

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Ganado Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 E Rogers Ganado, TX 77962	
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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 of 24 (Residents #27, #29) residents reviewed for Activities in that: 1.Residents #29, and #27 stated the activity schedule was not followed and there was no back up, if the activity director did not work. 2.The facility failed to provide activities as posted. This failure could affect all residents and could result in no Activity program for residents. The Findings:1.Record review of the Activity schedule for February 2026 revealed:2/21/2026 - Saturday -no activity scheduled.2/22/2026 - Sunday- no activity on the Activity schedule. (day of entrance)2/23/2026 - Monday9:00 AM - coffee and chat9:30 AM - one to one10:00 AM - Dominoes11:00 AM - Appetizer hour2:30 PM - Bingo4:00 PM - pretty nails 2/24/2026 Tuesday9:00 AM - coffee and chat9:30 AM - one to one10:00 AM - Board games11:00 AM - Appetizer hour2:30 PM - Bingo 2/25/2026 Wednesday9:00 AM - coffee and chat9:30 AM - one to one10:00 AM - Penny hour11:00 AM - Appetizer hour2:00 PM - Bingo Observation on 2/22/2026 12:30 PM the activity calendar on the wall, close to nurse's station, large enough for residents to read, had no activities scheduled for weekends. Observations on 2/22/2026 from 1:00 PM to 4:00 PM revealed no activities were observed for residents. Observations on 2/23/2026 at 3:00 PM revealed no bingo or activities were observed for the day for residents. Observations on 2/24/2026 at 5:00 PM revealed staff were playing a game with a few residents in the front lobby, no other activities for the day. Observations on 2/25/2026 at 2:00 PM revealed a community volunteer was calling out numbers for Bingo in the dining room Record review of the December 2025 Resident Council minutes documented their favorite activity was bingo and they wanted more bingo. Record review Resident Council Minutes for January 2026 was documented their favorite activity was bingo and they wanted to play twice a week. Record review of February 2026 Resident Council minutes documented their favorite activity was Bingo. 2.Record review of Resident #27's admission Record dated 2/25/2026 documented she was admitted on [DATE], re-admitted on [DATE] with diagnoses of dementia, cognitive communication deficit, osteoarthritis of hip, difficulty walking, major depressive disorder, unsteadiness on feet and need assistance with personal care. Record review of Resident #27's Annual MDS dated [DATE] revealed her BIMs score was 12/15 (moderately cognitive impaired), Activities (f section) included very important things with groups of people, do favorite activity; somewhat imported was go outside to get fresh air, participate in religious services/practices, and she required a wheelchair to mobilize. Record review of Resident #27's care plan dated 1/31/2026 was documented for Activity, provide a program of activities that accommodate the resident abilities. Also, Resident #27 would benefit out of room social, spiritual, and stimulus activities and mental stimulation related to decrease interest in doing things due to diagnoses of depression. The Activity Director will encourage and remind the residents of current activities. Resident #27 will attend activities of her choice, watch television, read, and socialize with (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676242
		If continuation sheet Page 1 of 14

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other residents at least 2 times weekly. Interview and observation on 2/24/2026 at 9:30 AM with Resident #27, while near the large Activity calendar for February 2026, near the nursing desk area. Resident #27 stated there was no Bingo yesterday, on 2/23/2026. Resident #27 stated there were no weekend activities, and nothing was planned, and the Activity Director had not worked for the last few days due to physical inability. 3. Record review of Resident #29's admission Record dated 2/25/2026 revealed the resident was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia, major depressive disorder, unsteadiness on feet, and need assistance with personal care. Record review of Resident #29's admission MDS dated [DATE] documented with BIMS score of 11/15 (moderate cognitive impairment), required a walker/wheelchair, and for Activities (f section) included very important was keep up with the news, do things with groups of people, do favorite activities, and go outside to get fresh air. Record review of Resident #29's care plan dated 1/27/2026 documented to encourage the residents to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Also, provide program of activities that accommodate the resident abilities. Interview on 2/25/2026 at 11:24 AM with Resident #29 stated they did not have pretty nails activity on 2/23/2026, Monday and no appetizer hour scheduled for today. Resident #29 stated they had activities this morning and did not have any all week, and no activities on weekends. Interview on 2/23/2026 at 10:00 AM with the ADM stated the Activity Director was not coming in today, Monday, 2/23/2026, due to physical ailments. ADM stated if Activity Director was not able to work, he would get staff together to ensure residents got the scheduled Activities. Interview on 2/24/2026 at 2:00 PM with the ADM stated the Activity Director was not coming in today, Monday, 2/23/2026, due to physical ailments. Interview on 2/25/2026 at 2:28 PM with the Activity Director stated she had been physically unable to go to work this week and does not work weekends. The Activity Director stated she comes in for resident activities once a month when she is the manager on duty. The Activity Director stated she did not have an assistant but had volunteers from community coming to visit and do different activities with residents. The Activity Director stated the one-to-one on the activity calendar; meant she meets with resident individually. The Activity Director stated the one-to-one notes were with her and not at the facility. The Activity Director stated she did not find out until later the volunteer bingo was cancelled. The Activity Director stated she was not aware the activities were not being held at the facility for residents. The Activity Director stated she did not have a back-up plan if she was not able to make it to work for the scheduled activities. The Activity Director stated on weekends she leaves board games and some volunteers for Bingo. The Activity Director stated church volunteers come in on Sundays. Activity Director usually gathers residents for activities and see if they wanted to come. Record review of policy Activity programming dated 2011, was documented The Activity Director and staff will provide for ongoing Activity program. 1. Recreation programs are based on the interest and needs of the resident expressed through the Activity assessment. 3. Activity program area based on resident's leisure interests and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents. 5. Those who cannot participate in group settings are provided individual programming. inability to participate could include those who refuse to participate in activities, those who are in isolation, or physician orders bed rest. 6. Programming includes large groups, small groups, individual and independent opportunities. 7. Programs may take place in the mornings, afternoons, and /or evenings that span throughout the entire week.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure menus reflected the needs of the resident population as well as input received from residents and resident groups for for 4 of 25 (Residents #29, #57, #22, and #17) residents reviewed for breakfast in that: 1. Resident #29 was bored of the same breakfast every morning and wanted variety.2. Resident #57 stated she was served the same breakfast every day and would rather have a variety of options. 3. Resident #22 stated she was served the same breakfast every day and would rather have a variety of options. 4. Resident # 17 stated he was served the same breakfast every day and would rather have a variety of options. This deficient practice could affect residents who consume breakfast and could result in psychosocial harm and/or weight loss. The findings were: 1. Record review of Resident #29's admission Record dated 2/25/2026 revealed the resident was admitted on [DATE] with diagnoses of Alzheimer's disease, dementia, major depressive disorder, unsteadiness on feet, and need assistance with personal care. Record review of Resident #29's consolidated orders for February 2026 documented Regular diet, Regular texture, and Regular consistency. Record review of Resident #29's admission MDS dated [DATE] documented with BIMS score of 11/15 (moderate cognitive impairment), required a walker/wheelchair, was independent with eating and had not weight loss. Record review of Resident #29's care plan dated 1/27/2026 documented potential risk for malnutrition, and intervention was updating food preferences as needed. Also, offer diet as ordered by the physician. Record review of Resident #29's dietary profile dated 11/14/2026 documented she was on a regular diet, no allergies to foods, she likes breakfast, she was independent with eating, and some confusion/dementia was marked. Record review of the Resident Council group meeting for February 2026 documented under Nutrition Services Review: Meal service compliments/concerns were, Variety on breakfast. Resident #29 was in attendance. Observation on 2/23/2026 at 8:30 AM, 2/24/2026 at 8:15 AM and 2/25/2026 at 8:45 AM during breakfast revealed the meal served was: scrambled eggs, toast, sausage patties, bacon, gravy, and choice of cereal. Interview on 2/23/2026 at 2:40 PM with Resident #29 stated the food was good, food comes out warm and stated she had the same breakfast every day. Resident #29 did report to ADM that breakfast was getting boring about 1 month ago Interview on 02/25/2026 at 11:07 AM with Resident #29 said if they just had a little variety for breakfast and it would be nice. Resident #29 stated dietary staff had not asked for her preferences. 2. Record review of Resident #57's facesheet, dated 02/25/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Degenerative Disease of Basal Ganglia, Altered (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mental Status, and Transient Cerebral Ischemic Attack. Record review of Resident #57's admission MDS, dated [DATE], revealed a BIMS score of 12 which indicated Moderate cognitive impairment. Record review of Resident #57's care plan, initiated 02/10/2026, revealed, The resident has an ADL Self Care Performance Deficit. Anticipate and meet the resident's needs. Record review of Resident #57's order summary as of 02/25/2026, revealed, Regular diet Regular texture, Regular consistency. During an interview with Resident #57 on 02/22/2026 at 10:32 a.m., the resident stated she had been served sausage and eggs every day since admission and though the food tasted good, she disliked having the same meal each morning and would rather have a variety of options. 3. Record review of Resident #22's facesheet, dated 02/25/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Atrial Fibrillation, Transient Cerebral Ischemic Attack, and Severe Protein Calorie Malnutrition. Record review of Resident #22's quarterly MDS, dated [DATE], revealed a BIMS score of 9 which indicated moderate cognitive impairment. Record review of Resident #22's care plan, initiated 12/19/2025, revealed, Determine food preferences and provide within dietary limitations. Record review of Resident #22's order summary as of 02/25/2026, revealed, Regular diet Regular texture, Regular consistency. During an interview with Resident #22 on 02/25/2026 at 8:26 a.m., the resident stated, I'm tired of the same thing every morning always eggs and sausage. 4. Record review of Resident #17's admission Record, dated 02/25/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Renal osteodystrophy, Pleural effusion, and Emphysema. Record review of Resident #17's admission MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #17's care plan, initiated 02/04/2026, revealed, Determine food preferences and provide within dietary limitations. Record review of Resident #17's order summary as of 02/25/2026, revealed, Renal diet Regular texture, Regular consistency, Large high protein portions. During an interview with Resident #17 on 02/25/2026 at 8:31 a.m., the resident stated, Breakfast is always the same and I'm tired of eggs and sausage. During an interview with the Dietary Manager on 02/25/2026 at 1:36 p.m., the Dietary Manager stated that the current menu has been in effect for a couple of month, and a few residents have told her that (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they are tired of having the same breakfast every day. The Dietary Manager stated that if the decision were hers to make, she would provide a variety, but that cooks must follow the menu. She stated that she had not discussed deviation to accommodate resident preference for variety with the consultant dietician. Record review of the facility menus, dated 09/02/2025 and encompassing the time period of November 2, 2025 through May 30, 2026, revealed breakfast for each day was: choice of juice, hot or cold cereal, fresh pasteurized eggs, bacon or sausage, breakfast bread, margarine, jelly, and whole milk. Record review of the facility policy, Menu Approval and Honoring Residents Special Requests, and Food Brought to the Facility from Unapproved Sources, dated 2012, revealed, .Every attempt will be made to honor resident food preferences.		

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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 maintain an Infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 4 of 6 residents (Residents #6, #23, #37 and #48) reviewed for infection control, in that: 1. On 02/24/2026, the facility failed to ensure CNA B and CNA C sanitized between their fingers while providing incontinent care for Resident #6 2. On 02/24/2026, the facility failed to ensure CNA D changed gloves between soiled and clean brief, while providing incontinent care for Resident #23. 3. On 02/24/2026, the facility failed to ensure CNA A sanitized her hands between change of gloves and after touching the resident's environment, while providing incontinent care for Resident #37. 4. On 02/24/2026, the facility Failed to ensure Medication Aide E changed her gloves and sanitized her hands after touching medication cart and the resident's environment, while administering eye drop medication for Resident #48. These deficient practices could place residents at-risk for infection due to improper care practices. The findings include: 1. Record review of Resident #6's face sheet , dated 02/24/2026, revealed an admission date of 03/12/2025, with diagnoses that included: Epilepsy (brain condition that causes recurring seizures), Down syndrome (genetic disorder associated with developmental delays and mild to moderate intellectual disability), Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), Type 2 diabetes mellitus (high level of sugar in the blood), Hypothyroidism (under active thyroid),, Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood). Record review of Resident #6's Quarterly MDS assessment, dated 01/29/2026, revealed the resident was rarely understood and her cognition was severely impaired. Resident #6 was dependent of the staff for care, had an indwelling catheter and was always incontinent of bowel. Record review of Resident #6's care plan dated 03/25/2025, revealed a problem of The resident has bowel incontinence and an intervention of Provide pericare after each incontinent episode. An observation on 02/24/2026 at 10:20 a.m., revealed while providing incontinent care for Resident #6, CNA B and CNA C, while sanitizing their hands during care, did not sanitize between their fingers. During an interview on 02/24/2026 at 11:03 a.m. CNA B and CNA C stated they should sanitize between their fingers when they used sanitizer just like they did when they use soap and water. They did not know why they did not sanitize between their fingers. They stated they received infection control within the year. During an interview with the DON on 02/24/2026 at 3:05 p.m., she stated that staff should sanitize all surfaces of their hands to ensure appropriate hand hygiene and prevention infection to the resident. She stated infection control training was provided and staff's skills were checked annually. Record review of the facility's policy titled Fundamentals of Infection Control Precautions , dated 03/2023, revealed, Recommended techniques for performing hand hygiene [.] applying product to the palm of one hand and rubbing hands together, covering all surfaces of hands and fingers. 2. Record review of Resident #23's face sheet, dated 02/24/2026, revealed an admission date of 02/23/2016 and a readmission date of 07/12/2022, with diagnoses that included: Type 2 diabetes mellitus (high level of sugar in the blood), Hypertension (High blood pressure), Chronic kidney disease (gradual loss of kidney function), Hypothyroidism (under active thyroid), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood). Record review of Resident #23's Quarterly MDS assessment, dated 02/17/2026, revealed the resident had a BIMS score of 15, indicating she was intact cognitively. Resident #23 was dependent of staff for toileting hygiene; she had an indwelling catheter and was always incontinent of bowel. Record review of Resident #23's care plan dated 09/27/2023, revealed a problem of is incontinent of bowel. She requires assistance for toileting tasks, incontinent care. and an intervention of Check on Resident #23 at routine intervals to assess needs and offer assist with Bowel incontinences x1 staff member. May include 2 staff members at times. An observation on 02/24/2026 at 3:25 p.m., revealed while providing incontinent care for Resident #23 CNA D touched a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	soiled brief to remove it from the resident and without changing her gloves and sanitizing her hands placed a clean brief on the resident. During an interview on 02/24/2026 at 3:38 p.m., CNA D stated she did not realize she had touched both brief with the same gloves but knew she should change her gloves between soiled and clean briefs. CNA D stated she received infection control training within the year. During an interview with the DON on 02/24/2026 at 3:40 p.m., she stated that staff should change gloves and sanitize their hands before touching clean briefs to ensure appropriate hand hygiene and prevention infection to the resident. She stated infection control training was provided and staff's skills were checked annually. Record review of the facility's policy titled Fundamentals of Infection Control Precautions , dated 03/2023, revealed, The following list is a list of some situations that require hand hygiene [.] after handling soiled or used linens, dressing, bedpans, catheter and urinals. 3.Record review of Resident #37's face sheet, dated 02/24/2026 , revealed an admission date of 09/04/2025 and, a readmission date of 10/17/2025, with diagnoses that included: Convulsions (involuntary movements of the body), Hypothyroidism (under active thyroid), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Dementia (decline in cognitive abilities), Hypertension (High blood pressure), Obstructive and reflux uropathy (urinary condition where blockages or backward urine flow can damage the kidneys if untreated). Record review of Resident #37's quarterly MDS, dated [DATE] , revealed a BIMS score of 2, which indicated the resident was severely impaired cognitively, and was indicated to always be incontinent of bowel and bladder. Record review of Resident #37's care plan, dated 09/25/2025, revealed a problem of The resident has bladder incontinence and, an intervention of Monitor/document for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. An observation on 02/24/2026 at 11:15 a.m., revealed while providing incontinent care for Resident #37, CNA A, after washing her hands and donning gloves, touched the bed remote to move up the bed. She did not change her gloves and sanitize her hands and started providing care. While providing care, CNA A did not sanitize her hands between change of gloves. During an interview on 02/24/2026 at 11:30 a.m., CNA A stated she knew she needed to use sanitizer in between change of gloves but did not have sanitizer with her. She stated she forgot to change her gloves after touching the bed remote but knew the bed remote was considered dirty. She stated she received infection control training within the year. During an interview with the DON on 02/24/2026 at 3:05 p.m., she stated that staff should change gloves and sanitize their hands after touching anything in the resident's environment and sanitize their hands between change of gloves to ensure appropriate hand hygiene and prevention of infection to the resident. She stated infection control training was provided and staff's skills were checked annually. Record review of the facility's policy titled Fundamentals of Infection Control Precautions , dated 03/2023, revealed, The following list is a list of some situations that require hand hygiene [.] after handling soiled or used linens, dressing, bedpans, catheter and urinals [.] after removing gloves[.]. 4.Record review of Resident #48's face sheet, dated 02/24/2026 , revealed an admission date of 06/23/2023, with diagnoses that included: Hemiplegia (Paralysis of one side of the body), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Hypertension (High blood pressure), Dementia (decline in cognitive abilities). Record review of Resident #48's annual MDS, dated [DATE], revealed a BIMS score of 7, which indicated the resident was severely impaired cognitively. Resident #48 required extensive assistance to total care for his activities of daily living. Record review of Resident #48's care plan, dated 10/28/2025, revealed a problem of has (L) side Hemiplegia/Hemiparesis r/t CVAHigh Spasticity to Left side and, an intervention of Give medications as ordered. Monitor/document for side effects and effectiveness. An observation on 02/24/2026 at 8:30 a.m., revealed while administering eye drops to Resident #48, Medication Aide E touched her medication cart key, medication cart, Resident's side table and Resident's bed remote with her gloved hand. She did not change gloves or sanitize her hands before touching Resident #48's face and administering the eye drops. During an interview on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/24/2026 at 8:55 a.m. Medication Aide E stated the key, medication cart, side table and bed remote were considered dirty or contaminated and she should have change her gloves and sanitize her hands before touching the resident and administering the drops. She stated she received infection control training with the year During an interview with the DON on 02/24/2026 at 8:58 a.m., the DON stated the staff should have changed her gloves and sanitize her hands before touching the resident and provide care. She stated the staff had received infection control training within the year. Record review of the facility's policy titled Eye Ointment Administration , dated 2025, revealed, Identify the resident before administering medication [.] wash hands, don gloves.		

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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. Based on observation, interview, and record review, the facility to ensure the resident environment remains as free of accident hazards as is possible for residents for 1 of 4 shower rooms reviewed, in that: The shower room at the end of 300 hall contained an unlocked cabinet in which were approximately eight razors for shaving and a container of germicidal wipes labeled not a skin or baby wipe and keep out of reach of children. This deficient practice could result in residents living in an environment that is not safe, clean, and comfortable. The findings were: Observation on 02/22/2025 at 11:48 a.m. revealed the shower room at the end of 300 hall contained an unlocked cabinet in which were approximately eight razors for shaving and a container of germicidal wipes labeled not a skin or baby wipe and keep out of reach of children. Further observation revealed no residents were noted in the hallway near the shower room. During an interview with the Maintenance Director on 02/22/2025 at 11:50 a.m., the Maintenance Director confirmed that the cabinet containing razors and germicidal wipes should have been locked so that the items were out of reach of residents. Record review of the facility policy, Policy and Procedure: Maintenance of Physical Environment undated, revealed, The facility is committed to maintaining a safe, clean, and hazard-free physical environment for all residents, staff, and visitors.		

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NAME OF PROVIDER OR SUPPLIER Ganado Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 107 E Rogers Ganado, TX 77962	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Residents #37) reviewed for incontinent care and catheter care, in that: The facility failed to ensure that, while providing incontinent care for Resident #37, CNA A used a front to back motion to clean Resident #37. These deficient practices could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #37's face sheet, dated 02/24/2026 , revealed an admission date of 09/04/2025 and, a readmission date of 10/17/2025, with diagnoses that included: Convulsions (involuntary movements of the body), Hypothyroidism (under active thyroid), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Dementia (decline in cognitive abilities), Hypertension (High blood pressure), Obstructive and reflux uropathy (urinary condition where blockages or backward urine flow can damage the kidneys if untreated). Record review of Resident #37's quarterly MDS, dated [DATE] , revealed a BIMS score of 2, which indicated the resident was severely impaired cognitively, and was indicated to always be incontinent of bowel and bladder. Record review of Resident #37's care plan, dated 09/25/2025, revealed a problem of The resident has bladder incontinence and, an intervention of Monitor/document for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observation on 02/24/2026 at 11:15 a.m. revealed while providing incontinent care for Resident #37, CNA A used a back and forth motion to wipe the resident instead of a front to back motion. During an interview on 02/24/2026 at 11:30 a.m. with CNA A, she stated she should have wiped front to back instead of using a back-and-forth motion and do multiple pass on the same area. During an interview with the DON on 02/24/2026 at 3:05 p.m., she stated that staff should not do back and forth motion with wipes during incontinent care. The staff should do a front to back pass with a wipe and change wipe before doing another pass to prevent fecal matter to enter the urinary tract and cause infection. She stated infection control training and incontinent care training were provided at least once a year and staff's skills were check once a year by the DON and ADON. Review of CNA proficiency audit for CNA A revealed she was passed proficiency on infection control and incontinent care on 10/15/2025. Record review of facility's policy titled Perineal care, dated 04/25/2022, revealed, Gently perform perineal care, wiping from clean urethral area to dirty, rectal area.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's drug regimen was free from unnecessary medication without adequate indication for its use, for 1 (Resident #11) of 15 residents reviewed for unnecessary medication, in that: Resident #11's prescription for Depakote did not have an associated diagnoses. This deficient practice could affect all residents who receive prescription medication. The findings were: Record review of Resident #11's face sheet, dated 02/24/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Adjustment Disorder with Mixed Anxiety and Depressed Mood, Generalized Anxiety Disorder, and Insomnia. Record review of Resident #11's quarterly MDS, dated [DATE], revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #11's care plan, initiated 07/26/2025, revealed, Adverse medication effect and behavior monitoring. Further review the resident's care plan revealed it did not address that the resident received Depakote. Record review of Resident #11's order for Depakote, dated 12/13/2025, revealed, Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium). Give 1 capsule by mouth two times a day for mood stabilization. During an interview with the DON on 02/25/2026 at 10:59 a.m., the DON stated that Resident #11's Depakote order should have had an associated diagnoses, stated she did not know why it did not have one, and that it would be corrected. Record review of the facility policy, Unnecessary Medications, revised 02/12/2025, revealed, It is the policy of this facility each resident remains free of unnecessary medications. An unnecessary drug is any drug when used - . without adequate indications for its use.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure the food and drink that is palatable, attractive, and at a safe and appetizing temperature for 3 of 25 (#17, #25, and #57) residents reviewed for food temperature in that: 1. Resident #17 stated food temperature was cold. 2. Resident #25 stated food temperature was cold. 3. Resident #57 stated her meals were always served cold. This deficient practice could affect all residents who consume meals and/or snacks from the facility and could result in psychosocial harm and/or weight loss. The findings were: 1. Record review of Resident #17's admission Record dated 2/25/2026 documented he was admitted [DATE] with diagnoses of end stage renal disease, anxiety disorder and heart failure. Record review of Resident #17's consolidated orders documented he ordered a Renal diet regular texture/consistency and large portions. Record review of Resident #17's Quarterly MDS dated [DATE] documented his BIMs score was 11/15 (moderately cognitive impairment) and was independent with eating with no weight loss. Record review of Resident #17's care plan dated 2/14/2026 documented he was on a renal diet, regular texture, regular consistency with interventions of determined food preferences and provide within dietary limits. Record review of Resident #17's dietary profile documented he was on a regular diet, favorite meal breakfast, he was alert and was independent in eating. Observation on 2/23/2026 at 2:57 PM with Resident #17s room revealed it was located at the end of the hall. Interview on 2/23/2026 at 2:58 PM with Resident #17 stated he ate in his room and the food was cold. 2. Record review of Resident #25's admission Record dated 2/25/2026 was admitted on [DATE], re-admitted on [DATE] documented with diagnosis of major depressive disorder, dementia, and anemia. Record review of Resident #25's consolidated orders for February 2026 was documented an order for Regular diet, texture and consistency. Record review of Resident #25's Quarterly MDS dated [DATE] was documented that he had a BIMs score of 11/15 (moderately cognitive impairment), he was independent with eating with no weight loss. Record review of Resident #25's care plan was documented with regular diet and regular texture. Record review of Resident #25's dietary profile dated 2/25/2026 was documented regular diet, regular texture, liked breakfast and eat in the dining room. Interview on 2/22/2026 at 3:12 PM with Resident #25 stated her food cold and usually ate meals in the dining room. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review of Resident #57's facesheet, dated 02/25/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Degenerative Disease of Basal Ganglia, Altered Mental Status, and Transient Cerebral Ischemic Attack. Record review of Resident #57's admission MDS, dated [DATE], revealed a BIMS score of 12 which indicated Moderate cognitive impairment. Record review of Resident #57's care plan, initiated 02/10/2026, revealed, The resident has an ADL Self Care Performance Deficit. Anticipate and meet the resident's needs. Record review of Resident #57's order summary as of 02/25/2026, revealed, Regular diet Regular texture, Regular consistency. During an interview with Resident #57 on 02/22/2026 at 10:32 a.m., the resident stated that she always ate in her room and all three meals were served cold. Resident #57 stated she generally enjoyed the taste of the meals, but that receiving cold food made it unpalatable. During an interview with the Dietary Manager on 02/25/2026 at 1:36 p.m., the Dietary Manager stated that no residents had informed her that meals were served cold. Record review of the facility policy, Daily Food Temperature Control, dated 2012, revealed, We will assure that food is served at a safe temperature.		

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Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 for 1 of 1 kitchen reviewed, in that: A jar of marmalade, labeled refrigerate after opening was stored in a non-refrigerated dry goods pantry after being opened. This deficient practice could affect all residents who consume meals and/or snacks provided by the facility and result in food-borne illness. The findings were: Observation on 02/25/2026 at 7:16 a.m. revealed an eighteen-ounce jar of marmalade, labeled refrigerate after opening was stored in the dry good pantry. Further observation revealed the marmalade had been opened and partially consumed. During an interview with Dietary [NAME] F on 02/25/2026 at 7:18 a.m., Dietary [NAME] F confirmed the jar of marmalade, labeled refrigerate after opening was stored in a non-refrigerated dry goods pantry after being opened and should have been refrigerated. Dietary [NAME] F stated she did not know why the marmalade had not been properly stored. During an interview with the Dietary Manager on 02/25/2026 at 1:36 p.m., the Dietary Manager stated the jar of marmalade, labeled refrigerate after opening was stored in a non-refrigerated dry goods pantry after being opened and should have been refrigerated. Record review of the facility policy, Food Storage and Supplies, dated 2012, revealed, All facility storage areas will be maintained in and orderly manner that preserves the condition of food and supplies.		