STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676393	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Ventanas DE Socorro	10064 Alameda Avenue Socorro, TX 79927

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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, recognizing each resident's individuality for 1 of 4 residents (Resident #15).The facility failed to ensure resident call lights were within reach for 1 resident (Resident #15).This failure placed residents at risk of having their needs unmet when they are unable to contact staff.Findings included:Record review of Resident #15's admission record, dated 10/01/2025, revealed an [AGE] year-old female with an original admission date of 06/30/2023.Record review of Resident #15's history and physical data, dated 09/24/2025, revealed the resident was diagnosed with dementia (a degenerative disease that alters an individual's cognition and functional capabilities), anxiety (a psychiatric disorder that makes an individual feel restless, nervous, and/or uneasy), and heart failure.Record review of Resident #15's Quarterly MDS, dated [DATE], revealed Resident #15 had a BIMS score of 14 (cognitively intact). Section GG -Functional Abilities (self-care) revealed Resident #15 required partial to moderate assistance for toileting, showering, upper/lower body dressing, and personal hygiene. Section GG- Functional Abilities (mobility) revealed Resident #15 required partial to moderate assistance for rolling to sides, sit to lying, lying to sitting, chair/bed-to-chair transfer, and was non-ambulatory.Record review of Resident #15's care plan, dated 07/09/2025, revealed Resident #15 was at risk for falling reaction to taking high fall risk medications with an intervention of keep call light in reach at all times.In an observation on 10/01/2025 at 9:23 AM, Resident #15's call device was out of reach. The call device was wrapped around the bed rail with the handle resting below mattress level.In an interview on 10/01/2025 at 1:33 PM, CNA N stated Resident #15 was non-ambulatory, could turn over, move in her bed unassisted but required one person for assistance with transfers. CNA N stated she did not remember who she assisted the morning during surveyor observation but believed she provided peri care to Resident #15. CNA N stated she did not know if it was in Resident #15 ‘s care plan for the call light to be wrapped around the bed rail. CNA N stated that as per facility policy the call light must always be within resident reach. CNA N stated residents whose call light was not within reach would shout out to the staff. CNA N stated that residents who did not have a call light within reach cannot communicate needs to staff. CNA N specified that nurses and CNAs were responsible for ensuring call light was within reach. CNA N was unable to recall the last in service or training received for call lights. CNA N viewed the photo taken of Resident #15's call light position and stated the call light was out of reach for the resident. During an interview on 10/02/2025 at 10:29 AM, LVN M stated call lights must be next to the resident, at bedside, or clipped the call light within reach of the resident. LVN M stated an intervention utilized was continuously educating and reminding residents to utilize the call light. LVN M stated residents who do not have access to their call light could fall, injure themselves, or not receive services. LVN M stated staff made rounds at least every two hours to ensure call devices were within reach. LVN M stated when she left a resident's room, she ensured the resident did not have additional needs and ensured the call device was within reach. LVN M stated the facility's policy was that call lights must be within reach of the resident. LVN M was provided with a photo of a call light during a surveyor's observation and identified the call light was positioned out of reach for the resident.In an interview on 10/03/2025 at 12:45 PM, The DON stated call lights were used so residents could communicate their needs to staff. The DON stated the call light must be accessible to the patient, defined as next to the patient, on the bed or wheelchair depending on the resident's current location. The DON stated all staff were responsible for ensuring call lights were within reach to include CNAs, nurses, housekeeping, dietary, and leadership. The DON stated staff were trained to ensure the call light was within reach before leaving the room. The DON reported that even if the resident's neighbor was the one receiving care, staff should review the environment of both residents to ensure accessibility to call devices. The DON was provided a photo of the call device and stated it was out of reach for the resident. The DON stated a resident without access to a call device could potentially fall trying to get it, infringes on resident's rights, and could need assistance. The DON stated the last call light in service was approximately one to two months ago. In an interview on 10/03/2025 at 04:05 PM, The Administrator reported the call device was used for residents to express their needs to staff and request assistance. The Administrator stated nursing staff and CNAs as responsible for responding to call lights. The Administrator stated all staff as responsible parties for ensuring residents' call lights was always within reach. The Administrator stated

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that the assessment accurately reflected the resident's status for 1 (Resident #2) of 14 resident reviewed for accuracy of MDS assessment, in that:The facility failed to ensure that Resident #2's Significant Change Assessment reflected Resident #2 required total assistance of two persons with bed mobility. The facility failed to ensure that Resident #2's Significant Change Assessment documented in Active Diagnoses resident had two types of autoimmune skin diseases. This failure could place residents at risk of not receiving appropriate interventions or care to meet their current needs. Findings included:Closed record review of Resident #2's Face Sheet dated 10/03/25 revealed, initial admission date 02/19/25, and re-admission date of 07/01/25. Review of History & Physical, dated 06/10/25, for Resident #2 revealed a [AGE] year-old male with past medical history of diabetes mellitus (a condition where the body has high blood sugar (glucose) because it does not make enough insulin or cannot use it effectively), osteoarthritis (wear and tear disease where the protective cushion on the ends of your bones wears away overtime), rheumatoid arthritis (an autoimmune disease where your immune system mistakenly attacks the lining of your joints, causing them to become inflamed, painful, swollen and stiff), pemphigus vulgaris (an autoimmune disease where the body mistakenly attacks its own skin and mucous membranes, causing painful blisters to form on the skin and in the mouth, nose, throat, and eyes) and [NAME]-[NAME] Syndrome (a rare, serious, and life-threating reaction, often to a medication, that causes a painful, blistering rash and sores on the skin and mucous membranes, mouth, throat, eyes, genital). Skin superficial ulcer wound to neck, resident non-compliant with dermatologist appointment due to difficulty with arranging transportation to Drs. Clinics. General appearance - alert and oriented. Skin - coccyx wound. Multiple lesions, scabs, rash throughout the body due to history of [NAME]'s Syndrome and pemphigus Vulgaris. Activities of daily living- impaired by symptoms. Review of Significant Change MDS dated [DATE] for Resident #2 revealed, Section I - Active Diagnoses Stevent-[NAME] syndrome, reduced mobility.Review of Care Plan dated 09/22/25 for Resident #2 revealed: - Problem Start Date: 07/01/25. Edited 09/16/25. Chronic Pain R/T Stevens-Johnson Syndrome and Rheumatoid arthritis. Approaches: Administer Acetaminophen-codeine as ordered.During a telephone interview 10/01/25 at 2:46 PM, CNA A revealed he worked on 9/21/25 on the night shift and he was not given report about his assigned residents by the Nurse or CNAs at the start of shift and was just assigned to work in the 100-Hall. He said he was not given access to the Kiosk to check how much assistance the residents required with ADLS. He said he had provided care to Resident # in room [ROOM NUMBER], on that night. He said he had entered the room to check if the resident was incontinent. He said he did not know how many people needed to turn and reposition the resident in bed since he did not have access to the Kiosk. He said the resident could not assist with turning & repositioning in bed. He said he had turned and repositioned the resident to be able to change the soiled brief. During an interview and record review on 10/07/25 at 2:00 PM, LVN MDS Nurse E and RN MDS Nurse F revealed, Section I - Active Diagnoses [NAME]-[NAME] syndrome and did not document resident also had a diagnosis of pemphigus vulgaris.Review of Nursing Policies and Procedures dated 09/28/25 revealed, Subject: Minimum Data Set (MDS) Policy: A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is a comprehensive, accurate, standardized reproducible assessment, will be completed for each resident, using the RAI process. Procedures: Review the resident's medical record. Review is to include, but not be limited to pre-admission, admission, and transfer notes; current plan of care, physician's orders, progress notes, history and physical; nursing, dietary, activity, social service, therapy notes and assessments; monthly summaries, medication administration records, treatment administration records, and resident and family interviews. Interview, observe and physically assess the resident to obtain validation of items identified on the medical record and to collect information for items where no documentation exists. Documentation of participation must include direct observation and communication with the residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. Perform interviews and test of physical functioning as required by MDS RAI Manual. Be sure to speak to staff that have firsthand knowledge of the residents. Talk to staff from all shifts. Ask about the residents' performance on ADLs. GG functional status. Interview with the resident's physician. Ask about medication and treatment orders. Discuss any negative outcomes identified during assessment. Interview with the resident's family. Ask them to clarify conflicting information and to provide

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan to include measurable objectives and timeframes to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being for 1 of 14 (Resident #2) residents reviewed for comprehensive care plans in that: The facility failed to revise or update Resident #2's care plan to reflect the need for two people for bed mobility due to pain caused by autoimmune skin disease. The facility failed to revise or update Resident #2's care plan to reflect physician's orders to treat autoimmune skin disease. This failure could place residents at risk of not receiving appropriate interventions or care to meet their current needs. The findings included:Closed record review of Resident #2's Face Sheet dated 10/03/25 revealed, initial admission date 02/19/25; and re-admission date 07/01/25. Review of History & Physical, dated 06/10/25, for Resident #2 revealed a [AGE] year-old male with past medical history of diabetes mellitus (a condition where the body has high blood sugar (glucose) because it does not make enough insulin or cannot use it effectively), osteoarthritis (wear and tear disease where the protective cushion on the ends of your bones wears away overtime), rheumatoid arthritis (an autoimmune disease where your immune system mistakenly attacks the lining of your joints, causing them to become inflamed, painful, swollen and stiff), pemphigus vulgaris (an autoimmune disease where the body mistakenly attacks its own skin and mucous membranes, causing painful blisters to form on the skin and in the mouth, nose, throat, and eyes) and [NAME]-[NAME] Syndrome (a rare, serious, and life-threating reaction, often to a medication, that causes a painful, blistering rash and sores on the skin and mucous membranes, mouth, throat, eyes, genital). Skin superficial ulcer wound to neck, resident non-compliant with dermatologist appointment due to difficulty with arranging transportation to Drs. Clinics. General appearance - alert and oriented. Skin - coccyx wound. Multiple lesions, scabs, rash throughout the body due to history of [NAME]'s Syndrome and pemphigus Vulgaris. Activities of daily living- impaired by symptoms. Review of Care Plan dated 09/22/25 for Resident #2 revealed: - Problem Start Date: 07/01/25. Edited 09/16/25. Chronic Pain R/T Stevens-Johnson Syndrome and Rheumatoid arthritis. Approaches: Administer Acetaminophen-codeine as ordered.- Problem Start Date: 05/30/25. Edited 09/16/25. Incontinent of Bowel & Bladder. Approach: Provide incontinent care after each incontinent episode.- Problem Start Date: 5/30/25. Edited 09/22/25. ADLS Functional requires assistance with ADLS. Approaches: Bed Mobility total dependence with assistance of 1-2 staff. During a telephone interview 10/01/25 at 2:46 PM, CNA A revealed he worked on 9/21/25 on the night shift and he was not given report about his assigned residents by the Nurse or CNAs at the start of shift and was just assigned to work in the 100-Hall. He said he was not given access to the Kiosk to check how much assistance the residents required with ADLS. He said he had provided care to Resident # 2, on that night. He said he had entered the room to check if the resident was incontinent. He said he did not know how many people needed to turn and reposition the resident in bed since he did not have access to the Kiosk. He said the resident could not assist with turning & repositioning in bed. He said he had turned and repositioned the resident to be able to change the soiled brief. He said he had slipped his right hand under the resident's hip and the left hand under the shoulder to turn and reposition the resident on his own because he was the only CNA assigned to work in the 100-Hall. He said the resident would grimace and moan when he was moved in bed. During a telephone interview on 10/06/25 at 9:56 AM with Resident #2's family member revealed, Resident #2 said a young man that had been assigned to care for him during the night on 09/21/25 had moved him without assistance causing pain and discomfort. She said Resident #2 could not move in bed without assistance. Resident #2's family member said, The attendant was new, and he did not know what type of care (Resident #2) needed and the attendant did not speak Spanish so they could not communicate with each other. She said Resident #2 was alert and can tell you what happened on that day. The family member said, He is right here, let me ask him if he wants to talk to you so he can tell you what happened on that day. Interview with Resident #2 revealed he was alert, oriented to person, place and time. He said the young man who had cared for him at night on 09/21/25 was very rough when he moved him in bed to change the soiled brief without assistance causing a lot of pain and discomfort. During an interview on 10/06/25 at 1:19 PM with RN B Charge Nurse on the 6-2 shift on the 100-Hall revealed, Resident #2 was alert, oriented to person, place, time and situation. She said the resident had a skin condition that caused sores, pain and skin peeling all throughout his body that caused pain when he was touched to provide care. She said the

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 1 (Resident #1) of 1 reviewed for quality of care.The facility failed to ensure that Resident #1 received an initial neurological check and continued neurological checks for 72 hours following an unwitnessed fall as per the facility's policy on fall management and and neurological checks, from 09/25/2025 to 09/27/2025. This failure could place residents at risk of head related injuries, decrease cognitive and functional abilities and not receiving the necessary care and services. Findings included:Record review of Resident #1's care plan, dated 09/16/2025, revealed Resident #1 has a history of falling related to age-related cognitive decline, unspecified dementia, unspecified severity, with other behavioral disturbance and has difficulty focusing attention/ understanding others due to age-related cognitive decline, unspecified dementia, unspecified severity, with other behavioral disturbance. Interventions included fall mat utilization (updated 09/24/2025), Keep personal items and frequently used items within reach (updated 09/02/2025; after 09/01/2025 fall incident), and provide proper, well maintained footwear (updated 09/02/2025; after 09/01/2025 fall incident). Record review of Resident #1's physical and health, dated 09/25/2025, revealed the resident was diagnosed with dementia (a degenerative disease that alters an individual's cognition and functional capabilities) with history of falls resulting in hospitalization and generalized weakness.Record review of Resident #1's MDS, dated [DATE], revealed a BIMS score of 99 (resident was unable to complete Brief Interview for Mental Status). Section GG -Functional Abilities (mobility) revealed Resident #1 required substantial/maximal assistance for rolling to sides, sit to lying, lying to sitting, sit to stand, and chair/bed-to-chair transfer; ambulation was scored an 88 signifying that attempts were not made due to the resident's medical condition or safety concerns.Record review of Resident #1's admission record, dated 10/01/2025, revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE].Record review of neurological checks binder and progress notes on 10/03/2025 at 09:00 AM, revealed Resident #1 there were no documented neurological checks for a fall that occurred on 09/25/2025 at 02:30 AM.During an interview on 10/02/2025 at 10:18 AM, LVN M, stated she was completing a neurological check sheet for a resident who experienced an unwitnessed fall. She stated that after a fall, the nurse completed the head-to-toe assessment, neurological check, SBAR, contacted the physician, family, hospice (if applicable), notified the DON and the administrator immediately. She reported that if the resident was not sent out for further evaluation, staff was to check the resident every 15-30 minutes following the fall and enter progress notes.In an interview on 10/02/2025 at 11:03 PM, CNA O stated she was on a break on 09/25/2025 at 2:30AM and walked by the resident's room out of familiarity with resident's sleep patterns. She stated she saw the call light illuminated and located the resident halfway on his bed with blood all over his face. She stated the resident said, I was asleep, and I fell. She stated the mattress was halfway off the bed with half the mattress protruding towards the window with the resident half way on the bed. She stated the resident climbed back on to his bed hallway, after the experienced fall. She stated she tried to readjust the mattress from the window side, while the resident was halfway on the mattress. She stated the resident slid against her legs; She stated the resident did not accrue additional injuries from transition. She stated she called for the shift nurses (LVN J and RN L). She stated the nurses conducted their assessments, cleaned resident, notified family, physician, and requested 911. She stated the last time the resident was checked on was at 1 am and he was asleep. She identified RN L who reported the incident to The DON and The Administrator. She stated how training and in-services were left at the nurse's station for third shift staff to read and sign or they were called in during the day for trainings. She stated the last in service was abuse, neglect and exploitation this week (09/30/2025 to 10/03/2025). She stated the steps for abuse and neglect reporting and identified shift nurse and The Administrator as key individuals to immediately report to. She stated the resident's injury was to the left side of his head, with no symptoms (nausea, headache, loss of consciousness, convulsions) present besides bleeding. She stated the resident denied being in pain, discomfort and did not want to go to the hospital.During an interview on 10/02/2025 at 11:24 PM, LVN J, stated the call light was illuminated on 09/25/2025 at 02:30 PM to Resident #1's room, and CNA O responded to call light. She stated CNA O had called out for assistance from room [ROOM NUMBER] where Resident #1 was assigned on the day of the incident. She stated she went to get the wound cart while RN L passed her to go tend to Resident #1. She stated the cut was less than an inch on

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review the facility failed to establish procedures for storing and disposing of drugs and biological in accordance with federal, state, and local laws. The facility failed to ensure medications pending return to the pharmacy were stored in a locked cabinet in the DON's office. This failure could place 68 residents living at the facility at risk of drug diversion. The findings included:During an observation on 10/01/25 at 9:26 AM revealed, the door to the DON's office was opened and unsupervised. There was an opened cardboard box that contained medication blister packets stored on the floor by a cabinet and several medication blister packets were visible from the entrance to DON's office. During an observation on 10/01/25 at 10:12 AM revealed, the DON was not in the office while the Housekeeper was vacuuming the office and the opened cardboard box that contained medication blister packets was still stored on the floor in the DON's office. During an observation on 10/01/25 at 10:14 AM revealed, the Corporate Clinical Service director was working in DON's office and the opened cardboard box that contained medication blister packets was still stored on the floor in the DON's office. During an observation and interview on 10/01/25 at 12:38 PM, with DON confirmed there were two cardboard boxes that contained medications stored on the floor in her office. She said the boxes contained medications that were pending return to the pharmacy for credit. She said, One of those boxes was stored in the office when I started working here in March 2025. I do not know how often medications are returned to the pharmacy for credit. I know that medications should not be left unattended when stored in my office because someone can come in my office and take the medications. The DON said the risk of leaving medications in her office unattended could result in residents and/or other unauthorized individuals taking the prescribed medications from her office. During an interview on 10/02/25 at 10:30 AM revealed, the DON's office door was still open, and no one was in the office. It was observed that the two white cardboard boxes that contained medications were still on the floor. The top box was still opened, and the several blister medication packets were visible from the entrance to DON's office. During an interview on 10/02/25 at 12:06 PM revealed, the DON's office door was wide open and unsupervised. It was observed that the two opened white cardboard boxes that contained medications were still on the floor. The top box was still opened, and the several blister medication packets were visible from the entrance to DON's office. During an observation and interview on 10/02/25 at 12:32 PM, with the Administrator, confirmed there were two white cardboard boxes stored on the floor by the cabinet in the DON's office that contained medications. He confirmed the top cardboard box was opened. He demonstrated to the state surveyor that the second box was not sealed and contained medication. He said, The door to the DON's office should be kept locked if medications are not stored in a locked cabinet. He said, Let me close the door and go tell the DON. He said the risk of leaving the door open and unsupervised could result in someone coming into the office and taking the medications. The DON's office was located by the living room and next to the central nurse's station. During an interview on 10/02/25 at 12:40 PM, the Administrator revealed medications pending return to the pharmacy for credit should be stored in the medication room. He said, Medications pending return to the pharmacy should be placed in the locked plastic containers that are kept in the medication room. The large plastic containers are locked, and they have an opening where the staff can drop the mediations containers into the locked containers. During an interview on 10/06/25 at 12:47 PM with RN G revealed, medications pending return to the pharmacy for credit were dropped into a locked container stored in the medication room pick-up from the provider pharmacy. She said she usually worked on the weekends and did not know when the last time was return medication were picked up by the pharmacy. During an interview on 10/06/25 at 12:49 PM, with LVN Charge Nurse H on the 300-Hall revealed, medications pending return to the pharmacy for credit were dropped into a locked container stored in the medication room pending pick-up from the provider pharmacy. She said she did not know who called the pharmacy to pick up the medication containers to return the medications to the pharmacy. During an interview on 10/06/25 at 2:51 PM with the DON revealed, she calls the pharmacy after she and the ADON went through the locked medication containers stored in the medication to determine which medications could be returned to the pharmacy for credit. She said they listed the medications on the Medications Return Logs before the medications were returned to the pharmacy for credit. She said after the medications were listed on the Medication Return Logs the medications were placed in locked plastic containers and kept in the medication room until the pharmacy sent someone to pick up the container to return to the provider pharmacy. She said the pharmacy did not have a set date or time to pick up the locked

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	676393	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Ventanas DE Socorro	10064 Alameda Avenue Socorro, TX 79927

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices, for 1 of 14 residents (Resident #2) reviewed for clinical records with transfer assistance. The facility failed to give access to the contracted agency CNA to document in the residents' electronic record the care provided to assigned residents in the 100-Hall. This failure place residents at risk of having incomplete and accurate clinical records. Findings included:Closed record review of Resident #2's Face Sheet dated 10/03/25 revealed, initial admission date 02/19/25; and re-admission date 07/01/25. Review of History & Physical, dated 06/10/25, for Resident #2 revealed a [AGE] year-old male with past medical history of diabetes mellitus (a condition where the body has high blood sugar (glucose) because it does not make enough insulin or cannot use it effectively), osteoarthritis (wear and tear disease where the protective cushion on the ends of your bones wears away overtime), rheumatoid arthritis (an autoimmune disease where your immune system mistakenly attacks the lining of your joints, causing them to become inflamed, painful, swollen and stiff), pemphigus vulgaris (an autoimmune disease where the body mistakenly attacks its own skin and mucous membranes, causing painful blisters to form on the skin and in the mouth, nose, throat, and eyes) and [NAME]-[NAME] Syndrome (a rare, serious, and life-threating reaction, often to a medication, that causes a painful, blistering rash and sores on the skin and mucous membranes, mouth, throat, eyes, genital). Skin superficial ulcer wound to neck, resident non-compliant with dermatologist appointment due to difficulty with arranging transportation to Drs. Clinics. General appearance - alert and oriented. Skin - coccyx wound. Multiple lesions, scabs, rash throughout the body due to history of [NAME]'s Syndrome and pemphigus Vulgaris. Activities of daily living- impaired by symptoms. Review of Significant Change MDS dated [DATE] for Resident #2 revealed, a BIMs Score of 7 (severely cognitively impaired), clear speech, able to make self-understood; preferred language was Spanish. functional limitation in range of motion to upper and lower extremities; Section GG0130 - Functional Abilities -OBRA/Interim: Toileting hygiene, upper/lower body dressing, and personal hygiene-dependent; Section GG0170 Mobility - substantial/maximal assistance with Roll left and right; incontinent of bowel and bladder; Section I - Active Diagnoses Stevent-[NAME] syndrome, reduced mobility; Section J0100 Pain Management in the last 5 days - 0 had not received PRN pain medications; has not received non-mediation interventions for pain. J0200 Should Pain Assessment Interview be conducted? Yes. Section: J0300 Pain Presence Code: 1 Yes. J410 Pain Frequency Code: 4 Almost constantly. Section: J0510 Pain Effect on Sleep Code: 2 occasionally hard to sleep; Section: J0600 Pain intensity - Code: 9 in a scale form 00-10 pain scale. 10 being the worst pain. Section: K0520 Feeding tube on admission. Section: M1040 D. Open lesion(s) other than ulcers, rashes, cuts. Section: M1200 Skin Condition: Application of ointments/medications other than to feet. Section: Section V0200 A. CAA (Care Assessment Area Assessment Summary revealed Cognitive Loss/Dementia, ADL Functional, Urinary Incontinence, Feeding Tube, Pressure Ulcer, and Pain. Review of Care Plan revised 09/22/25 for Resident #2 revealed, -Problem Start Date: 09/22/25 Psychosocial Well-Being.- Problem Start Date: 07/01/25. Edited 09/16/25. Chronic Pain R/T Stevens-Johnson Syndrome and Rheumatoid arthritis. Approaches: Administer Acetaminophen-codeine as ordered.- Problem Start Date: 05/30/25. Edited 09/16/25. Incontinent of Bowel & Bladder. Approach: Provide incontinent care after each incontinent episode.- Problem Start Date: 05/30/25. Edited 09/16/25. The resident has a pressure ulcer to sacrum 7 Left heel R/T reduced mobility and Stevens-Johnson Syndrome. Approaches: Conduct a systemic skin inspection weekly. Wound Care Nurse to assess the pressure ulcer for location, stage, size, presence/absence of granulation issue and epithelization weekly and as needed.- Problem Start Date: 5/30/25. Edited 09/22/25. ADLS Functional requires assistance with ADLS. Approaches: Bed Mobility total dependence with assistance of 1-2 staff. Review of facility's CNA/Nurses assignment Sheet dated 09/21/25 revealed Contracted agency CNA was not listed on the assignment sheet. During a telephone interview 10/01/25 at 2:46 PM, with Agency CNA A agency revealed, he worked on the 10-6 shift on 09/21/25. He said he was not given access to the Kiosk to document the care that he had provided to the residents assigned to him on the 100-Hall on that day. During a telephone interview on 10/06/25 at 9:21 AM, Agency CNA A said, I was not granted access to the Kiosk so I could not document in the resident's electronic record the care that was provided to my assigned residents in the 100-Hall. He said no one assisted him in charting in the Kiosk at the end of the shift at the end of the night

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for one of fourteen residents (Resident #2) reviewed for Enhanced Barrier Precautions. The facility failed to implement their policy on Enhanced Barrier Precautions for Resident #2 who had wounds, indwelling medical devices and was incontinent of bowel and bladder. This failure could place residents at risk for healthcare associated cross-contamination and at risk of the transmission of multi-drug-resistant organisms (MDROs). The findings included:Closed record Review of Resident #2's Face Sheet dated 10/03/25 revealed, initial admission date 02/19/25; and re-admission date 07/01/25. Review of History & Physical, dated 06/10/25, for Resident #2 revealed a [AGE] year-old male with past medical history of pemphigus vulgaris (an autoimmune disease where the body mistakenly attacks its own skin and mucous membranes, causing painful blisters to form on the skin and in the mouth, nose, throat, and eyes) and [NAME]-[NAME] Syndrome (a rare, serious, and life-threating reaction, often to a medication, that causes a painful, blistering rash and sores on the skin and mucous membranes, mouth, throat, eyes, genital). Skin superficial ulcer wound to neck, resident non-compliant with dermatologist appointment due to difficulty with arranging transportation to Drs. Clinics. General appearance - alert and oriented. Skin - coccyx wound. Multiple lesions, scabs, rash throughout the body due to history of [NAME]'s Syndrome and pemphigus Vulgaris. Activities of daily living- impaired by symptoms. PEG tube feedings (Is a feeding tube that goes directly from the outside of the body, through the skin of the belly, and into the stomach). Review of Significant Change MDS dated [DATE] for Resident #2 revealed, a Section I - Active Diagnoses Multidrug-Resistant Organism (MDRO), Septicemia, Gastrostomy status, Stevent-[NAME] syndrome, Feeding tube on admission. Section: M0300 one stage 2 pressure ulcer present upon admission. Section: M1040 D. Open lesion(s) other than ulcers, rashes, cuts. Section: Section V0200 A. CAA (Care Assessment Area Assessment Summary revealed ADL Functional, Urinary Incontinence, Feeding Tube, Pressure Ulcer, and Pain. Review of Care Plan revised 09/22/25 for Resident #2 revealed, - Problem Start Date: 07/01/25. Edited 09/16/25. Chronic Pain R/T Stevens-Johnson Syndrome and Rheumatoid arthritis. Approaches: Administer Acetaminophen-codeine as ordered.- Problem Start Date: 07/01/25. Edited 09/16/25. Requires feeding tube R/T Dysphagia. Approaches:- Problem Start Date: 05/30/25. Edited 09/16/25. Incontinent of Bowel & Bladder. Approach: Provide incontinent care after each incontinent episode.- Problem Start Date: 05/30/25. Edited 09/16/25. The resident has a pressure ulcer to sacrum 7 Left heel R/T reduced mobility and Stevens-Johnson Syndrome. Approaches: Conduct a systemic skin inspection weekly. Wound Care Nurse to assess the pressure ulcer for location, stage, size, presence/absence of granulation issue and epithelization weekly and as needed.Review of Physician Order Report dated 07/01/25 - 09/22/25, for Resident #2 revealed required Enhanced Barrier Precautions for wounds. During a telephone interview 10/01/25 at 2:46 PM with CNA A revealed he had worked on 9/21/25 on the night shift and he was not given report about his assigned residents by the Nurse or CNAs at the start of shift and was just assigned to work in the 100-Hall. He said he was not provided with an orientation prior to providing care to the residents on that day. He said he had provided care to Resident #2, on that night. He said he had entered the room to check if the resident was incontinent. He said the resident could not assist with turning & repositioning in bed and he had turned and repositioned the resident on that day on his own to provide incontinent care. He said he did not know which residents were on Enhanced Barrier Precautions, so he had not used PPE when providing direct care to the residents on that day. He said he had not seen postings by the entrance to the residents' rooms, that indicated which residents were on Enhanced Barrier Precautions. He said PPE was not available in the 100-Hall on that day when he had worked at the nursing facility. He said the risk of not using PPE when residents were on Enhanced Barrier Precautions could result in cross contamination of uniforms and spread of infection. During an interview on 10/06/25 at 1:19 PM with RN Charge Nurse B on the 6-2 shift on the 100-Hall revealed, Resident #2 had a skin condition that caused painful sores and skin peeling all throughout his body. She said Resident #2 was on Enhanced Barrier Precautions because of the skin sores, pressure ulcer and G-tube. She said the facility only posted the small CDC Pocket Guide by the entrance to the resident rooms. She said they had been trained to use EBP for residents with indwelling medical devices, wounds, or those who are colonized by or infected with a