STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676338	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coon Memorial Home	210 Texas Blvd Dalhart, TX 79022

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #14) of 12 residents reviewed for resident rights. Resident #14 was observed with her catheter bag not in a privacy bag. This failure could cause residents to feel uncomfortable and disrespected leading to feeling of isolation and deterioration in general health conditions. Findings include: Record review of Resident #14's face sheet revealed she was an [AGE] year-old female resident admitted to the facility originally on 2-17-2023 and readmitted on [DATE] with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movements to include tremors) with dyskinesia (abnormality or impairment of voluntary movement), sever dementia (a group of thinking and social symptoms that interferes with daily functioning), other disease of the musculoskeletal system and connective tissue (a wide range of condition affecting bones, joints, and the supporting tissues often causing pain, reduced mobility, and functional limitations), chronic peripheral venous insufficiency (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), and repeated falls. Record review of Resident #14's last MDS revealed an admission assessment completed on 12-12-2024 with a BIMS that was not completed because she was rarely/never understood, and she had a functional status of being dependent on staff for all her activities of daily living. Resident #14 was marked as having an indwelling catheter. Record review of the care plan with admitted [DATE] for Resident #14 revealed the following: Focus: Resident has an indwelling catheter . Interventions: -there are no interventions for catheter bag storage. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03-17-25 at 11:00 AM Resident #14 was in her room in her bed sleeping. Resident #14 awoke to introduction but went back to sleep without responding. Resident #14 had a catheter bag hanging from the left side of her bed that could be observed from the hallway through Resident #14's open door. Noted amber urine in the catheter bag due to no privacy bag provided. During an observation on 03-17-25 at 11:24 AM noted that Resident #14's room was the last doorway on the left before residents and staff entered the Memory Units dining room. The dining room was open to the resident hallway with no doorways to prevent observation of Resident #14's room. Resident #14's catheter bag could be observed from the hallway. This surveyor observed 4 residents in the dining room that entered and could have observed the resident's catheter from the hallway. At this time two more residents entered the dining room with a staff members assistance. During an observation on 03-18-25 at 08:33 AM Resident #14 was observed from the hallway in her bed with her catheter bag hanging from the side of her bed without a privacy bag. A small amount of amber urine could be seen from the hallway. During an interview on 03-18-25 at 10:28 AM CNA A had just finished catheter care for Resident #14 and had placed the catheter on the side of the resident's bed without a privacy bag. From the hallway CNA A verified that Resident #14's catheter bag could be observed without a blue bag (privacy bag) and that the residents used to have a blue bag, but she (CNA A) did not know what happed to it. When asked if the catheter not being stored properly and out of view of visitors or other residents especially with entering the dining room could be an issue, CNA A reported that she did not feel it was an issue and that it would not bother anyone. During an observation on 03-18-25 at 10:50 AM Resident #14's catheter bag could be observed from the hallway without a privacy bag. During an observation on 03-18-25 at 01:06 PM Resident #14 was observed in her bed sleeping with her catheter bag hanging from the foot of the bed with no privacy bag. During an interview on 03-18-25 at 01:12 PM RN B verified that Resident #14's catheter bag was on the floor and was not in a privacy bag. RN B reported that the catheter should be stored off the floor to prevent infection and for hygiene purposes. RN B reported that the catheter bag should be in a privacy bag to provide privacy for Resident #14, that some residents might ask what is that, and point to the bag, and it should be covered for dignity purposes. RN B reported that leaving Resident #14's catheter bag exposed can affect other residents especially resident who can see it from the dining room and RN B stated, I just don't want them to see pee when they eat. During an interview on 03-19-25 at 09:10 AM the DON reported that a residents catheter bag should be stored below the resident bladder level, off the floor, and in a privacy bag. The DON reported that if the resident's catheter bag was not stored in a privacy bag, then other residents might ask questions as to why the resident has a catheter. The DON reported that if residents could observe the catheter bag while they are eating then it could affect their appetite. The DON also reported that not having a catheter bag in a privacy bag could affect the dignity of the resident who has the catheter. Record review of facility provided in-service sheets revealed CNA A was trained on Resident Rights on 2-5-2025 by the DON (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility provided policy titled, Quality of Life-Dignity revised August 2009, revealed the following: Policy Statement: Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist resident as needed by: a. helping the resident to keep urinary catheter bags covers;

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview and record review the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #36) of 12 residents reviewed for advance directives. The facility failed to ensure Resident #36's DNR was filled out completely, thereby rendering it invalid. This failure could place residents at risk of not having their end of life wishes honored. Findings Included: Record review of Resident #36's admission record dated 03/19/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue). Resident #36's family member A was listed as her emergency contact. Resident #36 was noted to be receiving hospice care. Record review of Resident #36's quarterly MDS completed on 03/05/25 revealed Resident #36 had a BIMS score of 3 which indicated severely impaired cognition. Record review of Resident #36's care plan completed on 03/05/25 revealed she was receiving hospice services and was a DNR. Both focus areas were initiated on 12/03/24. Record review of Resident #36's active orders dated 03/19/25 revealed a DNR order with order date of 11/25/24 and an admit to hospice with an order date of 11/25/24. Record review of Resident #36's DNR with the title Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Texas Department of State Health Services revealed her family member A signed the DNR in section C with the heading Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication . Resident #36's family member A failed to sign the DNR again in the last section with the heading, All persons who have signed above must sign below, acknowledging that this document has been properly completed. During an interview on 03/19/25 at 08:28 AM with LVN G and RN H, LVN G stated everyone was responsible for ensuring a resident's advance directives were followed. She stated if a DNR was not filled out correctly it was not valid. RN H stated nurses and DON were responsible for ensuring resident DNRs were filled out correctly. She stated a possible negative outcome of a DNR that was not filled out correctly was, Their (resident) wishes aren't observed. LVN G stated the fact that Resident #36's family member A did not sign the DNR form in the bottom section meant the DNR was invalid. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 08:40 AM ADON stated she and the DON were responsible to ensure resident advance directives were followed. She stated DON was responsible for ensuring DNRs were filled out correctly. She added, But we all kind of are (responsible). But she (DON) usually does the admission paperwork and then the physicians go over and sign it as well. During an interview on 03/19/25 at 09:23 AM ADM stated ADON and DON were responsible for ensuring resident advance directives were completed. She stated a DNR that was not correctly filled out was not valid. ADM stated a resident's wishes would not be adhered to if the DNR was not filled out correctly. Record review of facility policy titled Do Not Resuscitate Order and dated April 2017 revealed the following: . 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 a blank Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Texas Department of State Health Services Instructions for Issuing an OOH-DNR Order revealed the following: . 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. Record review of a section of the facility's admission packet with the heading Advance Directives revealed the following: . Every adult of sound mind has the right to decide what may be done to his/her body int eh course of medical treatment. Texas law allows the resident to make an advance directive concerning his/her medical care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation and interview the facility failed to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 4 (Resident #1, Resident #19, Resident #24, and Resident #27) of 12 residents reviewed for homelike environment. The facility failed to ensure the walls in the rooms of Resident #1, Resident #19, Resident #24, and Resident #27 were free of gouges, scuffs, holes, peeling paint, smears of some white substance, and shredded sheetrock. This failure could place residents at risk of feeling uncomfortable and uncared for in their home. Findings Included: 1. Record review of Resident #1's admission record dated 03/17/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic congestive heart failure (a lifelong condition that affects the left ventricle. It occurs when the heart muscle is weak, and the ventricle can't contract normally. Symptoms include shortness of breath, fatigue, leg swelling, and increased risk of arrhythmias and organ failure), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), cognitive social or emotional deficit following nontraumatic intracerebral hemorrhage (cognition issues following a stroke), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #1's quarterly MDS completed on 12/12/24 revealed a BIMS score of 13 which indicated intact cognition. Record review of Resident #1's care plan revealed a completion date of 03/14/25. During an observation and interview on 03/17/24 at 10:40 AM Resident #1 was seated in her recliner in her room. She stated she only occasionally participates in activities outside her room. The wall running along the far side of Resident #1's bed had several gouges and scratches through the paint into the sheetrock, several areas where a plastic feeling white substance had been smeared and possibly used to patch holes, and two roundish areas larger than fifty cent pieces where the sheetrock was scraped off and metal was showing through. During an observation on 03/17/25 at 12:14 PM Resident #1 was seated in her recliner eating her lunch from a rolling table positioned over her lap. The wall along the far side of her bed was as described above. During an observation on 03/18/25 at 08:20 AM Resident #1 was seated in her recliner eating her breakfast from a rolling table positioned over her lap. The wall along the far side of her bed was as described above. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 03/18/25 at 01:16 PM Resident #1 was seated in her recliner eating her lunch from a rolling table positioned over her lap. The wall along the far side of her bed was as described above. She stated the wall had been in that condition since she moved into the facility. 2. Record review of Resident #19's admission record dated 03/17/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), behavioral and emotional disorders with onset usually occurring in childhood and adolescence, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Resident #19 was noted to be on hospice care. Record review of Resident #19's quarterly MDS completed on 03/03/25 revealed she was severely cognitively impaired according to the staff assessment for mental status. Record review of Resident #19's care plan revealed a completion date of 03/03/25. During an observation on 03/17/25 at 10:53 AM Resident #19 was lying in bed on her right side facing the wall which was approximately 2.5 feet from her bed with her eyes closed and the lights off. During an observation on 03/18/25 at 01:21 PM the wall running along the side of Resident #19's bed had 26 areas of peeling paint of varying sizes. 3. Record review of Resident #24's admission record dated 03/17/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to Parkinsonism (conditions that affect the ability to move and live independently), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (inability to control constant worrying), spondylosis cervical region (narrowing of the spine resulting in stiffness and inability to move neck freely), and primary osteoarthritis of right and left hands (a degenerative disease that causes joint destruction, loss of grip strength, and fine motor skills). Record review of Resident #24's significant change MDS completed on 03/03/25 revealed she was on hospice care and had a BIMS of 99 which indicated she was unable to complete the assessment. The staff assessment for mental status indicated Resident #24 had severely impaired cognition. Record review of Resident #24's care plan revealed a completion date of 03/03/25. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/18/25 at 10:22 AM Resident #24 was lying on her back in her bed with her eyes closed. Her bed was in the lowest position. The wall next to her bed had three areas of shredded paint and sheetrock. The sheetrock was a torn into at a depth of approximately .25 inch in some places. The shreds that were hanging from the wall curled at the ends. It looked like a giant cat used the wall for a scratching post. The first area was approximately 5 inches across, and the shreds were approximately 10 inches long. There were 5 shreds in the first area each one approximately 2 inches wide. The second area was approximately 8 inches across at the top and had shreds hanging down approximately 15 inches. This area had approximately 15 shreds of varying lengths. The third area was approximately 3 inches across and had one large shred hanging down approximately 8 inches. All three areas ended approximately 4 inches from the baseboard which situated them directly in Resident #24's line of sight when she was in her bed with bed in lowest position. During an observation on 03/18/25 at 10:54 AM Resident #24 was receiving incontinent care and the wall next to her bed was as described above. During an observation and interview on 03/18/25 at 01:08 PM Resident #24 was lying on her back in her bed. Her bed was in the lowest position. The wall next to her bed was as described above. She asked, What do I do now? When asked how long the wall next to her bed had looked the way it did, she stated, I supposed it has been that way the whole time. 3. Record review of Resident #27's admission record dated 03/17/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia, major depressive disorder, and senile degeneration of the brain (a state of mental, emotional, and social deterioration resulting primarily from degeneration of the brain in old age). Record review of Resident #27's quarterly MDS completed 03/07/25 revealed a BIMS score of 5 which indicated severely impaired cognition. Record review of Resident #27's care plan revealed a completion date of 03/14/25. During an observation and interview on 03/18/25 at 01:14 PM Resident #27 was seated in her room in her w/c. The wall running along the side of Resident #27's bed had ten vertical scratches through the paint and into the sheetrock. The longest of the scratches was approximately 14 inches and the shortest was approximately 2 inches. The scratches were approximately .25 to .5 inches in width. Five of the scratches had small identical rings with circumference smaller than a dime imprinted in a greyish hue along the line of the scratch. Resident #27 stated the wall had been in that condition ever since I've been here but we (she and her roommate/partner) didn't do it. I don't let it bother me much. During an interview on 03/19/25 at 08:20 AM CNA E stated she had noticed the wall in Resident #24's room but had not noticed the walls in Resident #1, Resident #19, and Resident #27's rooms. She stated she did not know what happened to Resident #24's wall. She stated she thought maintenance request had been turned in regarding Resident #24's wall. CNA E stated she did not know how long Resident #24's wall had been in the condition it was in. She stated a possible negative outcome of walls being in disrepair was, I know some of them are not really mentally there as much so they can't really tell but it can have a negative effect. If it was me, I think it would be kinda upsetting in a way, for the quality of my room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/19/25 at 08:25 AM CMA F stated she had noticed the condition of Resident #24's bedroom wall but had not noticed the walls in Resident #1, Resident #19, and Resident #27's rooms. She stated she had no idea what happened to Resident #24's wall. She stated she did not think having walls in disrepair in their bedrooms would have a negative effect on residents. During an interview on 03/19/25 at 08:28 AM LVN G stated she had noticed the condition of Resident #24's bedroom wall but had not noticed the walls in Resident #1, Resident #19, and Resident #27's rooms. She stated of Resident #24's wall, I have no idea what happened there. She stated she was not sure if a work order had been turned in regarding Resident #24's wall and she did not know how long the wall had been in that condition. She stated maintenance as responsible for keeping the walls of the facility in good repair. During an interview on 03/19/25 at 08:40 AM ADON stated she had not noticed the walls in Resident #1, Resident #19, Resident #24, and Resident #27's rooms. She stated, They (the powers that be) have been talking about a new facility for several years. I think they even have land to put it on. That (building a new facility) is the goal and the plan. She stated maintenance is responsible for ensuring the walls of the facility are in good repair. During an observation and interview on 03/19/25 at 08:56 AM MS stated he was not aware of the condition of the walls in Resident #1, Resident #19, Resident #24, and Resident #27's rooms. When shown a picture of Resident #24's bedroom wall he stated, I think she (ADM) did put in a work order yesterday about it. When shown a picture of Resident #1's wall he stated, There is a lot of gouges. Let me see if they put in a work order. MS then scrolled through his cellphone. He stated, Yep, I got work orders today for all of those (Resident #1, Resident #19, and Resident #27's walls). MS stated there was not a negative outcome for residents having walls in disrepair. During an interview on 03/19/25 at 09:23 AM ADM stated she noticed the wall in Resident #24's room on 03/17/25 before you guys came in. She stated she put in a work order regarding the wall on 03/17/25. She stated her suspicion regarding the damage to all four walls in question was that it was made by the beds being against the walls. She stated, I have been fighting them (facility staff) to get the beds off the walls. My suspicion is gouging the walls when they had the beds up against the walls. ADM stated she had worked for the facility for 11 months and a few weeks. She stated she did not know how long the walls in Resident #1, Resident #19, Resident #24, and Resident #27's rooms had been in their current condition. She stated, Everyone has access to put in work orders. She stated, They (the powers that be) keep thinking we are going to have a new nursing home real soon. They already have the land; the city donated the land. She stated maintenance is responsible for keeping the facility walls in good repair. She stated, regarding impact on residents, Well, nobody wants to live in things that feel like they are falling down around their head. Plus, . the walls anything breaking those barriers could allow for pests or it is just not a cleanable surface. During an interview on 03/19/25 at 10:13 AM, the DON stated having walls in disrepair could negatively impact residents. She stated, Yeah, to me it makes it not feel like a homelike environment. I mean we want them as comfortable as they can be and if they see the room is run down and isn't cared for and especially for those with dementia it could get them upset and cause them to feel uncomfortable. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled Quality of Life-Homelike Environment and dated May 2017 revealed the following: .Residents are provided with a safe, clean, comfortable and homelike environment . The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment; .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 2 (Resident #12 and #36) of 12 residents reviewed for respiratory care. The facility failed to store Resident #12's nasal cannula properly. The facility failed to administer oxygen at the correct dose for Resident #12. The facility failed to store Resident #36's nasal cannula properly. This failure could affect resident by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings include: Resident #12 Record review of Resident #12's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should),, and chronic ischemic heart disease (a condition where the heats blood supply is reduced due to narrowed or blocked coronary arteries, leading to a mismatch between the hearts oxygen supply and demand). Record review of Resident #12's clinical record revealed her last MDS was an annual completed 2-21-2025 listing her with a BIMS of 2 indicating she was severely cognitively impaired, and she had a functionality of being dependent on staff for most of her activities of daily living. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #12 was marked as having oxygen While a Resident. Record review of Resident #12's Order Summary Report with Active Orders as of 3-18-2025 revealed the following order: - . Oxygen at 0.5 L to 2 L per minute as needed every shift - Active 10/23/2024. Record review of Resident #12's clinical record revealed a care plan with the admitted [DATE], revealed the following: Focus: Resident has Congestive Heart Failure. Date Initiated: 11-22-2024. (continued on next page)

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	676338	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coon Memorial Home	210 Texas Blvd Dalhart, TX 79022

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention: Oxygen setting - O2 via NC @ 2L Date Initiated: 11-22-2024. -there were no interventions for respiratory equipment care to include nasal cannula storage. During an observation on 03-17-2025 at 10:27 AM Resident #12 was not in her room. Noted was an O2 concentrator in the room on the left side of Resident #12's bed with Resident #12's nasal cannula laying on the floor with both nasal prongs in contact with the floors surface. Noted the nasal prong area to be yellowish brown in color. Noted no date on the cannula, tubing, or the hydration bottle of when they were accessed for use. During an observation on 03-17-25 at 11:13 AM Resident #12's nasal cannula was on the floor in the same place and position as before. During an observation on 03-17-25 at 12:17 PM Resident #12's nasal cannula was on the floor in the same place and position as before. During an observation on 03-17-25 at 02:15 PM Resident #12 was in bed sleeping and snoring loudly. Resident #12 was wearing her oxygen via her nasal cannula at 3L/min. Noted the nasal cannula to still be yellowish/brown at the nasal prong area and no date if changed had been marked on the cannula, tubing, or hydration bottle. Resident #12 did not wake to knocking or introduction. During an observation on 03-18-25 at 08:31 AM Resident #12 was not present in her room and her oxygen cannula and tubing were rolled up and folded up in the handle of the O2 concentrator. The cannula was hanging off the side of the machine but was not on the floor. During an observation on 03-18-25 at 10:48 AM Resident #12 was not present in her room and her oxygen cannula and tubing were rolled up and folded up in the handled of the O2 concentrator. The cannula was hanging off the side of the machine but was not on the floor. During an observation on 03-18-25 at 01:08 PM Resident #12 was in her bed sleeping on her back and snoring loudly. Resident #12 was wearing O2 at 3.5L/min via nasal cannula. Resident #36 Record review of Resident #36's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), peripheral vascular disease (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), and rheumatoid arthritis (autoimmune inflammation of the joints). Record review of Resident #36's clinical record revealed her last MDS was a quarterly completed 3-4-2025 listing her with a BIMS of 3 indicating she was severely cognitively impaired, and she had a functionality of requiring set-up/clean-up assistance for most of her activities of daily living. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #36 was marked as having oxygen While a Resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's clinical record revealed a care plan with the admitted [DATE], revealed the following: Focus: Resident has COPD. Date Initiated: 12-03-2024. Intervention: Oxygen setting - O2 via PRN Date Initiated: 12-03-2024. During an observation on 03-17-25 at 10:18 AM Resident #36 was in her bed under her covers with her head covered. Noted her O2 concentrator in her room with Hospice written on the concentrator and she was not wearing the oxygen. She was noted to be sleeping peacefully and in no distress. Noted the date of 3-1-2025 on the hydration bottle for the O2 concentrator and no date on the O2 tubing or nasal cannula. Noted the cannula was on the floor with noted yellowish/brown slight discoloration to the nasal prong area from use. The oxygen was running at 2L/min. During an observation on 03-17-2025 at 11:11 AM Resident #36 had changed her position in her bed but her oxygen nasal cannula remained on the floor. During an observation on 03-17-2025 at 12:25 PM Resident #36 was in her bed with the HOB elevated and her nasal cannula placed on her face. Noted the same discoloration of the nasal cannula and the hydration bottle for the O2 concentrator was still dated 3-1-2025. The resident was unable to remember her lunch or if the staff had placed her oxygen on her. During an observation on 03-17-2025 at 02:13 PM Resident #36 was in her room sleeping in her bed on her right side not wearing her O2. From behind Resident #36 her nasal cannula could be observed between her ribs and the bed. Resident #36 did not wake to knocking or introduction. During an observation on 03-18-2025 at 08:30 AM Resident #36 was in her bed sleeping on her back with her mouth open. Resident #36 was snoring softly. Resident #36's O2 was running, and her nasal cannula was on the floor. Her hydration bottle on the O2 concentrator machine was dated 3-1-2025. During an observation on 03-18-2025 at 01:10 PM Resident #36 was in her bed sleeping without oxygen on. Resident #36's O2 concentrator had been moved and her nasal cannula was hanging from the back of the machine 2-3 inches off the floor. Noted no date on the nasal cannula, the same discoloration, and date of 3-1-2025 on the hydration bottle. During an interview on 03-18-2025 at 01:515 PM RN B reported that a nasal cannula should never be left on the floor. RN B reported that she had instructed her CNAs to keep the nasal cannulas off the floor. RN B reported that if a nasal cannula was on the floor, then it should be immediately changed because it can result in the resident getting an infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03-19-25 at 09:18 AM the DON reported that residents' oxygen equipment such as the nasal cannula, tubing, and hydration chamber should be changed every month on the first, each should be labeled with the date when they are changed, and they should always be stored in a clear plastic bag. The DON reported that if a residents tubing was left on the floor, it should either be replaced or cleaned, and that staff are to make rounds every 2 hours and that they should check the oxygen in each resident's room to make sure they are clean and stored correctly. The DON reported that if the resident used a nasal cannula that has been on the floor, then that resident could be at risk for infection. During an interview on 03-18-2025 at 01:37 PM RN B checked Resident #12's O2 and reported that it was set at 3L/min and should be set at 2L/min. RN B immediately adjusted the oxygen down to 2L/min. RN B reported that administering the oxygen above ordered dose is a medication error. RN B reported that the facility did have standing orders that they can titrate a resident oxygen above 2L/min if they have low O2 saturations. RN B reported that she checked Resident #12's O2 sat on 3-17-2025 without wearing oxygen and Resident #12 had an O2 sat of 92% on room air that did not require the oxygen to be titrated above the ordered 2L/min. RN B reported that any medication given incorrectly can affect a resident negatively depending on what the medication is being administered for. During an interview on 03-19-25 at 10:21 AM the DON reported that nursing staff should be checking all resident who are on oxygen every shift to ensure they are on the right dose and should check the residents O2 sat every shift and prn to ensure they are breathing adequately. The DON reported that if a resident was not getting the correct dose of oxygen, then that resident was not getting the proper supply of the medication that was ordered and that would be considered a medication error. The DON reported that this would affect a resident negatively because they would not be getting the O2 therapy that they would need, it would affect the level of oxygen in the resident blood, and if the resident has a diagnosis of COPD, it would be detrimental to their condition. The DON reported that the facility's policy was to follow standard nursing guidelines when implementing orders and that they did not have a specific policy for physician orders. Record review of the facility provided policy titled Departmental (Respiratory Therapy) - Prevention of Infection revised November 2011, revealed the following: Purpose: The purpose of this procedure is to guide prevention of infection associate with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Step in Procedure: 8. Keep the oxygen cannula and tubbing used PRN in a plastic bag when not in use.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to, if a bed or side rail is used, assess the resident for risk of entrapment from bed rails prior to installation and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 1 (Resident #27) of 12 resident reviewed for bed rail use. The facility failed to assess Resident #27 and get the consent of her representative prior to installing a bed rail on her bed. This failure could place residents at risk of injury or entrapment. Findings Included: Record review of Resident #27's admission record dated 03/17/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia, major depressive disorder, and senile degeneration of the brain (a state of mental, emotional, and social deterioration resulting primarily from degeneration of the brain in old age). Record review of Resident #27's quarterly MDS completed 03/07/25 revealed a BIMS score of 5 which indicated severely impaired cognition. Record review of Resident #27's care plan revealed a completion date of 03/14/25 and no mention of bed rails. Record review of Resident #27's active orders dated 03/18/25 did not contain an order for bed rails. Record review of Resident #27's Assessment tab in her EHR revealed no bed rail assessment. Record review of Resident #27's Miscellaneous tab in her EHR revealed no consent for bed rails. During a record review on 03/18/25 at 01:11 PM of Resident #27's paper chart no consent or assessment for bed rails was found. During an observation on 03/18/25 at 10:51 AM a bed rail was in the upright position on the left hand side of the top of Resident #27's made bed. During an observation and interview on 03/18/25 at 01:14 PM Resident #27 was in her wheelchair in her room. Her roommate/partner was in his recliner in the room. When asked if she used her bed rail, Resident #27 stated, Occasionally I use it to help me get up. At the same time she was speaking her roommate/partner stated, It keeps her from falling out of bed. Resident #27 then stated, Or to keep me from falling out of bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 08:28 AM with LVN G and RN H, RN H stated a resident needed a doctor's order and a consent to have bed rails. She stated the bed rails would also need to be in the resident's care plan. RN H and LVN G stated no one in the facility had bed rails. They stated if a resident had bed rails the nurses would be responsible for doing assessments and consents. When asked why Resident #27 had a bed rail on her bed, LVN G stated she did not know. RN H stated a possible negative outcome of a resident having a bed rail without a consent or assessment was if they fall, they have farther to fall. During an interview on 03/19/25 at 08:40 AM, the ADON stated a resident would need a doctor's order, consent and assessment to have bed rails. She stated nurses were responsible for assessments and consents. She stated of bed rails in the facility, We usually don't have them. The ADON stated in the case of Resident #27 it was likely her roommate/partner who put the bedrail up on her bed. She stated, "He (Resident #27's roommate/partner) tries to do everything for her (Resident #27). The ADON stated a bed rail without a consent or assessment could result in a resident getting hurt. She stated, Obviously it can do more damage than good. During an interview on 03/19/25 at 09:23 AM, the ADM stated a resident would need a doctor's order and assessment to have a bed rail. She stated, Have to have it (bed rail) care planned. She stated the ADON and the DON were responsible for completing bed rail assessments and consents. During an interview on 03/19/25 at 10:13 AM, the DON stated she an the ADON were responsible for completing bed rail assessments and consents. She stated Resident #27's roommate/partner most likely put the bed rail up on resident #27's bed. The DON stated she turned in a work order on 03/19/25 to have the bed rails removed from Resident #27's bed. Record review of facility policy titled Proper Use of Side Rails and dated December 2016 revealed the following: . 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. 4. The use of side rails as an assistive device will be addressed in the resident care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. 11. The resident will be checked periodically for safety relative to side rail use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31882 Based on observations, interviews, and record reviews, the facility failed to ensure that each resident received, and the facility provided foods that were at a safe temperature and palatable for 1 of 1 test tray in that: 1. The facility failed to serve food that was palatable. 2. Test tray lunch foods were lukewarm when served. The meat and carrots were tough and potato salad had a strong vinegar taste. These failures could affect all residents who ate their meals prepared by the facility kitchen by placing them at risk of weight loss, altered nutritional status, and diminished quality of life. The findings were: In an observation of the dining room lunch on 3/17/25 at 11:30 am, the food carts were observed in the hallway in a warming box for approximately 20 minutes before the facility staff began serving trays. In an observation and interview on 3/17/25 at 12:05 pm one resident was observed trying to cut the corned beef served at lunch with a fork and knife. After attempting to cut the meat, she picked up the meat with her fingers and tried to tear it into small pieces. The meat would not tear easily into smaller pieces. She stated the meat was so tough she could not cut it or tear it. After attempting to eat it, she stated it was too tough to eat. In an observation and interview on 3/17/25 at 12:12 pm of the lunch meal, one resident with a mechanical diet had been served the quarter sized sliced carrots with mechanical ground meat. She stated she could not eat the carrots as they were too tough to chew and were too tough to cut. On 3/17/25 at 12:30 pm, test trays for Mechanical Soft, Puree and Regular diets were requested. In an observation on 3/17/25 at 12:40 pm, a test tray from the kitchen was served to the surveyors. Present was the survey team. The regular tray was provided and consisted of Corned Beef slices, red potatoes, sliced carrots, corn bread and pudding with marshmallows on top. The mechanical tray consisted of mechanical ground Corned Beef with white gravy, mashed potatoes with white gravy and whole sliced carrots. The pureed meal consisted of pureed Corned Beef, pureed carrots and pureed potato salad. The sampling of the test tray revealed: The Corned Beef on the regular plate was so tough it could not be cut with a knife. The Corned Beef was so tough it was not able to be chewed. The sliced carrots were approximately the size of a quarter and were tough and chewy; The carrots were hard to chew. The cornbread was dry and hard to swallow. The carrots on the mechanical ground plate were large peices , the size of a quarter and were tough to chew. On the pureed tray, the potato salad was in a puddle, requiring the use of a spoon to eat it. The pureed potato salad had a strong taste of vinegar. There was no pureed bread on the tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All the foods in each sampled tray were cold. In an observation of the breakfast meal on 3/18/25 at 8:00 am, the food cart was observed sitting in the hallway by the dining room for 13 minutes before the nursing staff began passing the breakfast trays. In an observation of the breakfast meal on 3/18/25, residents in the dining room stated the eggs were cold when they were served. In an interview on 3/18/25 at 10:40 am, the acting DM stated she heard the resident's say the food was cold and they do not like some things that are served. She stated the food was hot when it was sent out of the kitchen, but the nursing staff do not serve the food right away. She stated the nursing staff let the food sit in the cart for 10 to 20 minutes before passing trays. When told the Corned Beef was tough and residents could not chew the meat, the DM stated she knew the meat was tough. She stated the consequences of cold food, and tough meat were resident dissatisfaction with meals which could lead to weight loss. She stated she was not aware residents with a mechanical diet were served sliced carrots and stated the carrots should have been chopped up into smaller pieces. She stated residents on a mechanical diet could choke on foods that were too large or too tough to chew. she stated the dietician has been notified about the issues in the kitchen. She stated the issues had been discussed in the facility Quality Assurance program and a plan had been made to adress the issues. In an interview on 3/18/25 at 10:45 pm the [NAME] D stated the corned beef served on 3/17/25 was tough and the potato salad was runny on the pureed trays and did taste of strong vinegar. She stated the purees were supposed to be a pudding consistency and they were not yesterday. She stated the carrots on the mechanical tray should have been chopped up for the mechanical trays. She stated the dietician has been aware of the issues in the kitchen. She stated the dietician trained the kitchen staff in the kitchen duties. In an observation and interview on 3/18/25 at 12:10 pm, one resident with a pureed meal had a runny green substance on her plate. She stated she did not know what that was and it did not taste good. She stated since it was green maybe it was avocado. She stated she was not sure. She stated she did not want anything else and did not want to order anything else. She stated whatever she ordered would not taste good either. Review of the resident meal ticket revealed the green substance was green beans. In an observation and interview on 3/18/25 at 12:11 pm, one resident stated the meatloaf was too hard to cut with a knife and he could not chew it. He stated he did not want an alternative. In a confidential group interview on 3/19/25 at 9:40 am, all 10 residents attending the group stated of breakfast lunch and dinner, the majority of the food is served cold. One resident in the group stated I don't think I've ever had scrambled eggs warm. And you can't eat a cold egg. All residents agreed. The group stated and agreed the meats were so tough you could not chew them. One resident stated the meatloaf served on 3/18/25 was so tough they could not cut it. All residents confirmed the foods had no flavor. One resident stated the food did not look good and they could not tell what the foods served were. All residents stated the food served as a replacement meal had the same issues of being cold and tough. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/19/25 at 8:30 am, the ADM stated she was aware the residents were complaining of the food being cold and not tasting good. The ADM stated she had tasted the food at least weekly and stated, It's kind of hit or miss with the taste. She stated the consequences of not having food that was palatable would-be poor nutrition, not having enough to eat, losing weight, and poor meal satisfaction. She stated the issues had been discussed in the facility Quality Assurance program and a plan had been made to adress the issues. The ADM stated she was not aware that the meal tray for lunch on 3/17/25 for mechanical soft foods had large, sliced carrots that were crunchy and hard to chew on 3/17/25. She stated the crunchy, hard to chew carrots would be a choking hazard for residents who were on a mechanical soft diet. The ADM stated she had no policy for test trays. Record review of the facility's resident council meeting minutes from the past 6 months revealed the month of September 2024 documented resident complaints of food being cold, tasted bad and was horrible. Record review of the facility's resident council meeting minutes from the past 6 months revealed the month of October 2024 documented many resident complaints of food being cold, hard, difficult to eat, the hot cereal was too runny and the eggs were gross. Record review of the facility's resident council meeting minutes from the past 6 months revealed the month of November 2024 documented resident complaints of food being awful. Record review of the facility's resident council meeting minutes from the past 6 months revealed the month of December 2024 documented resident complaints of food being cold. Record review of the facility's resident council meeting minutes from the past 6 months revealed the month of February 2025 documented resident complaints of food being cold, too salty and the hot cereal was too runny. Record review of the facility's grievance log from September through February revealed: In October residents did not get all the menu items listed on the menu for the dinner meals. In February 2025, five residents complained they did not get a dinner tray until the kitchen was contacted after everyone was served. The meals in February had multiple residents' complaints of cold food and not getting all the foods listed on the menu. Record Review of the facility policy dated October 2017, titled, Food and Nutrition Services revealed Each resident is provided with a nourishing, palatable well-balanced diet that meets his or her daily nutritional requirements and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure the correct meal is provided to each resident, the food appears palatable and attractive. Record Review of the facility policy dated 7/18/22, titled Standardized Diet Parameters revealed a Mechanical Soft diet is specific for those with difficulty chewing regular textured foods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 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 diseases and infections for 2 (CNA A and CNA C) of 4 staff observed for infection control. -CNA A did not ensure that a residents catheter bag remained off the floor after care was provided to Resident #14. -CNA C did not wash her hands while performing incontinent care for Resident #24. This deficient practice has the potential to affect residents in the facility receiving incontinent care by exposing them to care that could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene. Findings include: Resident #14 Record review of Resident #14's face sheet revealed she was an [AGE] year-old female resident admitted to the facility originally on 2-17-2023 and readmitted on [DATE] with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movements to include tremors) with dyskinesia (abnormality or impairment of voluntary movement), sever dementia (a group of thinking and social symptoms that interferes with daily functioning), other disease of the musculoskeletal system and connective tissue (a wide range of condition affecting bones, joints, and the supporting tissues often causing pain, reduced mobility, and functional limitations), chronic peripheral venous insufficiency (a circulatory condition in which narrowed blood vessels recue blood flow to the limbs), and repeated falls. Record review of Resident #14's last MDS revealed an admission assessment completed on 12-12-2024 with a BIMS that was not completed because she was rarely/never understood, and she had a functional status of being dependent on staff for all her activities of daily living. Resident #14 was marked as having an indwelling catheter. Record review of the care plan with admitted [DATE] for Resident #14 revealed the following: Focus: Resident has an indwelling catheter . Interventions: -there are no interventions for catheter bag storage. (continued on next page)

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	676338	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coon Memorial Home	210 Texas Blvd Dalhart, TX 79022

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03-18-2025 at 10:03 AM CNA A performed catheter care for Resident #14. Upon completion of the care CNA A place Resident #14's catheter bag at the foot of the bed and lowered the bed to the lowest position placing the catheter bag in contact with the floor. Resident #14 was noted to be unable to respond to questions during the performance of her catheter care. During an interview on 03-18-202 at 10:28 AM CNA A from the hallway of Resident #14's room observed Resident #14's catheter bag and reported that it was on the floor. CNA A reported that the catheter bag should be up off the ground and in a blue bag. CNA A reported that the catheter bag should be off the ground so it would not become contaminated. CNA A indicated this contamination could happen from infection or the chemicals housekeeping uses to clean the floors. During an observation on 03-18-2025 at 01:06 PM Resident #14 was in her bed sleeping with her catheter hanging from the foot of the bed with no privacy bag and the bottom half of the bag was in contact with the floor. During an interview on 03-18-2025 at 01:12 PM RN B verified that Resident #14's catheter bag was on the floor and was not in a privacy bag. RN B reported that the catheter should be stored off the floor to prevent infection and for hygiene purposes. During an interview on 03-19-25 at 09:10 AM the DON reported that a catheter bag should not be left on the floor and that if the bag was left on the floor, then it could place the resident at risk for infection such as a UTI. Resident #24 Record review of Resident #24's face sheet revealed she was an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movements to include tremors), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), cervical spondylosis (a degenerative condition that affects the bones (vertebrae) and discs in the neck (cervical spine). Record review of Resident #24's last MDS revealed a significant change of condition assessment completed on 2-26-2025 with a BIMS of 99 because Resident #24 could not complete the assessment, and she had a functional status of being dependent on staff for all her activities of daily living to include personal hygiene. Record review of the care plan with admitted [DATE] for Resident #24 revealed the following: Focus: Resident has an ADL self-care performance deficit . - Date initiated 10-30-2024 Interventions: Toilet Use-Resident is incontinent of bowel and bladder. 2 staff for brief changes. - Date initiated 10-31-2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03-18-2025 at 10:34 CNA C was performing incontinent care for Resident #24. CNA C removed wipes 5 times to remove a small amount of BM from Resident #24's rectal area, then remove her gloves, (CNA C did not wash her hands or uses ABHR) CNA C placed a new set of gloves, then placed the resident's new brief. During an interview on 03-18-2025 at 10:45 AM CNA C verified that she did not wash her hands between glove changes, that she had been taught by a night nurse that as long as she changed her gloves, she did not need to wash her hands, that she was still clean. CNA C reported that the night nurse was an agency nurse, and she did not remember the night nurse's name. CNA C verified that the facility did train her on incontinent care and hand hygiene when she was hired in October. CNA C reported that she did not feel the resident was at any risk for infection because she changed her gloves the way she was taught. During an interview on 03-19-2025 at 09:13 AM the DON reported that with incontinent care staff are expected to wash their hand or use hand sanitizer upon entering the resident's room. After they complete the dirty portion of the care staff should wash their hands or use hand sanitizer and then place new gloves before moving to the clean portion of the care such as putting on a new brief. Staff should also perform hand hygiene before exiting the resident's room. The DON reported that if staff do not wash their hands or use hand sanitizer between glove changes then they would place the resident at risk for infection such as a UTI. Record review of the facility provided training revealed CNA A and CNA C were trained on 2-5-2025 by the DON for the following: Hand Hygiene Peri-Care-Incontinence Care Record review of the facility provided policy titled Catheter Care, Urinary revised September 2014, revealed the following: Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control- b. Be sure the catheter tubing and drainage bag are kept off the floor. Record review of the facility provided policy titled Handwashing/Hand Hygiene revised August 2015, revealed the following: Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46534 Based on observation and interview the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in 2 (Hall L,and Hall CYNS) of 4 halls reviewed for environment. The facility failed ensure the flooring in the hallway running from the lobby into the locked unit (Hall L) remained affixed without the aid of tape. The facility failed to address tripping hazards in the hallway running in front of the courtyard nurses' station (Hall CYNS). These failures could cause residents to feel uncomfortable in their home, could place residents at risk of falling, and could lead to an unsanitary environment. Findings Included: During an observation on 03/18/25 at 01:06 PM 17 pieces of black tape the same width as duct tape and varying in length from 10 to 4 inches was noted on the floor of Hall L. Three of the pieces of black tape seemed to have missing floor underneath them. The other 14 pieces of black tape were over seams in the flooring. During an observation on 03/18/5 at 01:06 PM two rectangles formed from red tape the width of duct tape were observed in Hall CYNS. The red tape was worn through in several places and missing small pieces in several other places. The smaller of the two rectangles was out from the wall of the hallway approximately 2. 5 feet and measured approximately 6 X 9 inches. In the center of the rectangle the flooring was raised and cracked with grey underfloor showing through. This raised cracked area was approximately 3 inches across. The larger of the two rectangles was approximately 2.5 feet out from the opposite wall of the hallway and measured approximately 9 X 13 inches. In the center of this rectangle the flooring was cracked and raised with grey underfloor showing through. This raised cracked area was approximately 5 inches across. The two rectangles were separated from one another across the hall by approximately 10 inches and down the hall by approximately 22 inches. During an interview on 03/19/25 at 08:20 AM CNA E stated she had noticed the red tape rectangles on the floor of Hall CYNS. She stated, It is just to make sure everybody knows there's a bump there so they don't trip and fall. It has been that way since I started working here in 2023. She stated the floors being in disrepair could negatively affect residents in a way, probably. During an interview on 03/19/25 at 08:25 AM CMA F stated she had noticed the black tape on the floor of Hall L. She stated, I think it is when we had that flood thingy and they replaced it (the flooring). CMA F stated she had noticed the red taped rectangles on the floor of Hall CYNS. She stated she did not think having floors in disrepair would have a negative effect on residents. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/25 at 08:28 AM LVN G stated she had noticed the black tape on the floor of Hall L. She stated the tape was on the floor because the edges (of the flooring) looked like they were coming up. LVN G stated, Black tape is where the seams (of the flooring) meet, the corners were starting to peel from being walked on so much [and] wheelchairs rolling across; wear and tear I guess. She stated the pieces of black tape have gradually been added a piece here and a piece there since she began working in the facility about a year ago. She stated she did not know if the black tape in Hall L would negatively impact residents. LVN G stated she had noticed the red taped rectangles on the floor of Hall CYNS. She stated the taped rectangles were on the floor because there are bumps, so it is visual. LVN G stated the taped rectangles had been on the floor since she began working in the facility about a year ago. She stated maintenance was responsible for keeping the floors of the facility in good repair. She stated residents could trip on the raised cracked areas of flooring in the middle of the red taped rectangles. During an interview on 03/19/25 at 08:40 AM ADON stated she had noticed the black tape on the floor of Hall L. She stated, I think we had some of the little wood planks that were not just completely glued down so (they were taped) to prevent tripping. ADON stated she had noticed the red taped rectangles on the floor of Hall CYNS. She stated, They (the powers that be) have been talking about a new facility for several years. I think they even have land to put it on. That (building a new facility) is the goal and the plan. She stated maintenance is responsible for ensuring the walls of the facility are in good repair. She stated she did not think the floor being disrepair would have a negative effect on residents. During an interview on 03/19/25 at 08:56 AM MS stated he was aware of the black tape on the floor of Hall L. He said, The black tape is the floor coming up. They gave us the wrong floor. This floor was not meant for high foot traffic. He stated the floor of Hall L had been in that condition for 2 months. MS stated the black tape would not negatively effect residents. MS stated he was aware of the red taped rectangles on the floor of Hall CYNS. He said, The concrete (under the flooring) is coming up. He stated, I believe we are going to have to bust up the floor right there and level everything. He stated the floor of Hall CYNS had been in that condition for a while, 6 months or so. MS stated the floor in the red taped rectangles was a trip hazard. During an interview on 03/19/25 at 09:23 AM the ADM stated she had noticed the black tape in Hall L about two months ago. She stated the floor was put down in October of 2023 and it was chipping and coming up at the seams. ADM stated she had noticed the red taped rectangles in Hall CYNS. She stated the red taped rectangles were to alert peoples' attention to the area so they can avoid and it and not trip over it. ADM stated, Red tape has been here since before I came and they say it is a foundational issue, so to fix it they are going to have to break into the concrete and repour. She stated, They (the powers that be) keep thinking we are going to have a new nursing home real soon. They already have the land; the city donated the land. She stated maintenance is responsible for keeping the facility floors in good repair. She stated, regarding impact on residents, Well, nobody wants to live in things that feel like they are falling down around their head. Plus, it could be a trip hazard on the floor. During an interview on 03/19/25 at 10:13 AM the DON stated having floors in disrepair could negatively impact residents. She stated, Yeah, to me it makes it not feel like a homelike environment. I mean we want them as comfortable as they can be and if they see the room is run down and isn't cared for and especially for those with dementia it could get them upset and cause them to feel uncomfortable. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Quality of Life-Homelike Environment revealed the following: .Residents are provided with a safe, clean, comfortable and homelike environment . The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment; .