #20's triggered concern areas from the Quarterly MDS dated [DATE], but did not reveal any documentation of a IDT or care plan meeting. Record review of Resident #20's progress notes and assessments did not reveal any documentation of a IDT or care plan meeting between the dates 2/26/2026 through 4/28/2026. During an interview with Resident #20's family member on 4/28/2026 it was revealed she had never been invited to a care plan/IDT meeting to discuss Resident #20's care. Interview at an undisclosed dated and disclosed time revealed 10 confidential residents who stated they did not know what a care plan meeting was. They stated they were not invited to a care plan meeting and did not know what a care plan meeting was for. During an interview on 4/28/2026 at 12:45 PM with the MDS Coordinator revealed they did not send letters or have care plan meetings. The IDT team got together to discuss the plan of care, then the DON would call the families with any updates. During an interview on 4/28/2026 at 1:15 PM with the DON revealed they did get the IDT team together and went over the residents care plan. Usually, IDT team members would give input during the morning meeting. The (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated then she called the family and gave them the whole spill of that every 92 days there was a Quarterly assessment, then the next one is the annual assessment. The DON told the family member/responsible party for the residents at those times the IDT team got together to go over the plan of care. The DON stated she told the family member/responsible party if they would like to be here they could schedule a meeting to discuss it. The DON stated 9 out of 10 times they did not want to attend because they were out of town or there was a doctor appointment or something. The DON stated when COVID-19 happened they could not have the meetings and were doing it over the phone, so they just kept doing it that way. The DON stated she would look to see if there was any documentation when she notified the families. The DON voiced that their EMR program was basic, and she did not have anywhere to document her notes, so she noted it on paper. The DON stated they did not send letters to invite residents or family members to a care plan meeting. The DON stated she communicates with the family members with any updates or changes in that residents care. During an interview on 04/28/2026 at 1:58 PM with the Administrator it was revealed when she first started working at the facility she asked the MDS nurse about the care plan meeting and she told her she did not do them, but the DON notified the families with any updates. The Administrator voiced the DON told her during COVID-19 they could not do them, so they did them by phone, and they never started it back. Regarding the importance of having care plan meetings, the Administrator voiced it was important to notify the resident/family of any changes to their plan of care and a chance for them to talk to the IDT meeting for any questions or concerns. Maybe they were full code and now want to be a DNR, or maybe diet preferences changed, a chance to check on vaccines, just a chance to go over everything. The Administrator voiced she had always had care plan meetings in other facilities where she had worked.Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised March 2022, revealed: 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:a. participate in the planning process;b. identify individuals or roles to be included;c. request meetings;d. request revisions to the plan of care;e. participate in establishing the expected goals and outcomes of care.f. participate in determining the type, amount, frequency and duration of care;g. receive the services and/or items included in the plan of care; andh. see the care plan and sign it after significant changes are made.5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences.6. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to make information on how to file a grievance or complaint available to the residents for 9 of 10 confidential residents reviewed for grievances. The facility failed to ensure 9 of 10 residents were provided, through postings in prominent locations, the Grievance Procedure, were provided information who the facility grievance official was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place residents at risk of unresolved grievances and decreased quality of life. Findings include: In Interviews and Record Review at an undisclosed date and time, 9 of 10 confidential residents stated they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. The residents stated they did not know where to acquire a grievance form, who to turn the form into, and what happened once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Observations of prominent postings on 04/28/2026 at 3:00pm; the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Interview with the ADM on 04/28/2026 at 3:35pm; the ADM stated she was the Grievance Officer for the facility. The ADM stated the Grievance form was available on a shelf on the wall in the entryway hallway and at the nurses' station. The ADM stated the Activities Director completed Grievance forms during monthly, resident council meetings when concerns were vocalized by Residents. The ADM stated staff also complete Grievance forms for some complaints that were discussed with them face to face with residents. The ADM stated she assigned the Grievance to the appropriate department, that department addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution is documented on the Grievance form, and the completed form is submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook for 3 plus years. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance. The ADM stated she would also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated she was not aware the Grievance procedure was not being discussed in Resident Council; the ADM agreed the availability of the Grievance forms, the Grievance procedure, and procedure for submitting a Grievance form anonymously should be explained to Residents at admission and continually discussed in monthly Resident Council meetings. Record Review of the Grievance policy on 04/28/2026 at 2:27pm; reflected a copy of the Grievance/complaint procedure should be posted on the resident bulletin board. Record Review of the Grievance Policy last updated in April 2017 reflected: Policy Statement:All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievances. Policy Interpretation and Implementation: The ADM has assigned the responsibility of grievance investigation to the grievance officer. Upon receiving a grievance, the grievance officer will investigate the allegations. The department director will be notified pf the nature of the complaint. The grievance officer will record and maintain all grievances on the Resident Grievance Log. The Grievance form will be filed with the administrator. The resident or person filing the grievance on behalf of the resident will be informed of the findings of the investigation. The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food and drink that was palatable, attractive and at a safe and appetizing temperature for one of one kitchen. A. Resident #8, #11, #13, #32 voiced concerned of cold food, flavor and/or texture.B. Five of the 9 foods sampled on the meal tray were cold.C. One of the 9 foods sampled on the meal tray was mushy.D. One of the 9 foods sampled on the meal tray was sticky. E. One of the 9 foods sampled on the meal tray was chunky. These failures could affect the forms of food provided in the facility (regular, mechanical chopped and pureed) and could result in a decline in residents' consumption of food and residents to have unwanted weight loss. The findings included: On 04/26/2026 during initial tour of facility, four Residents (#8, #11, #13, #32) voiced concerns about the food. During an interview on 04/26/2026 at 1:22 PM, Resident #32 was asked how the food was and she responded by saying It is bad, I mean greasy, no seasoning, no taste, is cold, never hot. She stated the kitchen is horrible, they can't cook, and she ate in her room and in the dining hall. During an interview on 04/26/2026 at 4:02 PM, Resident #13 was asked how the food was and she stated, The food is not good, no texture, no varieties, not even hot and I am tired of Mexican food and chicken. She further added, the vegetable today was overcooked, and I do eat both in my room and at the dining hall. During an interview on 04/26/2026 at 4:26 PM, Resident #11 was asked how the food tasted and he stated, I don't eat it, it is of poor quality, I eat sandwiches, you have to see it a few days, to understand and I do eat in my room. He further stated, I understand that they are under budget. During an interview on 04/27/2026 at 9:28 AM, Resident #8 was asked how the food was and she responded by saying I have trouble with mine, they get my dislikes, no variety. I do eat in my room, and it is cold, the chicken is so dry. A sample tray was requested on 04/27/2026 at 10:02 AM, of all the food forms served including the alternate plate and requested to have the sample trays delivered after the last hall tray was delivered. The sample tray on 04/27/2026 was delivered to the survey room at 11:43 AM. Sample tray findings found by the survey team and [NAME] A were the following: FOOD ITEMS Taste, Temperature, TextureRegular [NAME] MushyMechanical vegetable ColdMechanical [NAME] Cold/stickyPuree Chicken Cold/chunkyPuree vegetable Cold/no flavorPuree [NAME] Cold During an interview on 04/28/2026 at 10:26 a.m., [NAME] A stated, I have worked here for three and half years now, whoever is cooking the meal that day is responsible for monitoring of temperature, texture and flavor and I am not sure why the meal were not palatable, I don't have any reason for that. She stated that the kitchen middle steamtable was not working for a while now, I have spoken to the ADM and DM, both said they will send somebody. She further stated, I have trained myself, and have never seen the food palatability policy. She stated, because of the age the residents are, with health concerns such meals could cause food illness, and could be fatal over a long period of time. During an interview on 04/28/2026 at 11:14 a.m., [NAME] B stated, I am responsible for monitoring of food temperature, texture and flavor and honestly don't know why the meals were not palatable, we are mostly worried about getting the meals out quick. She stated that maybe the meals were not served fast enough to the residents, and the kitchen middle steam table was not working properly for about a month now, and I think the vendor is waiting for the parts, when asked why the meals were cold. She further stated, yes I have been trained but have not come across food palatability policy before, and the residents wouldn't like such meal which will end up affecting their health. During a phone interview on 04/28/2026 at 11:57 a.m., the RD stated, that will be the cooks, that were responsible, and I am not sure why, surely that food should be palatable for residents to consume. The RD stated that, No, I don't know why the meals were cold, yes the steamtable issue was brought to my attention, and the DM is working on that to get it fixed. When asked about staff training, she stated, again that would be a good question for the DM. She further stated, such meals could cause the residents not to eat resulting in weight loss or malnutrition. She stated, nobody has directly told me about issues regarding food varieties, but I know that they are working on getting new menus but not sure when. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/28/2026 at 12:27 p.m., the ADM stated that will be the DM that is responsible for ensuring that all meals were palatable, but I am not sure why, I know the RD is telling me everything is good, the palatability and consistency are good, I think we could do more training on that. She further stated, we do have food palatability policy, and I don't know if the kitchen staff have seen one. She stated that the negative outcome of serving residents such meals could be fatal. She further stated, to me I looked at the menu, and it is not the same every day, it is not true regarding varieties, we give residents two choices. During an interview on 04/28/2026 at 1:01 p.m., the DM stated, every kitchen staff is responsible for ensuring that all meals were palatable, but I am the overall and I think the kitchen staff rushed cooking the food and not checking for food palatability and consistency before plating, the staff failed to follow recipes, and that is not acceptable. He further stated, The only thing that is possible is they are not turning in the meals on time after putting it on the serving line, in addition there is a lot of airflow and I don't recall coming across food palatability policy. He further admitted that one steamtable compartment was not working and work order had already been turned in. He stated serving such meals, definitely cause residents not to eat resulting to weight loss. Record review of the facility's policy and procedure titled, Food Palatability, undated, reflected the following: Policy Statement: The facility is committed to providing meals that are palatable, visually appealing, and served at appropriate temperatures, while meeting each resident's dietary needs and preferences. Policy Guidelines: 1, Food Quality & Taste Taste testing will be conducted routinely by dietary staff prior to service.Meals shall be prepared using standardized recipes to ensure consistent flavor and quality.2, Appearance & PresentationMeals shall be attractively plated with attention to color, contrast, and portion size.Pureed foods shall be molded or presented to resemble original food items when possible3, Temperature Control Hot foods shabby served hot and cold food served cold.Food temperatures shall comply with state and federal food safety guidelines at times of service.Delays in mail service shall be minimized to preserve quality.4, Texture & ConsisitencyFoods shop meat prescribed diet orders (e.g., pureed, minced, soft).Textured-modified food shall maintain moisture and flavor to enhance palatability.Thickened liquids should be prepared to correct consistency and serve promptly.8, Staff TrainingDietary staff shall receive training on food preparation techniques that enhance flavor and presentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in facility 1 of 1 kitchen reviewed for food safety. 1) The facility failed to ensure food items in the refrigerator (x1), and freezer (x1), were labeled and stored in accordance with the professional standards for food service. 2) The facility failed to ensure the garbage can used for food waste was covered unless in use. These failures could place residents at risk for food-borne illness and cross contamination.The findings included: During kitchen tour observations on 04/26/2026 that began at 10:39 a.m. and concluded at 11:09 a.m., revealed the following: Garbage can, next to food prepping table, was uncovered and not in use. Walk-in refrigerator revealed the following: -What resembled hamburger burns, and lettuce in different clear plastic bags, all with no use by date. Walk-in Freezer revealed the following: -What resembled chicken breast patty, mixed vegetable, and grilled chicken meat burgers in different clear plastic bags, all with no use by date. During an interview on 04/28/2026 at 10:26 a.m., [NAME] A stated, I am responsible for putting the labels and dating (use by date) on all food items, and also whoever put in the food items in there, while the DM is responsible for monitoring the labels and dating of all food items.She stated that because nobody gets written up for their mistakes, no discipline when something is wrong and the kitchen staff are not taking things serious because they think they can get away with it, and I have been trained on labelling and dating of food items. She further stated that the garbage can next to the food prepping table was supposed to be covered all times, unless in use and that could cause cross contamination, which would make the residents sick. During an interview on 04/28/2026 at 11:14 a.m., [NAME] B stated, I have worked here for 2years now and I am responsible for putting the labels and dating (use by date) on all food items, including all the kitchen staff and the DM is responsible for monitoring the labelling and dating of all the food items, and I have come across the food storage & kitchen sanitation policies. [NAME] B stated, honestly I might have been rushing, and I forgot to put up the dates and labels. She further stated that the garbage can next to the food prepping table should have a lid over it. She stated that, the food items with no use by date could have been expired, alongside the uncovered garbage container, would make the residents sick due to food contamination. During a phone interview on 04/28/2026 at 11:57 a.m., the RD stated, that will be all the kitchen staff, that were responsible for dating (use by date) and labelling the food items, and further stated garbage can, should be covered if not in use. The RD stated, the kitchen staff must have missed them due to the pressure of working in the kitchen. She further stated all the kitchen staff, and herself were responsible for monitoring the labelling and dating of all the food items in the kitchen. When asked if the staff have been trained on such tasks, the RD stated, yes I conducted an in-service on that recently either a month or 2 months ago, but not sure if they have come across the food storage and kitchen policies. She further stated that she was not sure why those food items had no use by date on them. The RD stated that food items not labeled or dated, alongside the opened garbage can, could potentially cause food borne illness to the residents. During an interview on 04/28/2026 at 12:27 p.m., the ADM stated all the kitchen staff were responsible including the DM for dating and labelling of all food items in the kitchen. Yes, the no use by date is very important and added it could cause food poisoning to the residents. She further stated that, the kitchen staff were all trained on such task, and I am thinking it is an oversight. I would say that the DM was responsible for monitoring that. When asked about the open garbage can, the ADM stated No, the garbage can, should have lid if not in use, that is unsanitary and could cause food contamination. During an interview on 04/28/2026 at 1:01 p.m., the DM stated, everyone in the kitchen is responsible for putting the date (use by date) and labelling of all food items, there is no excuse for it, all the food items should have dates. He stated, oh yes they were all trained on that and have come across food storage and kitchen policies, it would be me that is responsible for monitoring the dating (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and labelling of all the food items in the kitchen, it will definitely cause the residents to be sick when served undated or unlabeled food items. He further stated that the garbage can, should have lid, the can is supposed to be covered if not in use, such failure could lead to food contamination. Record review of the facility's policy and procedure titled, Food Receiving and Storage, revised November 2022, reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: Refrigerated/Frozen StorageAll foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Record review of the facility policy and procedure titled, Sanitation, revised November 2022, reflected the following: Policy Statement: The food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation: Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 of 6 residents (Residents #20) reviewed for advanced directives. The facility failed to ensure Resident #20 who was listed as DNR (Do Not Resuscitate), had an Out-of-Hospital Do Not Resuscitate form that did not have missed required information. These failures could place residents at risk of not having their end of life wishes honored and incomplete records.Findings include: Resident #20 Record review of Resident #20's, undated, face sheet revealed a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #20 had diagnoses which included Dementia (irreversible that causes mental deterioration), Acute Kidney Failure (rapid loss of kidney function), and Type 2 Diabetes (high blood sugar). The face sheet indicated under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #20's physician order summary, dated [DATE], reflected the following order: DNR-Do Not Resuscitate dated [DATE]. Record review of Resident #20's care plan, dated [DATE], reflected care plan for DNR. Record review of Resident #20's DNR form dated [DATE] reflected the physician did not print his name following his signature, and his license number was not present. During an interview on [DATE] at 3:05pm with the BOM, she stated the DNR was not valid if it's not filled out correctly. She stated she and the ADM were responsible for ensuring DNRs were completed correctly. She verified missing information on DNR for Residents #20. She stated there was no system for monitoring DNRs for accuracy. She stated the reason the DNR's were not complete was human error. She stated she was trained on DNRs. The BOM stated the potential negative outcome for residents if a DNR was not completed correctly was the family may be upset that CPR was performed on their loved one. During an interview on [DATE] at 3:35PM with the ADM, she stated the DNR was not valid if not filled out correctly. She stated the DON was responsible for making sure the DNR was completed accurately. She stated they did not have a system to monitor DNR for accuracy. She stated the DON should be reviewing the OOH DNRs for accuracy. She verified missing information on the DNR for Resident #20. She stated she did not know why the information was missing. She stated the potential negative outcome was the Resident's end of life wishes may not be honored. She stated she was trained in how to complete DNR and her expectations were for them to be filled out completely and be correct. Record review of the Social Services Policies and Procedures Advanced Directives (Revised [DATE]) reflected the following: Policy Advance Directives will be respected with state law and facility policy. Upon admission, the resident will be provided with information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Should the resident be transferred to the hospital, a photocopy of the DNR order form must be provided to the personnel transporting the resident to the hospital. The DNR orders will remain in effect until the resident or legal surrogate provides the facility with a signed and dated request to end the DNR order. The interdisciplinary care planning team will review advance directives with the resident during quarterly care planning sessions to determine if the residents wish to make changes in such directives. The resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes to clarify and adhere to the resident's wishes. Inquiries concerning do not resuscitate orders/requests should be referred to the administrator, director of nurses, or the social services director.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs are limited to 14 days for 2 of 20 (Resident #21 and #40) residents reviewed for unnecessary medications.The facility failed to ensure Resident #21 was free from unnecessary anxiolytic medication (prescription drugs that treat anxiety disorder symptoms, such as fear, dread, and physical tension, by balancing brain chemicals or calming the nervous system) and failed to ensure a PRN order for Lorazepam (medication used to treat anxiety disorders) dated 9/19/2025 had a stop date and did not extend beyond 14 days. The facility failed to ensure Resident #40 was free from unnecessary anxiolytic medication and failed to ensure a PRN order for Lorazepam (medication used to treat anxiety disorders) dated 10/01/2024 had a stop date to ensure the medication did not extend beyond 14 days. This failure placed residents with PRN psychotropic drugs at risk for side effects of psychotropic drugs. Findings include:Resident #21Record review of Resident #21's undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #21 had a medical history of UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY (represents a stable cognitive decline where the specific type is not determined, and no significant psychiatric or behavioral issues are present), TYPE 1 DIABETES MELLITUS WITH DIABETIC NEPHROPATHY (a chronic autoimmune condition where the immune system destroys insulin-producing beta cells, with nerve damage often caused by diabetes), and CEREBRAL INFARCTIO (tissue death caused by a severe reduction in brain blood flow due to arterial blockage). Record review of Resident #21's quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns a BIMS score of 8 which indicated Resident #21 had moderate cognitive impairment. Section I- Active Diagnoses section of the MDS did not reveal Resident #21 had anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia or post-traumatic stress disorder. Section O- Special Treatment, Procedures and Programs section revealed resident had received Hospice care. Record review of Resident #21's care plan revealed a focus dated 10/09/2025 for I [Resident #21] receive anxiolytic medications for restlessness, anxiousness. I am receiving hospice care. Care plan goal revealed The resident [Resident #21] will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date, last revised 4/15/2026. Care plan interventions revealed Administer Lorazepam Intensol 0.25-0.5ml Q4hr (every four hours) prn (as needed) as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT (every shift) .Record review of Resident #21's physician orders with a start date of 9/19/2025 revealed Lorazepam Intensol Oral Concentrate 2mg/mL give .25mL by mouth every 4 hours as needed for MILD TO MODERATE ANXIETY OR AGITATION and Lorazepam Intensol Oral Concentrate 2mg/mL give .50 mL by mouth every 4 hours as needed for MILD TO MODERATE ANXIETY OR AGITATION. Record review of Resident #21's MAR for February 2026 did not reveal any administration of Lorazepam. The MAR for March 2026 revealed Resident #21 received Lorazepam 0.50mL on 3/22, 3/23, and 3/25. The MAR for April 2026 revealed Resident #21 received Lorazepam .25mL on 4/14/2026. Resident #40 Record review of Resident #40's undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #40 had a medical history of shortness of breath, delirium due to known physiological conditions (fluctuating disturbance in attention, awareness, and cognition) and dementia (decline in cognitive function) .unspecified severity, with mood disturbance (a mental health condition that primarily affects your emotional state. They can cause persistent and intense sadness, elation and/or anger). Record review of Resident #40's quarterly MDS dated [DATE] revealed Section C- (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cognitive Patterns a BIMS score of 6 which indicated Resident #40 had severe cognitive impairment. Section I- Active Diagnoses section of the MDS did not reveal Resident #40 had anxiety disorder, depression, bipolar disorder, psychotic disorder, schizophrenia or post-traumatic stress disorder. Section O- Special Treatment, Procedures and Programs section revealed resident had received Hospice care. Record review of Resident #40's care plan revealed a focus dated 08/09/2025, The resident [Resident #40] uses psychotropic medications with the potential for adverse side effects. Interventions for Resident #40 revealed Administer .Lorazepam 0.25-1ml Q2hr (every two hours) prn (as needed) as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT (every shift). Record review of Resident #40's physician orders with a start date of 10/01/2024 revealed the following orders; Lorazepam Conc [concentrate] 2mg/mL Give 0.25ml sublingually (medication is placed under the tongue to dissolve) every 2 hours as needed for ANXIETY AND RESTELSSNESS, Lorazepam Conc 2 MG/ML Give 0.5 ml sublingually every 2 hours as needed for ANXIETY AND RESTLESSNESS Lorazepam Conc 2 MG/ML Give 0.75 ml sublingually every 2 hours as needed for ANXIETY AND RESTLESSNESS Lorazepam Conc 2 MG/ML Give 1ml sublingually every 2 hours as needed for ANXIETY AND RESTLESSNESS. Record review of Resident #40's MAR for February, March and April of 2026 did not reveal any administered Lorazepam doses. During an interview on 4/26/2026 at 3:50pm with Resident #40's family representative, they stated they were aware of Resident #40 having an order for Lorazepam and it was used to treat her anxiety. She stated she had been educated on the side effects of the medication and had no concerns about the order. She stated she was aware the medication was as needed and she was okay with that. During attempted interviews with Resident #21 on 4/27/2026 at 1:35pm and 4/28/2026 at 12:31pm, Resident #21 was confused and unable to answer questions. During an interview on 4/27/2026 at 2:09pm with the DON, she stated the pharmacist from the hospital usually reviewed the resident's' medication regimen for unnecessary medication. She stated PRN psychotropic medication should not go past 14 days except if the resident was on hospice and she believed that was the only exception. She stated Resident #21 and Resident #40 were on hospice and hospice had originally ordered the Lorazepam for comfort. She stated there were different dosages on the Lorazepam, in order for staff to titrate up if needed but they would administer the lowest dose first and go up as needed every two to three hours depending on the order. She stated Resident #21 and Resident #40 did not have the 14 day stop date because they were on hospice, but she was aware that if any resident had a PRN psychotropic medication, it required a stop date. She stated a potential negative outcome of residents not having a 14 day stop date on PRN psychotropic medication could be residents getting medication they don't need. She stated PRN psychotropic medications are audited monthly and reviewed for stop dates. During an interview on 4/28/2026 at 10:25am with the ADM, she stated the DON is responsible for ensuring residents PRN psychotropic are reviewed for stop dates. She stated if a resident does not have a stop date after 14 days, the nurses and DON should be notifying the physician and discontinue the medication or to reassess the need for the medication. She stated a potential negative outcome of not having the 14 day stop date on PRN psychotropic medication could be the facility not being in compliance, and a danger to the residents. She stated the pharmacist from the hospital comes to the facility once a month and does medication reviews. She stated she was not aware Resident #21 and Resident #40 did not have a stop date to their Lorazepam. Record review of facility policy titled Psychotropic Medication Use last revised February 2025 revealed; PRN Medication 1. Psychotropic medications are not prescribed or administered on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. 3. PRN orders for psychotropic medications are limited to 14 days.a. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order.b. For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for 2 out of 4 residents (Resident #20 and Resident #1) observed for perineal care. 1. CNA A failed to change gloves or utilize hand hygiene prior to putting a clean brief under Resident #20. 2. CNA B failed to utilize hand hygiene prior to putting on a clean pair of gloves before assisting Resident #1 to stand to pull up her brief and pants. This failure could result in residents contracting infections or spreading infections to others by direct contact with contaminated surfaces. Findings include: Resident #20: Record review of Resident #20's facesheet dated 1/19/2024 revealed resident is a [AGE] year-old female who admitted to the facility on [DATE], with a readmission on [DATE] with a primary diagnosis of Dementia (progressive decline in cognitive function). Record review of Resident #20's Quarterly MDS dated [DATE] revealed resident's BIMS score was 6/15 (severe cognitive impairment). Resident #20 was always incontinent of bladder and bowel. Observation on 4/27/26 at 9:12 AM, CNA A had turned Resident #20 to her right side and cleaned residents buttock of bowel movement. CNA A removed glove to left hand only and applied glove to the left hand only without utilizing hand hygiene. CNA A continued to clean Resident #20's buttocks. CNA A grabbed the clean brief and placed it underneath Resident #20 and assisted with fastening the brief. CNA A did not change gloves or use hand hygiene before putting the clean brief under Resident #20. During an interview on 4/27/2026 at 3:10 PM with CNA A who stated the infection preventionist was the DON or ADON. She stated she had been trained on incontinence care, and her last skills checkoff was approximately 1 month ago. She stated she was aware she had not changed her gloves after cleaning Resident #20's bottom but had gotten nervous. She stated she had changed the glove to the left hand only because there was stool on it and she did not want to get it on the resident. She stated a potential negative outcome of not changing gloves and using hand hygiene is contaminating the residents and could cause skin breakdown or infections. Resident #1: Record review of Resident #1's facesheet dated 2/5/2026 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of fracture of right femur. Record review of Resident #1's admission MDS dated [DATE] revealed resident's BIMS score was 11/15 (moderate cognitive impairment). Resident #1 was continent of bladder and bowel. Observation on 4/27/2026 at 2:00 PM CNA B voiced Resident #1 was in the bathroom on the toilet. After cleaning Resident #1's front side then back side, CNA B removed gloves and put on a new pair of gloves without using hand sanitizer or washing hands. CNA B assisted Resident #1 to stand and then pulled up brief and pants. Interview on 4/27/2026 at 3:20 PM CNA B regarding observation of peri-care on Resident #1, CNA B voiced she should have used hand sanitizer prior to putting on a new pair of gloves, saying she was nervous and just missed doing it. CNA B voiced she had been checked off on peri-care about a week ago. CNA B voiced that the ADON would demonstrate peri-care, then she will watch them repeat the demonstration, and give them feedback or suggestions. CNA B stated a potential negative outcome of not doing hand hygiene could be to spread infection to the resident. Interview on 4/27/2026 at 4:00 PM with the ADON revealed she is also the Infection Preventionist. ADON reported that she already knew there was a problem, because a couple of the CNA's had reported what they had done, and she told them that was not right. ADON voiced her expectations for peri-care is to knock on door, talk to the resident, wash hands, gather items. She also suggests having another staff help that can stay clean, so when the other staff is finishing care, the clean one can start with the brief, while the staff who was cleaning can remove gloves and utilize hand hygiene before assisting with the brief. ADON voiced she tells her staff one wipe per swipe: in front down sides, then the middle, backside one wipe per swipe. Remove gloves and utilize hand hygiene. ADON showed me the check-off sheet she uses with staff. Record Review of Observation and Documentation of Policy Demonstration: Has date and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what direct care staff member was observed giving perineal care based on facility policy and procedure for perineal care. 1) The facility policy and procedure were followed: Yes or No. 2) Direct care staff member was observed demonstrating proper handwashing based on facility policy and procedure for handwashing: Yes or No. 3) Direct care staff member was observed demonstrating proper transfer technique based on facility policy and procedure for transferring: Yes or No. If any question is answered no, there is a question: If No, was proper procedure reviewed until performed properly: Yes or No. Record review of facility policy titled Standard Precautions with the last revision date of September 2022 revealed: Policy Statement: Standard precautions are used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions include the following practices: Hand HygieneHand hygiene refers to handwashing with soap (anti-microbial) or the use of alcohol-based hand rub (ABHR), which does not require access to waterHand hygiene is performed with ABHR or soap and water: (5) after removing gloves. GlovesGloves (clean, non-sterile) are worn when in direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material. d. Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. f. Gloves are changed as necessary, during care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one).i. After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environments.