STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676347	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amarillo Center for Skilled Care	6641 W Amarillo Blvd Amarillo, TX 79106

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to consider the views of a resident group and act promptly upon the grievances of such groups concerning issues of resident care and life in the facility and demonstrate their response and rationale for such response for 3 of 4 months of Resident Council meetings reviewed in that: Feedback and follow-up to concerns expressed during Resident Council Meetings was not provided for December 2025, January 2026, and February 2026. This deficient practice had the potential to affect residents participating in Resident Council meetings and placed them at risk for decreased quality of life and unresolved grievances.The findings were: Record review of Resident Council Minutes dated 12/04/2025 revealed concerns regarding the Nutrition Services, specifically incorrect menu tickets and meals not matching what was ordered. There was no documentation indicating resolution of these concerns. Record review of Resident Council Minutes dated 01/01/2026 revealed concerns regarding the Nutrition Services, specifically incorrect menu tickets and meals not matching what was ordered. There was no documentation indicating resolution of these concerns. Record review of Resident Council Minutes dated 02/06/2026 revealed concerns regarding the Nutrition Services, specifically incorrect menu tickets and meals not matching what was ordered. There was no documentation indicating resolution of these concerns. During an anonymous interview on 02/19/2026 at 10:30 AM, with residents, 5 of 5 residents stated they had ongoing concerns about not receiving the correct meal according to their tickets and reported feeling staff were not listening to their concerns because nothing has been done. One resident reported at times that she would order the alternative meal for that day but would not get it but would get the original meal for that day. During an interview with the AD on 02/19/2026 at 1:34 PM, The AD stated she took notes during the meetings as requested by residents. The AD stated she would provide the meeting notes to the ADM or the SW. The AD stated she did not believe it was her responsibility to follow up on concerns expressed during the meetings, as her role was limited to documenting the discussion.The AD acknowledged concerns were raised during the meetings; however, she stated she did not know what actions were taken to resolve the concerns after the meetings concluded. The AD stated she believed the ADM or SW were responsible for follow up. The AD was unable to explain how she verified that concerns raised during Resident Council were addressed or resolved. During an interview on 02/19/2026 at 2:00 PM, the SW, who had worked at the facility for two months stated she had not received the Resident Council meeting notes containing resident concerns. The SW stated had she received the notes, she would have followed up by addressing the concerns with the Resident council or the appropriate department. The SW acknowledged that the failure to follow up on Resident Council concerns could result in resident feeling they are not being heard. During an interview on 02/19/2026 at 2:04 PM, the ADM who began working at the facility approximately two weeks prior, stated he met with the Resident Council in February. The ADM acknowledged it was the ADM's responsibility to ensure residents' concerns were addressed and followed through to resolution. During an interview on 02/20/2026 at 8:28 AM, the DM stated she was not aware of the Resident Council meetings concerning any dietary issues, including incorrect menu items or meal tickets. The DM stated the only correspondence she would receive regarding Resident Council was the meal of the month. The DM stated if she had been informed of the concerns, she would have addressed them. The (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DM acknowledged residents should get the meal they ordered for that day, and their meal ticket should be accurate. Record review of facility's policy on grievances dated 1/12/2023 revealed the following:The resident has a right to organize and participate in resident groups in the facility. The facility must consider the views of a resident or family group and act promptly upon the grievance and recommendation of such groups concerning issues of resident care and life in the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 6 of 6 medication carts reviewed to meet the needs of each resident. The Controlled Drugs Count Record on 6 medication carts for shift-to-shift narcotic counts had multiple blanks which indicated that the narcotic count was not completed at shift change. The Glucometer Quality Control Log High/Low Controls were not tested every night. This failure could result in narcotics being misappropriated from the facility which could result in ineffective treatment resulting in exacerbation of residents' disease processed. Findings include: Observations on 2/18/26 of the facility's shift-to-shift narcotic count books revealed the following: *Controlled Drugs-Count Record for February 2026 documented the following on every sheet:Signing below acknowledges that you have counted the controlled drugs on hand, have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record. -At 1:50 p.m. - Hall 100 narcotic sheet for February revealed 5 blanks where nurse signatures should be. -At 1:55 p.m. - Hall 200 back narcotic sheet for February revealed 6 blanks where nurse signatures should be. -At 2:00 p.m. - Hall 200 front narcotic sheet for February revealed 2 blanks where nurse signatures should be. -At 2:04 p.m. - Hall 300 front narcotic sheet for February revealed 25 blanks where nurse signatures should be. -At 2:07 p.m. - Hall 400 narcotic sheet for February revealed 12 blanks where nurse signatures should be. -At 2:12 p.m. - Hall 300 Back narcotic sheet for February revealed 25 blanks where nurse signatures should be. During an observation on 2/19/26 of Glucometer Quality Control Log High/Low Controls for February 1st through 19th revealed the following: -At 8:30 a.m. - Hall 100 glucometer Quality Control Log revealed the glucometer was checked 3 out of 19 days. -At 9:05 a.m. - Hall 300 back glucometer Quality Control Log revealed the glucometer was checked 10 days out of 19 days. -At 9:18 a.m. - Hall 300 front glucometer Quality Control Log revealed the glucometer was checked 0 out of 19 days. -At 9:25 a.m. - Hall 200 back glucometer Quality Control Log revealed the glucometer was checked 10 out of 19 days. -At 9:45 a.m. - Hall 200 front glucometer Quality Control Log revealed the glucometer was checked 10 out of 19 days. -At 9:54 a.m. - Hall 400 glucometer Quality Control Log revealed the glucometer was checked 1 day out of 19 days. During an interview on 2/19/26 at 2:41 p.m., the Administrator stated he was aware that the nurses need to sign the shift-to-shift narcotic sheet to ensure all narcotics were accounted for. The Administrator stated he did not know anything about taking care of the glucometers. During an interview on 2/19/26 at 2:51 p.m., Corp RN stated she started an in-service on signing the narcotic sheets last night. The Corp RN stated the nurses sign the narcotic sheet at every shift change when they count the narcotic drawer. The Corp RN stated she already knew there was an issue with the glucometer checks as they should be conducted daily on the night shift. During an interview on 2/20/26 at 8:15 a.m., LVN B stated when she first comes on shift, the nurse going off shift and her would count the narcotics first thing and both nurses would sign the narcotic sheet. LVN B stated if the narcotic count was wrong, they would count the narcotic again and if the count was still off, they would call the DON to get further instructions. LVN B stated it was night shifts job duty to check the glucometers to ensure they were accurate. During an interview on 2/20/26 at 8:35 a.m., RN C stated both nurses would count the narcotics together and then both nurses sign the shift-to-shift narcotic sheet. RN C stated the count must be correct before she would take over the medication cart. RN C stated she always cleans the glucometers in between residents, and the night shift checks the glucometers to ensure they were properly working. During an interview on 2/20/26 at 8:42 a.m., LVN D stated they count narcotics with the nurse going off shift and they both make sure the count was correct and then both sign the shift-to-shift narcotic count sheet.LVN D stated the night shift checks the glucometers, so they are working properly. During an interview on 2/20/26 at (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:51 a.m., RN E stated the nurse coming on shift and the nurse going off shift count the narcotics and the blister packs and then both nurses sign the shift-to-shift narcotic count sheet. RN E stated checking the glucometers for accuracy was a night shift duty. Record review of the facility policy, Controlled Medications - Administration, undated, revealed the following:Policy:Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedure: At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. Review of the facility policy Glucometer, undated, revealed the following: Quality Control TestingTesting will be done routinelyPerform quality control testing by using Control Solutions: High and Low every per manufacturer recommendations.Perform Check Strip TestCall toll-free number if test remains out of range.Report unresolved problems to DON/ ADON.Do not use meter until problem is resolved. Obtain meter from another station.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1of 1 kitchen when they failed to: A. Ensure stored food was secured, dated and used or discarded before the expiration date.B. Ensure hairnets were worn by all staff while in the kitchen. These failures could place all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings included: Observations of the walk-in freezer on 2/18/26 at 8:40 AM revealed the following:A. opened box of peanut butter cookie dough, open to air and unsecuredB. opened box of corn, open to air and unsecuredC. opened box of frozen biscuits, open to air and unsecured Observation of the pantry on 2/18 /26 at 8:50 AM revealed the following:A. 3 cans [NAME] Chacherie creole seasoning, dented, with a best if used by date of 10/2024.B. 4 containers of Smucker's plate syrup with a best if used by date of 9/30/25. C. 4 Containers of Horseradish with a best if used by date of 7/20/25, Observation of the kitchen shelving holding spices on 2/18/26 at 9:00 am, revealed a container of Sesame Seeds with a best by date of June 2025, Cloves best by September 2025, Celery Seeds expired January 2025 and Thyme best by [DATE]. Observations of the pantry on 2/19/26 at 9:40 AM revealed the same conditions in the kitchen were present with no corrections. In an observation and interview on 2/19/26 at 2:00 pm, [NAME] A was observed in the kitchen with no hair net covering his hair. [NAME] A stated he should have had a hairnet on his head while in the kitchen. He stated hair could get in food and food borne illness could occur. In an interview on 2/20/26 at 10:00 am the DM stated she expected all employees to wear a hairnet while in the kitchen. The DM stated all foods should be closed to air and securely sealed. The DM stated all expired foods should have been thrown out and not used. The Dm stated all issues in the kitchen could cause food borne illness. The DM stated the dietician had trained her in the kitchen and she had trained the staff. Record Review of the facility policy titled Dietary Food Services Personnel Policy and Procedures dated 2012, revealed hairnets are worn at all times. Record Review of the facility policy titled Dry Storage and Supplies dated 2012, revealed: Opened packages of food are stored in closed containers with tight covers and dated as to when opened.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision to prevent accidents for 1 of 16 residents (Resident #60) reviewed for accidents and hazards. The facility allowed Resident #60 to possess large sharp scissors in her room despite facility policy prohibiting sharp objects in resident's rooms. The facility failed to ensure the sharps storage compartment on the 200 Hall Front Medication cart was secured. The lock was broken and the compartment contained used sharps. This failure could affect the residents at the facility by placing them at risk of injury. Findings included:Record review of Resident #60's face sheet dated 02/18/2026 revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #60 had diagnoses that included but not limited to depression (feeling sadness), anxiety disorder (feeling anxious), weakness and personal history of malignant neoplasm of thyroid (thyroid cancer).Record review of Resident #60's admission MDS assessment dated [DATE] revealed she had a BIMS of 14 out 15 indicating her cognition was intact. In Section J1700 it was noted Resident #60 had a history of falling prior to admission.Record review of Resident #60's care plan dated 02/04/2026 revealed Resident #60 was a risk for falls with interventions to have a safe environment.Record review of admission Packet for the facility revealed the following: Items not allowed in Residents rooms. Safety Hazards .Scissors or knives, only blunt edge scissors are permitted.During an Observation on 02/18/2026 at 9:10 AM, Resident #60 was sitting up in her bed. She had several papers on her bedside table and a pair of large cutting scissors with sharp edges.During an observation on 02/18/2026 at 2:32 PM, Resident #60 was not in her room. The door was slightly open, and the large cutting scissors were laying on her bed.During an interview and observation on 02/18/2026 at 4:15 PM, Resident #60 was sitting in her bed. Scissors were located on her lap. Resident #60 stated the scissors belonged to her and she used them to open packages because she was no longer able to tear items open. Resident #60 stated staff were aware she had the scissors and had allowed her to keep them.During an interview on 02/18/2026 at 4:18PM CNA G stated she was aware Resident #60 had scissors in her room. She stated Resident #60 wanted the scissors and staff allowed her to have them. CNA G acknowledged that allowing residents to possess sharp objects could result in resident injury.During an interview on 02/18/2026 at 4:19 CNA H stated she was aware Resident #60 had scissors in her room. CNA H stated she knew possession of sharp scissors was against facility policy. CNA H acknowledged a potential negative outcome of allowing the resident to have sharp scissors could include injury to herself or other residents. CNA H stated staff were responsible for ensuring resident safety.During an observation on 02/19/2026 at 9:43 AM, the 200 Hall front Medication Cart had a sharps container lock box located on the right side of the cart. The lock box was unlocked and appeared broken. The door was open, and the lock box contained several used sharps.During an interview and observation on 02/19/2026 at 9:45 AM, RN F stated the lock box for the sharps on the 200 Hall Front Medication Cart did not have a functioning lock. RN H stated that she reported this to DON and the ADON., RN F stated having the lock box open and unlocked could cause needlestick injury to residents.During an interview on 02/19/2026 at 1:45PM, the DON stated he was not aware Resident #60 possessed scissors and confirmed that sharp scissors were against facility policy. The DON stated staff were expected to follow facility protocol regarding prohibited items in resident rooms.During an interview on 02/19/2026 at 2:04PM, the ADM was not aware Resident #60 possessed sharp scissors. The ADM confirmed that sharp scissors were against facility policy and stated staff were expected to follow facility policies and procedures. The ADM acknowledged a potential negative outcome of allowing the resident to have sharp scissors could include falling while holding them or sustaining injury.During an observation on 02/20/2026 at 8:20 AM, the lockbox on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the200 Hall Front Medication Cart was observed to be broken. Tape had been placed on the box in an attempt to keep it secure.During an interview on 02/20/2026 at 11:00am, the Corp RN stated that although Resident #60 was cognitively intact, she should have been educated regarding safe use of scissors. The Corp RN stated that if scissors were permitted for use, staff should have secured them at the nurses' station after each use. The Corp RN further stated the facility had blunt scissors available for resident use.During an interview on 02/20/2026 at 11:15 AM, the DON stated all staff were responsible for ensuring any safety hazards were addressed and he was responsible for overseeing staff compliance. The DON said a negative outcome for having a broken sharps lock box on the medication cart would be that a resident could get hurt.During an interview on 02/20/2026 at 1:20 PM, ADON I stated she was told by the staff the sharps lock box was broken on 200 Hall Front Medication Cart. She stated she reported it to the DON and believed it was being repaired. The ADON stated it was all staff's responsibility to ensure the safety of the residents; therefore, the lockbox should be secured to ensure safety of residents.On 02/19/2026, the Accidents and Hazards policy was requested; however, it was not provided.

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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** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided with such care consistent with professional standards of practice for 1 (Resident #85) of 22 residents reviewed for respiratory care. RN J started breathing treatment on Resident #85 and left the resident's room, so the resident was unsupervised. This failure could affect residents by placing them at risk for respiratory compromise by not receiving their full breathing treatment, and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition.Findings include: Record review of Resident #85's face sheet, dated 2/19/26, revealed a [AGE] year old male resident admitted to the facility on [DATE] with diagnoses which included: acute respiratory failure with hypoxia (tissues are deprived of adequate oxygen leading to impaired cellular function and potential organ damage), chronic obstructive pulmonary disease (progressive, long-term long disease that makes it difficult to breathe due to damaged, inflamed airways and destroyed air sacs/ Record review of Resident #85's Medicare 5-day MDS resident assessment, dated 2/13/26, listed him with a BIMS of 13 indicating he was cognitive intact, he had a functionality of being dependent on staff formost of his activities of daily living and was listed as having shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. Record review of Resident #85's care plan with admission date, 2/10/26, revealed the resident has emphysema/COPD with interventions/tasks - give aerosol or bronchodilators as ordered. Monitor/documented any side effects and effectiveness. The resident had oxygen therapy - if the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal. Record review of Resident # 85's order summary report printed 2/19/26 revealed the following: Oxygen 1 - 5 liters via nasal cannula every shift.Budesonide Inhalation suspension 1 mg/2ml - one inhalation treatment every 6 hours. During an observation on 2/18/26 at 11:15 a.m., RN J provided Resident #85 new tubing and a mask for breathing treatment. RN J started the breathing treatment and told Resident #85 that she would be back to check on him in 10 or 15 minutes. During an interview on 2/18/26 at 11:16 a.m., RN J stated that she usually did not stay in the room with the resident because the breathing treatment takes 10 to 15 minutes to complete. RN J stated she would come back in 10 to 15 minutes to check on Resident #85. During an interview on 2/19/26 at 2:41 p.m., the Administrator stated he was aware nurses needed to stay with residents when they are receiving breathing treatments. During an interview on 2/19/26 at 2:51 p.m., Corp RN stated she has talked to the nurse who did that and she will start an in-service covering the need for nurses to stay with a resident while they were getting a breathing treatment. During an interview on 2/19/26 at 3:22 p.m., the DON stated his expectations would be accountability and communication. Review of the facility policy, Aerosolized Hand-Held Nebulizer revealed the following: Purpose: To provide guidelines for administration of nebulized medication to patients.Instruct patient to close his/her lips tightly around the mouthpiece and breathe deeply, pause 2 - 3 seconds and then exhale slowly. This allows the medication time to distribute evenly throughout the lungs. Instruct the patient in diaphragmatic breathing techniques. Encourage and work with the patient throughout the treatment for use of the proper and most effective technique. (Refer to Deep Breathing and Cough Procedure). Continue treatment until all medication has been nebulized. Periodically tap the compressor and allow the patient to rest for a few minutes and then resume the treatment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medication was labeled and stored in accordance with currently accepted professional principles for 1 of 6 medication carts reviewed for medication storage.The Hall 200 front medication cart had loose medication in a clear plastic drinking cup 3/4 full of unidentified medication. This failure could result in ineffective treatment resulting in exacerbation of residents' disease processes. Findings include:During an observation on 2/19/26 at 9:48 a.m., of the Hall 200 front medication cart with RN F present, there was loose medication in a clear plastic drinking cup 3/4 full of unidentified medication. During an interview on 2/19/26 at 9:52 a.m., RN F stated the medication in the clear plastic cup was Colace and she did not know they were in her medication cart. During an interview on 2/19/26 at 2:51 p.m., the Corp RN stated the pills in the cup were docusate (a stool softener The Corp RN stated there was a large bottle in the bottom drawer of the medication cart. The Corp RN stated she has found that some nurses pour some pills in cups to use during medication pass and then throw the pills out when finished with the medication pass. During a follow-up interview on 2/19/26 at 3:13 p.m., RN F stated that the medication in the plastic drinking cup was not given by her and that she disposed of them. When asked what a negative outcome could be, RN F stated medications not in their original container cannot be properly identified by all staff and should never be given. RN F stated that a negative outcome to the resident would be that the resident could get the wrong medication and have adverse side effects because of that.Reviewed the facility policy Medication Administration and General Guidelines, undated, revealed the following:Medications are administered at the time they are prepared. Medications are not pre-poured.