| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676269 | A. Building<br>B. Wing | 01/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Rayburn Health Care & Rehabilitation | 144 Bulldog Avenue<br>Jasper, TX 75951 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to review and revise resident's comprehensive care plans based on changing goals, preferences and needs of the resident and in response to current interventions for 4 of 18 (Residents #1, #3, #35, and #41) residents reviewed for comprehensive care plans.1.The facility failed to ensure Resident #1's care plan was updated to indicate Resident #1 had a diet change of Low Concentrated Sweets, pureed textures with nectar/mildly thick consistency on 06/15/2025.2. The facility failed to ensure Resident #3's care plan was updated for her change from Full Code to DNR on 01/07/26.3. The facility failed to ensure Resident #35's care plan was updated to indicate d Resident #35 had oxygen on 01/11/26. 4. The facility failed to ensure Resident #41's care plan was updated to indicate Resident #41 had an immobilizer applied to her (l) shoulder, upper arm and elbow on 1/9/2026. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs. Findings Included: 1.Record review of Resident #1's admission Record dated 01/20/2026 indicated she was an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included pneumonia (inflammation and fluid in your lungs caused by a bacterial, viral or fungal infection), dementia (loss of cognitive functioning), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), dysphagia (difficulty swallowing) following cerebral infarction, and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).<br><br>Record review of Resident #1's quarterly MDS assessment, dated 11/26/2025, indicated she was unable to complete an interview for BIMS score because she was rarely/never understood. She had short- and long-term memory loss and severely impaired cognitive skills for daily decision making. She rarely/never made herself understood and rarely/never understood others. She had behaviors of inattention (difficulty focusing attention, easily distracted or having difficulty keeping track of what was being said) indicated during the 7-day look back period prior to completing the MDS assessment. The functional abilities self-care indicated she is dependent with all tasks. Her functional abilities mobility indicated she is dependent with all tasks. She used a manual wheelchair for mobility dependent on staff. Her nutritional approach indicated Mechanical altered therapeutic diet.<br><br>Record review of Resident #1's physician order dated 06/12/2025 indicated a Low concentrated sweet diet with pureed texture, nectar/mildly thick consistency.<br><br>Record review of Resident #1's care plan, revision dated 07/21/2024, indicated her diet was a therapeutic or altered consistency diet of low concentrated sweet diet, no salt on table mechanical soft texture with nectar thick liquids/chopped meats. The care plan did not indicate Resident #1 had an updated or revised care plan for new diet order on 06/12/2025 indicated a Low concentrated (continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sweet diet with pureed texture, nectar/mildly thick consistency. Further review of care plan indicated no interventions added since 07/21/2024.<br><br>During an observation on 1/19/2026 at 12:45 p.m., revealed Resident #1 was being fed a pureed diet with nectar/mildly thick consistency by CNA C and the SLP was standing by monitoring the feeding process.<br><br>During an interview on 1/19/2026 at 12:46 p.m., CNA C said Resident #1 was on a pureed diet and must be fed and encouraged to swallow the food and not pocket it. CNA C said Resident #1 did not seem to pocket her food much at breakfast but tended to pocket food at lunch, but staff must monitor her closely and encourage her to swallow food at each meal.<br><br>During an interview on 1/19/2026 at 12:50 p.m., the SLP said she had been working with Resident #1 since December 2025 after returning to facility following a hospital stay. She said Resident #1's dementia had progressed, and she was holding or pocketing food and forgetting to swallow the food during some meals. The SLP said she monitored Resident #1 during some meals and instructed staff on encouraging Resident #1 to swallow the food to avoid food pocketing and aspiration (when food, liquid, salvia, or stomach contents enter the airway and lungs instead of esophagus/tube to stomach). The SLP said Resident #1 had been on a pureed textured diet with mildly thick consistency since December 2025.<br><br>2. Record review of a face sheet dated 01/19/26 indicated Resident #3 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), hypotension (a condition in which the force of the blood against the artery walls is too low), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), hypertension heart disease (heart problems that arise due to prolonged high blood pressure), and kidney failure (condition where the kidney reaches advanced state of loss of function).<br><br>Record review of an OOH-DNR dated 01/07/26 indicated Resident #3 wished to have no CPR (an emergency lifesaving procedure performed when the heart stops beating), transcutaneous cardiac pacing, defibrillation (a non-invasive emergency procedure used to temporarily stimulate the heart in patients), advanced airway management (procedures used to ensure a patient is receiving adequate oxygen), or artificial ventilation (a medical procedure used to assist or stimulate breathing in individuals who are unable to breathe adequately on their own).<br><br>Record review of physician orders for January 2026 indicated Resident #3 had an order dated 01/14/26 for DNR but the care plan was not updated as of 01/19/26 to include the DNR.<br><br>Record review of a care plan reviewed on 12/23/25 indicated Resident #3 was care planned as a Full Code-one who has chosen to receive all possible life-saving treatments in the event of cardiac or respiratory arrest.<br><br>During an observation and interview on 01/19/2026 at 09:05 a.m. Resident #3 was sitting in the common area in the hallway. She said she was doing fine. She was not able to answer any questions regarding her DNR status.<br><br>During an interview on 01/21/2026 at 10:17 the MDS Nurse said she was responsible for updated care<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | plans. She said she was made aware of Resident #3's DNR and had updated the care plan as of 01/20/26 (after surveyor intervention).<br><br>3. Record review of a face sheet dated 01/20/26 indicated Resident #35 was an [AGE] year-old male admitted on [DATE]. Her diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), lung disorder (health conditions that affect your airways (tubes leading into your lungs) or tissue that makes up your lungs), and kidney disease (condition where the kidney reaches advanced state of loss of function).<br><br>During an observation and interview on 01/19/2026 at 09:02 a.m. Resident #35 was in his bed in his room. An oxygen concentrator was at the bedside with a nasal cannula attached. Resident #35 said he was doing fine and had no issues.<br><br>Record review of an MDS dated [DATE] indicated Resident #35 had severely impaired cognition with a BIMS of 01 out of 15 and he had no oxygen use for the look back period.<br><br>Record review of the Nurse Notes with entry dated 01/11/2026 at 08:29 a.m. Resident #35 was non-responsive. His pupils were pinpoint and non-reactive. His vital signs were BP 110/52, P 48, RR 18, Oxygen saturation was 95% on room air. Hospice was notified. The RP was notified. The nurse with hospice indicated a hospice nurse would come to assess Resident #35. Oxygen at 2 liters per nasal cannula was applied.<br><br>Record review of the care plan reviewed 01/09/26 indicated Resident #35 was care planned for shortness of breath and was revised on 03/20/25. There was no intervention of oxygen use. Resident #35 was not care planned the use of oxygen and how much, O2 tubing and humidifier changing.<br><br>During an interview on 01/20/2026 at 01:15 p.m. LVN H said she received a verbal order from the hospice nurse to place Resident #35 on oxygen on 01/11/26 due to a decline in condition.<br><br>During an interview on 01/21/2026 at 10:17 a.m. the MDS Nurse said she was responsible for updated care plans. She said she was not aware of Resident #35's order for oxygen. She said she was not aware of Resident #35's oxygen order. She said the care plans should be updated when an order was received from the physician.<br><br>Record review of an Oxygen Administration policy revised October 2010 indicated Preparation: .2. Review the resident's care plan to assess for any special needs of the resident.<br><br>4. Record review of Resident #41's admission Record dated 01/20/2026 indicated she was an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included senile degeneration of brain (mental deterioration associated with aging), atherosclerotic heart disease (a condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), hypertension (a condition in which the force of the blood against the artery walls is too high), hypertensive heart disease (is a condition with damage to your heart from years of unmanaged or undermanaged high blood pressure), fracture of shaft of left humerus (broken bone upper arm), and osteoporosis (condition in which bones become weak and brittle).<br><br>Record review of Resident #41's quarterly MDS assessment, dated 11/11/2025, indicated she had a BIMS score of 09 indicating that she was moderately impaired cognitively. She made herself<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | understood and usually understood others. She required maximum assistance for self-care of toilet hygiene, upper and lower body dressing, and putting on/taking off footwear. She required set up and clean up assistance with eating, oral hygiene and personal hygiene. She required maximum assistance for mobility of sit to lying, lying to sitting, sit to stand, and chair/bed to chair transfer. She required moderate assistance to roll left and right and supervision or touch assistance with toilet transfer. She uses a manual wheelchair for mobility with moderate assistance from staff.<br><br>Record review of Resident #41's progress note dated 01/05/2026 indicated the nurse was summoned to resident's room, and the resident was observed on the floor in supine position. She had a hematoma (localized swelling of blood that occurs when a vessel ruptures) with laceration to right side of head. She stated she was reaching for water bottle on the floor and fell. She complained of pain, pain medication administered. She was able to move all extremities. She was transferred to local ER by local ambulance service for evaluation and treatment.<br><br>Record review of Resident #41's progress note dated 01/09/2026 indicated she returned to the facility and readmitted . She was able to move all extremities with limitations, and a splint to her left arm was in place.<br><br>Record review of Resident #41's care plan, revision dated 08/20/2025, indicated she had a risk for falls and a fracture of left humerus (upper arm bone) related to fall prior to admission. The care plan did not indicate Resident #1 had an updated or revised care plan for 01/09/2026 for a fall on 01/05/2026 or new intervention for fracture of shaft of left humerus or for immobilizer/splint to (l) shoulder, arm, and elbow until after surveyors' intervention. Further review of care plan indicated no interventions added since 08/20/2025 for fall interventions and intervention of splint to remain in place until follow up appointment added 1/20/2026 (after surveyors' intervention).<br><br>During an interview and observation on 01/19/2026 at 10:26 a.m., revealed Resident #41 was up in a wheelchair in the hallway, requesting staff to place her shirt/blouse on. Staff informed Resident #1 due to the immobilizer that her shirt/blouse sleeve would not fit over the splint/immobilizer. Resident #41 said she had a sling on her (l) arm and after her recent fall a new splint/immobilizer was applied. She said she thought the local ER applied the splint/immobilizer.<br><br>During an interview on 1/19/2026 at 10:28 a.m., CNA E said Resident #41 was admitted to the facility with a fractured (l) arm and had a recent fall (01/05/2026) and was sent to the local ER and returned several days later with the splint/immobilizer to her (l) shoulder, upper arm, and elbow. She said that Resident #41 had a sling prior to the fall on 01/05/2026 and she could wear her blouses but now that she had the immobilizer/splint her blouse sleeves would not fit over the splint. CNA E said she had the splint/immobilizer since she returned from the hospital about 1 to 1.5 weeks ago.<br><br>During an interview on 01/20/2026 at 11:00 a.m., the Administrator said Resident #41 had fallen on 01/05/2026 and was sent to the local ER for evaluation. She said Resident #41 was transferred to an inpatient hospice facility after her ER visit. She said Resident #41 returned to the local ER for pain from the inpatient facility and was transferred back to the facility. She said Resident #41 returned to the facility on [DATE] with the new immobilizer/splint to (l) shoulder, arm, elbow. She said hospice informed the facility that family had decided to have Resident #41 seen by an orthopedic for the (l) arm/shoulder injury and an orthopedic visit was scheduled by hospice.<br><br>During an interview on 01/21/2026 at 12:15 p.m., LVN A said she was the nurse for Resident #41. She said Resident #41 was admitted to the facility with a fractured (l) arm and she was supposed to wear (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | a sling but was not compliant with wearing the sling. She said today (01/21/2026) was her first day back on the hall and she was not aware Resident #41 had a new immobilizer/splint to her (l) shoulder/arm/elbow. She said Resident #41 was out of the facility at an orthopedic appointment for a reevaluation for her (l) shoulder, arm, elbow this morning and was awaiting her return. She said when residents had changes in care, the care plans were revised or updated by the MDS Coordinator or DON.<br><br>During an interview on 01/21/2026 at 1:15 p.m., the MDS Nurse said she participated in morning meetings, reviewed orders, 24-hour reports and incident reports and allegations. She said those were discussed during the morning meeting, if residents' care plans required updating and/or an IDT care plan meeting she would schedule it, if applicable. She said she recently took over the responsibilities of the MDS Coordinator when the previous MDS Coordinator retired. She said that Resident #1's care plan should have been updated with the current diet texture and Resident #41's care plan should have included interventions related to the splint/immobilizer to (l) shoulder, arm, and elbow when she returned from the hospital on [DATE]. She said not updating the residents' care plans could place residents at risk of not receiving appropriate interventions to meet their current needs. She said she was responsible for updating or revising care plans and the DON reviews the care plans for completion. She said if care plans were not updated or revised, the care plan would not reflect the current residents' needs.<br><br>During an interview on 01/21/2026 at 01:30 p.m., the Regional Nurse said the MDS Coordinator was responsible for updating or revising resident care plans when needed. She said DON was responsible for reviewing for accuracy. She said that Resident #1's care plan should have been updated with the correct diet texture and Resident #41's care plan interventions should have included the splint/immobilizer to the (l) arm, and she had added it to Resident #41's care plan on 01/20/2026. She said if care plans were not updated or revised, the care plan would not reflect the current residents' needs.<br><br>During an interview on 01/21/2026 at 1:40 p.m., the DON said that all incidents and allegations were discussed during morning meetings (including herself, Assistant DONs, Administrator, department heads, MDS Coordinator, and Regional Nurse per phone if needed) and the MDS coordinator was notified of any changes requiring care plan revisions, and she was responsible for updating the care plans. She stated new interventions should be added to the care plan regarding Resident #1's diet change and Resident #41's (l) shoulder, arm, and elbow immobilizer. She said the MDS Coordinator was responsible for updating and revising the care plan as indicated. She said she was responsible for monitoring and ensuring that the care plans were completed and updated by the MDS Coordinator. She said if care plans were not updated or revised, the care plan would not reflect the current residents' needs.<br><br>During an interview on 01/21/2026 at 02:00 p.m., the Administrator said she expected staff to update and revise residents care plans to accurately reflect the residents' needs.<br><br>Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised in 2023 indicated; Policy statement: A comprehensive, person-centered care plan that includes measurable objects and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 11. Assessments of residents are ongoing, care plans are revised as information about the residents and residents'' condition change. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 1 Medication Storage room and 1 of 3 medication carts (Hall 400 medication cart) reviewed for pharmacy services.The facility failed to remove expired normal saline (sodium chloride) vials that expired on 04/2025 from Hall 400 medication cart. The facility failed to ensure 2 individual prefilled 0.9 % normal saline (sodium chloride) vials for injection with an expiration date of [DATE], 13 red top plastic lab vials (small sealed container to store, transport and analyze liquid or solid samples in scientific settings) with an expiration date of [DATE] and 5 light green top plastic lab vials with an expiration date of [DATE] were removed from use in the Medication storage room.These failures could place residents at risk for not receiving the intended therapeutic response of medications and items which could result in diminished health and well-being.Findings included:During an observation and interview on [DATE] at 9:10 a.m., an inspection of Hall 400 medication cart with LVN A indicated 2 opened 0.9% sodium chloride 15 ml vials (typically used for cleansing, irrigation or wound care or washing eyes) with an expiration date of 04/2025 and 3 unopened 0.9% sodium chloride 15 ml vials with an expiration date of 04/2025. LVN A said she was responsible for Hall 400 medication cart today. She said the nurse that gave medication from the medication cart was responsible for checking for expired medication and items and the ADON double checked the medication carts monthly for expired medication and items. She said they were overlooked. LVN A said she had not given any of the expired medication or items today, and today ([DATE]) was her first day back on the cart after time off during her shift rotation. She said she was in-serviced to check her medication cart for expired medication and items. LVN A said the resident risk of expired medication and items on the medication cart was they may potentially not be as effective as they should be. During an observation and interview on [DATE] at 9:40 a.m., an inspection of the facility medication storage room with the MDS Nurse indicated 2 individual prefilled 0.9 % normal saline (sodium chloride) vials for injection (typically used for intravenous administration) 6.0 ml with an expiration date of [DATE] and 13 red top plastic lab vials (small sealed container to store, transport and analyze liquid or solid samples in scientific settings) with an expiration date of [DATE] and 5 light green top plastic lab vials of 4.5 ml with an expiration date of [DATE]. The MDS Nurse said the facility was no longer using the lab facility that used those vials, they had changed lab companies recently. She said the administrative nurses, ADON, MDS Nurse and DON were responsible for ensuring the medication room did not have expired medication and items and the pharmacy consultant was the backup that checked the medication carts and medication room monthly. She said she was in-serviced recently on ensuring the medication storage room did not have expired medication and supplies. She said the expired items should have been removed from the medication storage room. The MDS Nurse said the resident risk of expired medication and items was they potentially could be used on a resident and not be as effective as should be and the labs could be inaccurate. During an interview on [DATE] at 9:49 a.m., the ADON said she was responsible for reviewing the medication room for expired medication and items and drug destruction. She said she last checked the medication room yesterday ([DATE]) but the expired items were overlooked. The ADON said the facility recently changed lab facilities and were no longer using the found expired lab vials. She said the nurses that gave medication off the medication carts were responsible for the medication carts and she made random checks for expired medication on the medication carts. The ADON said she had not checked the medication carts this week. She said the nurses and MAs were educated to monitor medication carts for expired medication. She said the potential resident risk was abnormal lab values if the expired lab vials were used and the expired medication may not be as effective as they should be. During an interview [DATE] at 9:54 a.m., the (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | DON said she started working at the facility Tuesday ([DATE]) of last week. She said the nurses giving medication were responsible for ensuring all expired medication was removed from the medication carts. The DON said the ADON, MDS and DON were the back up to double check the medication carts. The DON said the nurses were responsible for ensuring the medication room was tidy and all expired medication and items were removed and the ADON, MDS and DON were the back up and would check monthly and as needed. She said the staff were in-serviced on removal of expired medication and items. She said the resident risk of expired medication and items was the medication may not be as effective and not take care of what it was meant to take care of. The DON said they were overlooked. She said her expectation was medication or items that were out of date to be removed from service before expiration. During an interview on [DATE] at 10:05 a.m., the Administrator said the nurses were responsible for medication carts with monthly checks by the pharmacy consultant and the ADON was responsible for the medication room with the DON as a backup to double check for expired medication and items. She said the staff were educated on reviewing the medication room and medication carts for expired medication and items. The Administrator said the expired medication and items were overlooked. She said the resident risk of expired medication and items in use was they may potentially not be as effective. The Administrator said her expectation was the medication room and medication carts be clean and organized with no expired medication or items. Record review of the Executive Summary of Consultant Pharmacist's Medication Regimen Review dated [DATE] indicated, .Overall, the carts/medication room were found secured, clean, and organized. Continue to secure internal/external medication stored separately. The staff is doing a good job removing expired/ discontinued medications with very few expectations. Continue to ensure medications requiring a date opened are dated. Record review of a facility policy revised [DATE], titled, Administering Medications: indicated, . 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were completely documented for 2 of 7 residents reviewed for complete medical records. (Residents # and #35)* The facility did not have orders for Residents #4 to reside on the secured unit. * The facility did not have orders for Resident #35 having oxygen This failure could place residents at risk of restraint, isolation, and not receiving the care needed. Findings included:1. Record review of a face sheet dated 01/19/26 indicated Resident #4 was a [AGE] year-old male admitted on [DATE]. His diagnoses included dementia (loss of cognitive functioning), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), mood disorder (mental disorders that primarily affect a person's emotional state), psychosis (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of the admission MDS dated [DATE] indicated Resident #4 had severely impaired cognition with a BIMS of 00 out of 15; had potential indicators of psychosis of hallucinations and delusions; physical behavioral symptoms directed at others for 1 to 3 days of the look back period; other behavioral symptoms not directed at others daily of the look back period; Put the resident at significant risk for physical illness or injury; Significantly interfere with the resident's care; Significantly interfere with the resident's participation in activities or social interactions; Resident had rejection of care behavior daily; wandering behavior daily; and wandering significantly intrude on the privacy or activities of others. During an observation and interview on 01/19/2026 at 09:03 a.m. Resident #4 was on the secured unit. He was in his room with many personal pictures hanging on the walls of the room. He was lying in bed. He said he had no issues. He was able to answer simple questions. Resident #4 got up and walked around his room. Record review of a Nurse Note for Resident #4 with an entry dated 10/01/2025 at 11:43 a.m. indicated Elopement Evaluation : History of elopement while at home: Yes. Wandering behavior a pattern or goal-directed: Yes. Wanders aimlessly or non-goal-directed: Yes. Wandering behavior likely to affect the safety or well-being of self / others: No. Wandering behavior likely to affect the privacy of others: No. Recently admitted or re-admitted (within past 30 days) and has not accepted the situation: No. Elopement Score: 5.0. Record review of the care plan dated 10/07/25 indicated Resident #4 was at risk for wandering/elopement identified-secured unit with appropriate interventions. Record review of the physician orders for January 2026 indicated Resident #4 did not have a physician order to reside on the secured unit. During an interview on 01/20/2026 at 01:15 p.m. LVN H said she was not aware of Resident #4 not having an order to reside on the secured unit. She said he was placed on the unit when he admitted . A record review of the undated Memory and Secure Care Unit Program Disclosure policy indicated .23.C.3. admission and discharge: Facilities with Memory and Secure Care Units shall have a written policy of preadmission screening, admission and discharge procedures. admission criteria shall require, at a minimum, a physician's diagnosis Alzheimer's Disease and/ or other Dementia, Cognitive Memory condition and/or exit seeking or wandering. The facility will obtain medical records, history and physical, medication administration record, lab reports. A physical assessment may be necessary based on the medical records. The policy shall include criteria for moving residents from within the facility, into or out of the unit. If a resident of the nursing facility exits or attempts to exit the facility and the resident has cognitive or safety concerns, the IDT team will evaluate the resident for placement on the Memory and Secure Unit. 2. Record review of a face sheet dated 01/20/26 indicated Resident #35 was an [AGE] year-old male admitted on [DATE]. Her diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), lung disorder (health conditions that affect your airways (tubes leading<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | into your lungs) or tissue that makes up your lungs), and kidney disease (condition where the kidney reaches advanced state of loss of function). Record review of an MDS dated [DATE] indicated Resident #35 had severely impaired cognition with a BIMS of 01 out of 15 and he had no oxygen use for the look back period. During an observation and interview on 01/20/2026 1:30 p.m. the O2 tubing was not on the floor but the O2 tubing was on Resident #35 with no date on the tubing. Resident #35 said he was doing fine and had no issues. Record review of the Nurse Notes with entry dated 01/11/2026 at 08:29 a.m. Resident #35 was non-responsive. His pupils were pinpoint and non-reactive. His vital signs were BP 110/52, P 48, RR 18, Oxygen saturation was 95% on room air. Hospice was notified. The RP was notified. The nurse with hospice indicated a hospice nurse would come to assess Resident #35. Oxygen at 2 liters per nasal cannula was applied.Record review of the physician orders for January 2026 indicated Resident #35 did not have a physician order During an interview on 01/20/2026 at 01:15 p.m. LVN H said she received a verbal order from the hospice nurse to place Resident #35 on oxygen on 01/11/26 due to a decline in condition. She said the orders for the oxygen were put in today. She said she should have transcribed the verbal order into the chart when she received it. She said if an order was not transcribed a resident could not receive the care needed. During an interview on 01/20/26 at 02:13 p.m. the DON said she expected the nurses to transcribe orders or a resident could not receive the care needed or be inappropriately placed on the secured unit. Record review of an Oxygen Administration policy revised October 2010 indicated Preparation: 1.Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 12 residents (Residents #8, #28, #35 and #39) observed for Infection Control. 1. The facility failed to implement EBP for Resident #8 during a G-tube dressing change on 01/20/2026.2. The facility failed to immediately implement Contact Isolation Precautions for Resident #28 when she admitted on [DATE], for MRSA of a wound.3. The facility failed to ensure the enhanced barrier precaution signage was posted on Resident #39's door. 4. The facility failed to ensure Resident #35's oxygen tubing was labeled and dated and the nasal cannula was not laying on the floor.<br><br>1. Record review of admission Record dated 01/20/2026, indicated Resident #8 was [AGE] years old with diagnosis including protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), dysphagia (difficulty swallowing) and gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) tube status.<br><br>Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 15 indicating that she was intact cognitively. She usually made herself understood and usually understood others. She required maximum assistance for self-care and mobility tasks. She receives nutrition and water by tube feeding.<br><br>Record review of Resident #8's care plan, dated 08/06/2024, indicated Resident #8 required tube feeding related to dysphagia and protein-calorie malnutrition and enhance barrier precautions. Interventions included gowns and gloves are recommended when performing high-contact resident care activities, residents are not restricted to their rooms and do not require placement in a private room, and EBP do not impose the same activity and room placement restrictions as contact precautions, they are intended to be longer-term approach to managing individuals colonized with targeted pathogens.<br><br>Record review of physician's orders for Resident #8 dated 10/17/2025 indicated requirements: 1. Gowns and gloves are recommended when performing high-contact resident care activities, 2. Residents are not restricted to their rooms and do not require placement in a private room, 3. EBP do not impose the same activity and room placement restrictions as contact precautions, they are intended to be longer-term approach to managing individuals colonized with targeted pathogens every shift. USE for residents with any of the following (when contact precautions do not otherwise apply): wounds or indwelling medical devices regardless of MDRO colonization status infection or colonization with MDRO<br><br>During an observation on 01/19/2026 at 10:55 a.m., revealed outside Resident #8's room was an EBP signage. There was a 3-drawer PPE cart located at entrance to Resident #8's room.<br><br>During an interview on 01/19/2026 at 10:56 a.m., Resident #8 said that facility staff performed her G-tube dressing change on the night shift, usually late night or early morning. She thought they wore gowns and gloves during the care, but she usually slept through the procedure.<br><br>During an observation on 01/20/2026 at 2:26 p.m., revealed LVN B provided G-tube dressing change.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | LVN B did not wear a gown during the dressing change/direct contact with Resident #8.<br><br>During an interview on 01/20/2026 at 2:40 p.m., LVN B said that she failed to follow the EBP because she forgot to wear a gown during the G-tube dressing change. She said she had been trained on EBP and should have applied a gown prior to entering the room to perform care to Resident #8's G-tube but forgot. She said that not wearing a gown during the G-tube dressing change could spread infection or cross contamination.<br><br>During an interview on 01/21/2026 at 1:40 p.m., the DON said she was recently hired at the facility. She said her expectations were for staff and visitors to perform hand hygiene upon entering and when leaving a resident's room, and when hands were soiled. She said EBP should be followed by staff with direct care provided to residents with MDROs, wounds, and indwelling devices. The DON said the risk of failing to perform EBP could lead to spread of infection to other residents or even staff.<br><br>During an interview on 01/21/2026 at 3:26 p.m., the Administrator said her expectations were that all staff adhere to the EBP when providing high contact care for residents with MDROs, wounds, and indwelling devices. She said not following EBP as required could cause spread of infection or cross contamination.<br><br>2. Record review of Resident #28's admission Order Summary Report dated 12/29/2025, indicated Resident #28 was [AGE] years old with diagnosis including a cutaneous abscess of buttock. Physician's orders included Contact Isolation Precautions related to abscess to left buttock. In addition, Contact Isolation for MRSA of a wound. (Methicillin-resistant Staphylococcus aureus (MRSA) infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections.) (Contact precautions are infection control measures designed to prevent the spread of germs transmitted through direct or indirect contact with a patient or their environment. Essential steps include placing patients in private rooms, wearing gloves and gowns for all interactions, and performing hand hygiene before entering and upon leaving the room).<br><br>Record review of Resident #28's admission MDS assessment dated [DATE] indicated a surgical wound requiring applications of nonsurgical dressings. Resident #28 was on antibiotics, opioid pain medication, and isolations precautions while a resident.<br><br>Record review of Resident #28's Care Plan Report dated 12/30/2025 indicated Resident #28 had an abscess. Interventions included Contact Isolation.<br><br>During an observation on 01/19/2026 at 09:00 a.m., noted outside Resident #28's room was EBP signage. A white sign was on the opened door that reflected to check at the nurse station before entering. There was a 3-drawer PPE cart located at entrance to Resident #28's room. The PPE cart did not contain the necessary PPE items such as isolation gowns, a stethoscope and blood pressure cuff, or digital thermometer. There was one partially empty box of disposable gloves sitting on top of the PPE cart.<br><br>During an observation and interview on 01/19/2026 at 12:00 noon, CNA D was observed entering Resident #28's room without donning PPE. She went into the room and gave Resident #28 a beverage. While in the room, she used Resident #28's cell phone to text her family member for her and then placed the phone on the overbed table. CNA D exited the room without performing hand hygiene. CNA D said she had been employed at the facility for approximately 2 years on a PRN (as needed) basis.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | She said she had been educated on infection control and on EBP and contact isolation precautions. CNA D acknowledged the lack of isolation gowns in the PPE cart at Resident #28's door. She said she thought she was to use PPE if only in direct contact such as bathing or assisting with clothing. She said she did not know who was responsible for stocking PPE carts and she could use PPE from any cart on the hall.<br><br>During an observation and interview on 01/19/2026 at 3:45 p.m., the ADON said she was the Infection Control Preventionist for the facility. She said Resident #28 was on contact isolation precautions for MRSA of a wound to her buttock. She acknowledged the EBP signage at Resident #28's room was unacceptable, and she should have had a Contact Isolation Precaution sign posted. She said the sign with instructions to check at nurse station before entering was intended for contact precautions. She said she was responsible for ensuring the PPE carts were stocked with adequate supplies. The ADON said she was responsible for in-service training of the staff regarding Infection Control.<br><br>During an interview on 01/21/2026 at 08:30 a.m., NP G said Resident #28 was on contact isolation for a wound with MRSA to her buttock. She said staff should be wearing full PPE and performing hand hygiene when entering and exiting the room. NP G said failure to follow the contact isolation protocols could result in an increased risk of spreading infections. She said the entrance to Resident #28's room should indicate the type of isolation and PPE usage needed.<br><br>During an interview on 01/21/2026 at 08:45 a.m., the Regional Nurse said her expectations were for the PPE carts to be always stocked with necessary supplies. She said not utilizing proper PPE could lead to the spread of germs. She said she expected staff and visitors to perform hand hygiene upon entering and exiting an isolation room as well as any time visibly soiled. The Regional Nurse said the transmission of MRSA could be transmitted to others by not following proper Infection Control protocols.<br><br>During an interview on 01/21/2026 at 1:40 p.m., the DON said she was recently hired at the facility. She said her expectations were for staff and visitors to perform hand hygiene upon entering and when leaving a resident's room, and when hands were soiled. She said gloves should be changed frequently when performing care with each resident. The DON said the risk of failing to perform hand hygiene or following specific isolation protocols could lead to other residents or even staff becoming ill.<br><br>3. Record review of a face sheet dated 01/21/2026 indicated Resident #39 was an [AGE] year-old female admitted on [DATE]. Her diagnosis included end stage renal disease (permanent failure of kidney function requiring hemodialysis or transplant for survival).<br><br>Record review of Resident #39's Order Summary Report dated upon admission on [DATE] indicated she had a right chest catheter port (an indwelling medical device used for hemodialysis) which was provided as an outpatient on Mondays, Wednesdays, and Fridays. A physician's order dated 01/06/2026 indicated EBP precautions to be followed due to indwelling medical devices.<br><br>Record review of the admission MDS dated [DATE] indicated Resident #39 was receiving hemodialysis and she was cognitively intact with a BIMS score of 14 out of 15.<br><br>During an observation and interview on 01/19/2026 at 09:15 a.m., revealed Resident #39 was observed exiting her room with her walker to ambulate in hallway. The surveyor noticed a dressing on her right chest wall. Resident #39 said it was her dialysis catheter and that she went to dialysis on Mondays, Wednesdays, and Fridays.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 01/19/2026 at 12:00 PM, CNA D said she was aware Resident #39 received hemodialysis 3 times per week but was unaware that she should be on EBP. She said she went by the signage placed on each resident's door to their room.<br><br>During an observation and interview on 01/19/2026 at 3:45 p.m., the ADON said she was the Infection Control Preventionist for the facility. She said Resident #39 was recently admitted to the facility and had been receiving hemodialysis 3 times per week. She said Resident #39 was on EBP precautions and should have signage attached to her door indicating precautions. She acknowledged there was no signage indicating Resident #39 was on EBP precautions and it must have been overlooked.<br><br>Record review of facility policy Enhanced Barrier Precautions dated August 2022 indicated the following: . Enhanced barrier precautions are utilized to prevent the spread of multi-drug-resistant organisms to residents.10.) Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11.) PPE is available outside of the resident rooms. 12.) Residents, families and visitors are notified of the implementation of EBPs throughout the facility.<br><br>Record review of facility policy Handwashing/Hand Hygiene dated 2001 indicated the following: . This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Administrative Practices to Promote Hand Hygiene.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors.Indications for Hand Hygiene: Hand hygiene is indicated: a) immediately before touching a resident. b) before performing an aseptic task c) after contact with blood, body fluids, or contaminated surfaces d) after touching a resident; e) after touching the resident's environment; g) immediately after glove removal.<br><br>Record review of facility policy Isolation – Categories of Transmission-Based Precautions dated 2001 indicated the following: . Transmission Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact Precautions: .1) Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the residence environment. 7) Staff and visitors wear gloves when entering the room. a.) while caring for a resident staff will change gloves after having contact with infective material for example when drainage b.) gloves are removed and hand hygiene performed before leaving the room c.) staff avoid touching potentially contaminated environmental surfaces or items in the residence room after gloves are removed. 8) staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated environmental surfaces or atoms in the residence room after gloves are removed)<br><br>4. Record review of a face sheet dated 01/20/26 indicated Resident #35 was an [AGE] year-old male admitted on [DATE]. His diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), lung disorder (health conditions that affect your airways (tubes leading into your lungs) or tissue that makes up your lungs), and kidney disease (condition where the kidney reaches advanced state of loss of function).<br><br>During an observation and interview on 01/19/2026 at 09:02 a.m. Resident #35 was in his bed in his room. An oxygen concentrator was at the bedside with oxygen tubing and a nasal cannula attached. The oxygen tubing and nasal canula was lying on the floor and not bagged. Resident #35 said he was (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | doing fine and had no issues. He was not able to answer questions appropriately.<br><br>Record review of an MDS dated [DATE] indicated Resident #35 had severely impaired cognition with a BIMS of 01 out of 15 and he had no oxygen use for the look back period.<br><br>During an observation and interview on 01/20/2026 1:30 p.m. the O2 tubing was on Resident #35 with no date on the tubing or the bag. LVN H said the O2 tubing should have a date on it or on the bag, so it was known when it was placed. She said the O2 tubing was to be changed weekly on Sunday nights by night shift. She said since this O2 tubing had no date on it then it was not known if it was the tubing surveyor saw on 01/19/26 during initial tour.<br><br>During an interview on 01/20/26 at 02:13 p.m. the DON said she expected the nurses to label the O2 tubing, O2 tubing was to be bagged when not in use and should not touch the floor. She said the tubing touching the floor could contaminate it and cause respiratory infection.<br><br>Record review of an Oxygen Administration policy revised October 2010 provided at the request of the surveyor had no indication of infection control procedures of the oxygen tubing and devices when not in use. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to formulate an advance directive was provided for 1 of 2 residents reviewed for resident rights. (Resident #26) * The facility did not have a valid Out of Hospital-Do Not Resuscitate (OOH-DNR) for Resident #26. This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, electrical shocking of the heart, having a tube placed in the throat and provided artificial breathing methods, and possibly being brought back to life in an unaware and unresponsive state. Findings included: Record review of physician orders for [DATE] indicated Resident #26 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), atrial fibrillation (a type of irregular heartbeat), diastolic heart failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), and convulsions (rapid, involuntary muscle contractions that can cause uncontrollable shaking and limb movement). An order dated [DATE] indicated Resident #26 had a DNR order. Record review of a quarterly MDS dated [DATE] indicated Resident #26 had adequate hearing, she had unclear speech, she was able to make herself understood sometimes, she was able to understand others sometimes, and she had severely impaired cognition with a BIMS of 3 out of 15. Record review of a Care Plan for Resident #26 indicated a care plan for Code Status: DNR with a problem start date of [DATE] and reviewed [DATE]. Record review of the OOH-DNR form dated [DATE] for Resident #26 indicated the Two Witnesses had the second witness with no date of when the witness signed the form. During an observation and interview on [DATE] at 09:14 a.m. Resident #26 was in bed in her room. She said she was doing fine. She was able to answer simple questions. She said she had no issues. During an interview on [DATE] at 02:32 p.m. the SW said she did some of the OOH-DNRs but not all of them. She said an OOH-DNR should be complete. She said Resident #26's OOH-DNR was missing the date of the second witness's signature. She said it would not be a valid OOH-DNR and the resident would be considered a full code. She said if a resident did not have a valid OOH-DNR the staff would have to initiate CPR. During an interview on [DATE] at 02:52 p.m. the DON said an OOH-DNR that was not complete was not valid and the resident was considered a full code. She said CPR would have to be initiated against a resident's wishes. Record review of a Do Not Resuscitate Order policy dated 2001 indicated Policy Statement: Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. Policy Interpretation and Implementation1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record.2. A Do Not Resuscitate (DNR} order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law} and placed in the front of the resident's medical record.a. Use only state-approved DNR forms.b. If no state form is required, use facility-approved form.3. In addition to the advance directive and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include:a. Physician Orders for Life-Sustaining Treatment {POLST};b. Physician Orders for Scope of Treatment {POST};c. Medical Orders for Life-Sustaining Tre'atment {MOLST};d. Medical Orders for Scope of Treatment {MOST};e. Clinicians Orders for Life Sustaining Treatment {COLST}; andf. Transportable Physician Orders for Patient Preference {TPOPP}.4. 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.5. Do not resuscitate {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.a. Verbal orders to cease the DNR will be permitted when two {2} staff members witness such request.b. Both witnesses must have heard the request<br>(continued on next page) |

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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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and both individuals must document such information on the physician's order sheet.c. The attending physician must be informed of the resident's request to cease the DNR order.6. The interdisciplinary care planning team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives.7. 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 in an effort to clarify and adhere to the resident's wishes.8. Inquiries concerning do not resuscitate orders/requests should be referred to the administrator, director of nursing services, or to the social services director. Record review of the INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER revised [DATE] indicated .In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses. Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676269 | A. Building<br>B. Wing | 01/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 7 residents (Resident #39) reviewed for new admissions.The facility did not accurately complete a baseline care plan within 48 hours of admission for Resident #39 to address EBP (Enhanced Barrier Precautions) related to hemodialysis (a procedure that acts as an artificial kidney to filter waste products, toxins, and excess fluid from the blood when the kidneys are no longer functioning properly).This failure could lead to residents not receiving necessary care and decreased quality of life.Record review of Resident #39's face sheet dated 01/21/2026 indicated Resident #39 was an [AGE] year-old female admitted on [DATE]. Her diagnosis included end stage renal disease (permanent failure of kidney function requiring hemodialysis or transplant for survival). Record review of Resident #39's Order Summary Report dated upon admission on [DATE] indicated she had a right chest catheter port (an indwelling medical device used for hemodialysis) which was provided as an outpatient on Mondays, Wednesdays, and Fridays. A physician order dated 01/06/2026 indicated EBP precautions to be followed due to indwelling medical devices. Record review of the admission MDS dated [DATE] indicated Resident #39 was receiving hemodialysis and she was cognitively intact with a BIMS score of 14 out of 15.Record review of a Baseline Care Plan dated 01/05/2026 gave no indication Resident #39 was on EBP while a resident. Section 3A, 1h Isolation or quarantine was left unchecked. Section 3F, 2 indicated Resident #39 required hemodialysis. During an observation and interview on 01/19/2026 at 09:15 a.m., Resident #39 was observed exiting her room with her walker to ambulate in hallway. The surveyor noticed a dressing on her right chest wall. Resident #39 said it was her dialysis catheter and that she went to dialysis on Mondays, Wednesdays, and Fridays. During an interview on 01/21/2026 at 01:30 p.m., the Regional Nurse said the admission nurses usually filled out the baseline care plans when the residents were admitted . She said the DON was responsible for reviewing for accuracy. She said Resident #39 was a dialysis patient and was on EBP. The Regional DON said the baseline should have reflected Resident #39 having been on isolation precautions and it was important for staff to be aware protecting Resident #39 from possible infections.During an interview on 01/21/2026 at 1:40 p.m., the DON said admission nurses input assessments of the baseline care plans. She said baseline care plans should be accurate and complete, and Resident #39's baseline should have included EBP. During an interview on 01/21/2026 at 02:00 p.m. the Administrator said she expected staff to be professional and complete information for the baseline care plan to accurately reflect the residents' needs. Record review of a Care Plans-Baseline policy dated March 2022 indicated. Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety. The facility failed to close, label and date a box of biscuits and bag of tater tots in freezer #4, to prevent exposure to air. This failure placed residents who ate food served by the kitchen at risk of cross contamination and food-borne illness.Findings include: During initial observation and interview on 01/19/2026 at 08:33 a.m., revealed freezer #4 in the kitchen contained the following: *an open unlabeled (missing the name of the food item, the open date, the expiration or use by date) original cardboard box containing a clear plastic bag of frozen biscuits that was not properly sealed and exposed to the elements. The Dietitian Manager said the bag contained frozen biscuits. *an open, unlabeled (missing the name of the food item, the open date, the expiration or use by date), clear plastic bag of frozen tater tots that was not properly sealed and exposed to the elements. The Dietitian Manager said the bag contained frozen tater tots. During an interview on 01/19/2026 at 08:40 a.m., the Dietitian Manager said that she was not aware that the frozen biscuits had to be resealed once original cardboard box was opened. She said that the plastic bag of tater tots should have been resealed and labeled with name of the food item, the open date, the expiration or use by date) once opened. She said moving forward her expectations were all products in the kitchen be stored correctly. She said packages of food items should be sealed so not to expose food to the elements. The Dietitian Manager said it was the responsibility of all the dietary staff to ensure products were labeled and stored correctly. She said she did spot checks periodically in kitchen to be sure everything was working in kitchen and completed a walk-through checking for sanitary conditions. She said not storing and preparing food appropriately could cause contamination and/or freezer burn affecting the freshness and quality of resident's food. During an interview on 01/19/2026 at 8:45 a.m., [NAME] F said she did not know who left the bags of food opened in the freezer, and used bags of food being stored should be sealed or they could cause freezer burn. She said she had been trained to ensure that after opening a food item, it should be labeled with the open date and stored in a sealed container. During an interview on 01/21/2026 at 3:24 p.m., the Administrator said she was the direct supervisor of the Dietary Manager, and she expected kitchen staff to follow policies on food storage and preparation including all open items to be closed/sealed, labeled/dated when open and discarded when expired. She said not storing and preparing food appropriately could cause freezer burn, affecting the freshness and quality of resident's food. Review of a facility policy, revised November 2022, on Food Receiving and Storage indicated Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerated/Frozen Storage: 1. All foods sored in the refrigerator or freezer are covered, labeled and dated ( used by date) . 8. Frozen foods are maintained at a temperate to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 01/21/2026 indicated: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers .(B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date. |