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	02/18/2026

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the residents' status for 2 (Resident #70 and Resident #79) of 10 residents reviewed for assessment accuracy.The facility failed to accurately reflect Resident #70's ability to hear on his MDS.The facility to reflect Resident #79's surgical wound care and external Fixator on her MDS.This failure placed residents at risk for not receiving care specific to their condition.Findings includeRecord review of Resident #70's face sheet dated 2/18/2026 revealed a [AGE] year-old male with an admission date of 11/5/2024.Record review of the Resident #70's History and Physical dated 11/07/2024 revealed the resident had diagnoses of cerebrovascular accident (blood flow interrupted to part of the brain), unspecified dementia without behavioral disturbance (a syndrome characterized by decline in cognitive function, memory and ability to complete daily tasks), essential hypertension (high blood pressure), and atherosclerotic heart disease (plaque buildup in the arterial walls).Record review of Resident #70's MDS dated [DATE] revealed under Section B, Resident #70 was coded for having adequate hearing and did not utilize a hearing aid. Under Section C, Resident #70 scored a 10 on his BIMS score, this signified the resident had moderate cognitive impairment. Under Section Q, Resident #70 had himself and family listed as participants in assessment and goal setting.Record review of Resident #70's MDS dated [DATE] revealed under Section B, Resident #70 was coded for having adequate hearing and did not utilize a hearing aid.Record review of Resident #70's MDS dated [DATE] revealed under Section B, Resident #70 was coded for having adequate hearing and did not utilize a hearing aid.Record review of Resident #70's care plan dated 2/17/2026 revealed the resident had difficulty understanding others related to hard of hearing on right side with interventions of refer to audiologists, speech-language pathologists, repeat phrases as needed, speak clearly and adjust tone as needed.Record review of Resident #79's face sheet dated 02/16/2026 revealed a [AGE] year-old female with admission date 02/03/2026.Record review of Resident #79's history and physical dated 02/04/2026 noted the following medical history: Diabetes Mellitus, left eye prosthetic, right eye legal blindness. It also noted the resident had a fall at home which resulted in a left trimalleolar fracture that required a procedure and Resident #79 had a closed reduction and external fixation ().Record review of Resident #79's Comprehensive MDS dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact. Section I-Active Diagnoses noted Resident #79's primary medical condition that best described the primary reason of admission was Fractures and other Multiple Trauma and Presence of other medical devices. Under Section M- Skin Conditions, it did not include surgical wound care or pressure ulcer wound care.Record review of Resident #79's care plan with revision date 02/09/2026, did not include the resident's wound care or the external fixator. The care plan noted Resident #79 was at risk for falls relating to the presence of external fixator with staff interventions as follows: keep the call light within reach, keep personal items within reach, and keep room clutter free.Record review of Resident #79's wound care order with start date 02/05/2026, noted daily wound treatment: Left medial ankle blister: Clean gently with Normal Saline or wound cleanser, pat dry, apply betadine and leave open to air.Record review of Resident #79's Wound Care Administration Record History dated 02/18/2026, revealed wound care was provided from (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/05/2026 to 02/16/2026.In an observation conducted on 2/15/2026 at 2:08 PM, Resident #70 was observed not responding to conversation attempts but was visually acknowledging surveyor. Resident #70 continued pointing to his right ear saying no oigo which translated to I can't hear. Resident #70 was able to converse with the surveyor after a higher tone was used but was observed speaking in low tone.In an interview on 2/15/2026 at 2:09 PM, Resident #70 stated he had been at the facility for 2 years and had been having trouble hearing for 1 year. He stated he needed loud speech to hear what was being said but sometimes his hearing capability in his right ear was completely gone and toned out with a continuous ringing. He denied having a hearing aid and receiving assistance from the facility to address hearing concerns. He stated he communicated with staff by calling his family members on the landline in his room.In an interview with RN A on 2/16/2026 at 2:10 PM, she stated Resident #70 was independent and completed his own ADLs. She stated Resident #70 would sometimes appear fearful of people he was unfamiliar with. She added that she spoke to Resident #70 in a normal tone and had no suspicion Resident #70 was hard of hearing. She stated that he usually responded the first time and displayed signs of comprehension to what she said. She stated Resident #70 never asked her to repeat what she had said. She clarified if she noticed hearing impairment in a resident she would notify the Doctor, document findings in a progress note, and request a referral from the Doctor to send the resident out to audiology. She stated that it was important to asses residents' hearing accurately because a hearing impairment affected the resident's ability to communicate. She stated there was not an annual hearing assessment completed for residents as it was only completed when staff noticed a change in condition. She stated she spoke to Resident #70 in Spanish and he would provide mostly non-verbal head nods/shakes and not much vocalization or elaboration. In an interview with CNA B on 2/16/2026 at 2:15 PM, stated Resident #70 was alert and oriented and was capable of telling staff when he did or did not want services. She stated she spoke to Resident #70 in English and would use standard communication tone with him but did have to repeat herself to Resident #70. She stated if she suspected a resident had a hearing impairment, she would speak louder, slower, and notify the nurse. She stated she needed to report it to the nurse because the resident might not be able to effectively communicate. She stated CNAs and nurses were responsible for reporting, documenting and notifying Doctors for residents with hearing impairments.In an phone interview on 2/16/2026 at 2:33 PM, Resident #70's family member stated Resident #70 did have an undiagnosed hearing impairment that the family began noticing over the past year. He stated the family had to speak to Resident #70 in a louder tone, and noted Resident #70 began speaking in a whispering tone and frequently used hand gestures. He stated the facility did complete a hearing assessment but could not recall when. He added the facility had not further assisted with Resident #70's hearing complication beyond the undated assessment.In an interview with the Social Worker on 2/16/2026 at 2:53 PM, stated she would speak a little bit louder to Resident #70 for him to understand what she had said. She added the resident spoke English and Spanish. She stated that the quarterly MDS assessment was completed every 3 months or whenever a significant change occurred. She stated family had never mentioned concerns about Resident #70's hearing capabilities during care plan meetings or over the phone conversations. She stated there was no tool or assessment utilized to measure a resident's hearing ability. She added that she would just ask the resident if they had difficulty hearing and monitored for abnormalities or consistent prompting during conversation. She stated that if she discovered an abnormality, she would share the information with the MDS nurse and the IDT. She stated a resident with an unaddressed hearing impairment could receive delay in treatment, impeded their needs, have trouble when provided instructions, and limit his ability to talk with people. She stated that the CNAs and nurses were responsible for continuous monitoring and reporting appropriate parties for change in condition. She stated Resident #70 had an referral with an Ear, Nose and Throat Doctor on 2/4/2025 regarding an intermittent ear and throat pain; she was uncertain as to what the outcome was or if the referral was fulfilled.In an interview on 02/17/2026 at 3:12 PM, MDS Nurse L stated the external fixator and wound care should have been included in the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS. He stated the purpose of including the surgical wound care was to increase reimbursement as it was a service provided by the facility. He stated that not including the surgical wound care in Resident #79's MDS would not affect the resident. He stated that the MDS nursing reviewed the MDS quarterly or as needed for a significant change.In an interview with MDS C on 2/18/2026 at 4:38 PM, the MDS team was comprised of various staff members with different disciplines. She stated she reviewed the work completed by other team members when she would meet with the resident to complete her portion of the MDS assessment. She stated she was familiar with Resident #70 as she was his night nurse from October 2024 to October 2025. She stated Resident #70 never reported having difficulty hearing, and she never noted any hearing difficulty when she conversed with Resident #70. She stated she spoke to Resident #70 at a normal tone, and Resident #70 would respond to questions at a normal tone with delay between responses. She stated if a resident had a hearing impairment, they would be evaluated by Speech-Language Pathology, notify the Doctor, and obtain a referral to a specialist for the resident. She added that if she noticed a discrepancy in the MDS, she would speak to the DON and Social Worker to further evaluate the concern and update the resident's care plan and MDS accordingly. She stated that hearing impairment in residents could affect them by delay of care and communication issues. She stated no employees had mentioned concerns about Resident #70's hearing abilities to her. She stated that if there was a concern, the direct care staff would document progress notes and notify the MDS nurse immediately. She stated Resident #70's family was only involved in the care plan and collateral if they were in the room during the MDS assessment. She stated that the MDS assessments take 10-15 minutes to complete. She stated that was enough time to note for hearing deficits in Resident #70.Record review of the facility's Nursing Policy and Procedures, dated 05/05/2023, read in part: Policy: A licensed nurse will conduct or coordinate each assessment with the interdisciplinary team. It continued, Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified. Then, it read, The facility is responsible for addressing all the needs and strengths of each resident. Under Procedures, it read in part, 1. Review the resident's medical record. This review may include pre-admission activities. Identify resident's status, care, and services rendered during the Observation Period for the current assessment. Review is to include, but not to be limited to pre-admission, admission, and transfer notes; current plan of care, physicians' orders, progress notes, history and physical; nursing dietary, activit, social service, and therapy notes and assessments; monthly summaries, lab and x-ray reports consultations, medication administration records, treatment administration records, and resident, staff and family interviews. 2. If a Care Area Assessment is triggered, the facility will further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need affects the resident. Supplemental infromation must be gathered and analyzed by the facility based on the triggered CAAs prior to developing the comprehensive care plan. It also read, The Facility addresses all risks identified within the context of the MDS assessment, even if they do not cause a CAA to trigger. It continued to read, 9. Each assessment must represent an accurate picture of the resident's status during the observation period of the MDS. When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. If it did not occur during the observation period, it is not coded on the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for two (Resident #26 and Resident #79) of 9 residents reviewed for care plans.The facility failed to include Resident #26's wound care for her right lower leg wound on her care plan.The facility failed to include Resident #79's wound care and external fixator on her care plan.These failures could affect residents requiring wound care by placing them at risk for not receiving care and services to meet their needs.The findings include:Record review of Resident #26's face sheet dated 02/16/2026 revealed an [AGE] year-old female with admission date of 01/22/2026.Record review of Resident #26's history and physical dated 02/12/2026 revealed a medical history of the following: Chronic Kidney Disease (a condition meaning damage to the kidneys causing it to not filter the waste in the blood), Type II Diabetes Mellitus (metabolic condition that causes the body to become resistant to insulin or the pancreas fails to produce enough insulin), and had wounds on both legs.Record review of Resident #26's Discharge MDS dated [DATE] revealed a BIMS score of 15, indicating resident cognitively intact.Record review of Resident #26's care plan with revision date 02/04/2026 revealed Resident #26 had a wound/disruption of skin surface, left lower leg venous ulcer. Interventions for staff included to provide wound care as ordered, and to use aseptic techniques.Record review of Resident #26's Wound Care Order dated with start date 01/24/2026 and discharge date [DATE], noted: Daily wound treatment: Left lower Lateral Distal Leg: Clean with Normal Saline or wound cleanser, apply thin layer of Mupirocin ointment (an antibiotic ointment) followed by a small piece of Hydrofera Blue MUST be moistened with Normal Saline, cover with a 4x4 gauze, ABD pad, and roll gauze. Cover foot and leg with Tubigrip (a multi-purpose elasticated tubular bandage that provides uniform compression and support for wound dressings) from just below toes to just below the knee.Record review of Resident #26's Wound Care Orders dated 02/17/2026 noted with start date 02/04/2026, read: Daily wound treatment: Left lower Lateral Distal Leg: Clean with Normal Saline or wound cleanser, nickel thick layer of Santyl (an ointment used to treat chronic skin ulcers) followed by calcium alginate, apply ABD pad, and wrap roll gauze. Cover foot and leg with Tubigrip from just below toes to just below the knee.Record review of Resident #26's Wound Management Detail Report dated 02/18/2026 noted resident was seen on 02/03/2026 by the Wound Care Physician. The report noted a Venous Ulcer on the left shin lateral distal measured at 2 centimeters long, 1 centimeter wide, and 0.3 centimeters in depth. It was noted that the discharge was pale red to pink, thin, and watery. It was noted that the wound healing was stable. On 02/10/2026, the wound was noted as 1.8 centimeters long, 1 centimeter wide, and 0.3 centimeters in depth. The wound discharge was pale red to pink, thin, and watery. The wound healing was noted as stable.Record review of Resident #79's face sheet dated 02/16/2026 revealed a [AGE] year-old female with admission date 02/03/2026.Record review of Resident #79's history and physical dated 02/04/2026 noted the following medical history: Diabetes Mellitus, left eye prosthetic, right eye legal blindness. It also noted that the resident had a fall at home which resulted in a left trimalleolar fracture that required a procedure and Resident #79 had a closed reduction and external fixation ().Record review of Resident #79's Comprehensive MDS dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact. Section I-Active Diagnoses noted Resident #79's primary medical condition that best described the primary reason of admission was Fractures and other Multiple Trauma and Presence of other medical devices. Under Section M- Skin Conditions, it did not include surgical wound care or pressure ulcer wound care.Record review of Resident #79's care plan with revision date 02/09/2026, did not include the resident's wound care or the external fixator. The care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted Resident #79 was at risk for falls relating to the presence of external fixator with staff interventions as follows: keep the call light within reach, keep personal items within reach, and keep room clutter free. The baseline care plan noted wound care but did not specify location of site, or frequency of wound care.Record review of Resident #79's wound care order with start date 02/05/2026, noted daily wound treatment: Left medial ankle blister: Clean gently with Normal Saline or wound cleanser, pat dry, apply betadine and leave open to air.In an interview on 02/17/2026 at 1:33 PM with RN I, she stated the baseline care plan and acute changes were completed by nursing staff, and MDS completed the Comprehensive care plans. She stated the purpose of a care plan was for nursing staff to be aware and follow the plan of care. She stated surgical incisions and equipment was to be added on the care plan so staff could be aware of the site, what type of incision, what to monitor, and type of equipment. She stated possible risks of not including wound care included infection, swelling, and even possibility of losing a limb. She stated there were many risks. She stated nursing reviewed care plans every shift, and MDS nursing reviewed it quarterly. In an interview on 02/17/2026 at 3:14 PM with MDS Nurse L, he stated baseline care plans were completed by the admitting nurse which was to be completed from 48 to 72 hours after a resident's admission into the facility. He stated that the Comprehensive care plan was completed up to 21 days after admission. He stated that the wound care relating to Resident #79's external fixator was not on the care plan. He stated care plans were to be specific to the residents and to communicate their needs to the facility staff. He stated Resident #79's wound care was included but was not specific. He stated care plans were reviewed quarterly by MDS nursing.During an interview on 02/18/2026 at 4:18 PM with the DON, she stated nursing staff were responsible for the basic care plan which was to be completed within 48 hours of admission. She stated MDS was responsible for the Comprehensive Care Plan and stated she was unaware how often they reviewed the care plans. She stated the purpose of the care plan was for facility staff to be aware of the residents' needs, including wound care and the external fixator. She stated the risks of not including wound care or the external fixator would be a delay in patient care.Record review of the facility's Nursing Policy and Procedures titled Care Plan Process, Person-Centered Care, with revision date 05/05/2023, read in part: Policy: The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. Under Procedures, read in part: 2. The baseline person-centered care plan will include the minimum healthcare information necessary to properly care for the resident, including but not limited to initial goals based on admission orders, resident goals, physician orders . and 4A. The baseline Person-centered care plan Summary includes immediate resident needs. It continued, 6 . For the comprehensive assessment the review will be completed . no more than 21 days after admission.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 5 residents (Resident #4, Resident #7, and Resident #11) reviewed for ADL care.The facility failed to ensure Resident #4 and Resident #7 was groomed for facial hair on 2/15/2026.The facility failed to ensure Resident #11 had trimmed and clean nails on 02/15/2026.This failure could place residents who required assistance with ADLs at risk for unmet care needs.Findings included: Record review of Resident #4's face sheet dated 02/16/2026 revealed a [AGE] year-old female with initial admission date 04/28/2018 and readmission date 01/11/2026. Record review of Resident #4's history and physical dated 03/04/2025 revealed the resident was diagnosed with the following: Generalized Muscle Weakness, and Type II Diabetes Mellitus (metabolic condition that causes the body to become resistant to insulin or the pancreas fails to produce enough insulin). Record review of Resident #4's Discharge MDS dated [DATE] revealed the resident was unable to complete the BIMS interview and did not score. Section GG Functional Abilities revealed Resident #4 was completely dependent on showering/bathing, and oral hygiene, meaning the resident does none of the effort, and the helper does all the effort to complete the task. Record review of Resident #4's care plan with revision date 01/16/2026 revealed the resident required ADL assistance with intervention, one staff member to assist with personal hygiene. Record review of Resident #7's face sheet dated 2/18/2026 revealed a [AGE] year-old female with an initial admission of 8/14/2022 and readmission on [DATE]. Record review of Resident #7's history and physical dated 11/14/2024 revealed the resident was diagnosed with hemiplegia and hemiparesis affecting right dominant side (loss of function and movement to a side of one's body), cerebral infarction (blocked blood flow to the brain), unspecified dementia without behavioral disturbance (a syndrome characterized by decline in cognitive function, memory and ability to complete daily tasks). Record review of Resident #7's MDS dated [DATE] revealed under section C, Resident #7 had a BIMS score of 9 which implies the resident had moderate cognitive impairment. Under section GG, Resident #7 was coded for requiring partial/moderate assistance to substantial/maximal assistance for completing ADLs, dressing self, bathing, toileting, and oral hygiene. Under Section O, Resident #7 was coded for receiving Hospice services. Record review of Resident #7's care plan dated 1/16/2026 revealed Resident #7 required assistance with ADLs due to hemiplegia and hemiparesis to right dominant side and dementia. The care plan revealed that the resident required partial/moderate assistance for personal hygiene and substantial/maximal assistance for bathing and transferring. Resident #7 entered Hospice care in December 2024 with an agreement that Resident #7 would be kept clean and comfortable, will monitor skin needs during care daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's face sheet dated 02/16/2026 revealed a [AGE] year-old male with initial admission date 08/21/2025 and readmission date 08/29/2025. Record review of Resident #11's health and physical dated 08/22/2025 revealed a medical history of the following: depression (mood disorder that consists of persistent sadness or loss of interests in activities of interest), Dementia (a group of symptoms affecting memory, thinking and social abilities), and left hemiplegia (weakness of one side of a person's body, usually due from brain or spinal problems). Record review of Resident #11's Quarterly MDS 12/18/2025 revealed a BIMS score of 10, indicating moderate cognitive impairment. Section GG Functional Abilities revealed Resident #11 required substantial/maximal assistance with personal hygiene, meaning the helper does more than half the effort to finish the task. Record review of Resident #11's care plan with revision date 02/16/2026 revealed the resident required ADL assistance and intervention included for 1 staff member to provide maximal assistance with personal hygiene. An observation on 02/15/2026 at 9:30 AM, Resident #11 was in her bed resting with her eyes closed. Her nails were long and untrimmed, approximately 1 inch, and with black and dark debris under her fingernails of both hands. An observation and interview on 02/15/2026 at 10:09 AM, Resident #4 was observed with hair on her chin. She stated staff assisted her with showers and personal grooming every other day. She stated she was aware she had facial hair and would like it shaved if offered by the facility staff. An observation conducted on 2/15/2026 at 11:12 AM, revealed Resident #7 had a mustache and chin hair measuring approximately a quarter to half an inch in length (longer than normal stubble). When asked about her preference, Resident #7 became notably embarrassed based on facial expression, pigment variation, and seeking behavior through her nightstand for her personal trimmer. In an interview on 2/15/2026 at 11:02 AM, Resident #7 stated she was on Hospice care but could not recall for how long. She stated staff and Hospice provide her bathing services and assistance since she was non-ambulatory and had limited range of motion to her right dominant side. She stated she received showers on Monday, Wednesday, and Friday. She stated she did not like having facial hair and staff/Hospice had not offered to shave it for her during recent showers. In a follow-up interview on 2/18/2026 at 9:01 AM, with Resident #7 stated the staff was recently short staffed and were limited to provide shaving services. She added she did not like the electric shaver the facility used because it operated at a high temperature and caused discomfort; she denied being injured by the electric shaver staff used. She clarified that it was difficult for her to shave herself because of her condition and would often forget. She stated she had never denied grooming or showering services from staff and added that staff was aware she had her own personal electric shaver in her room that they could utilize for her shaving needs. In an interview on 2/17/2026 at 3:24 PM, RN E who stated residents could request assistance with ADLS throughout the day or during their showering schedule. She stated CNAs would usually provide showers and would document any new conditions in skin/appearance in addition to documenting when residents denied services. She stated if a resident denied service, the nurse would follow-up (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and enter progress notes for rationale of denial. She stated that facial hair on a female would take 2-3 weeks to grow half an inch. She stated any staff member could notify the nurse and CNA about a female resident's facial hair so that services could be offered. She stated the normal shower schedule for residents was every other day excluding weekends. She stated facial hair on a female resident could affect them by causing mental anguish or causing low self-esteem. She stated a female resident could become itchy and potentially scratch themselves and cause irritation. She stated the last time she received in-service training for ADLs was in January 2026 and patient advocacy training in November 2025. In an interview on 02/18/2026 at 9:53 AM, CNA G stated she was familiar with Resident #7 and listed the ADLs she required assistance for was: showering, grooming, changing incontinence, and transfers bed to chair. She stated Resident #7 had no strength or movement to one side of her body (unknown). She clarified because Resident #7 was on Hospice, facility staff did not provide showering or grooming anymore as this was Hospice CNAs responsibility. She stated Resident #7 never had long facial hair because she would use her personal electric shaver in her nightstand. She stated the facility used to provide shaving services using the facility's electric shaver before Resident #7 obtained her own; was unable to recall when Resident #7 obtained her personal electric shaver. She stated that if a resident denied services, she would document it and notify the nurse. She added that if Hospice did not complete the services, staff were permitted to offer and provide services to the resident to include showers and grooming. She stated facial hair on a female resident could potentially affect residents by making them feel ugly, bad, or embarrassed. She stated the last in service for Abuse Neglect and exploitation was the second week of February. She stated CNAs did not communicate with Hospice as this was a nurse's responsibility. In an interview on 2/18/2026 at 1:14 PM, RN F who stated hospice CNAs communicated with the charge nurse for refusal of services by resident and would additionally report refusals to the hospice nurse. He added the charge nurse was responsible for reviewing the hospice CNA log and sign off on the services provided during hospice visit; he clarified this was in the hospice database which the facility did not have immediate access to. Stated he would evaluate the hospice CNA's services and review for abnormalities found such as bruises, cuts, refusals, etc. He stated charge nurses would review for abnormalities and not compare documentation of services provided compared to the resident's appearance. He stated he had never been notified by hospice CNA that a female resident denied shaving services. He stated facial hair on a female resident affected them because it could bother the resident; He added the facility staff would be able to provide grooming services for female residents as well if hospice did not. In an interview on 2/18/2026 at 4:56 PM, the DON stated the charge nurse and CNA could review the resident's grooming status to notify the hospice company. She stated the nurse and CNA sign off on the hospice CNAs tablet on services provided. She stated the CNA would notify the charge nurse if the services provided do not match what was observed on the resident. She stated hospice provided bathing and grooming 2-3 times a week. She stated that facial hair on a female would take 2-3 weeks to grow half an inch. She stated the nurse was supposed to review services documented in comparison to the resident's appearance. Record review of the facility's Nursing Policies and Procedures, titled Activities of Daily Living, Optimal Function, read in part: Definition: Activities of Daily Living (ADLs), refer to tasks related to personal care including grooming . and, under Policy, it read The Facility provides care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, hygiene. In an interview on 02/17/2026 at 1:57 PM, with RN I, she stated residents were monitored for nails and facial grooming during the provided showers which was three times a week, or as needed. She stated resident shower sheets were completed by CNAs and they notated any concerns such as nails and facial grooming was needed. She stated the nurses review shower sheets during their shift and sign off to confirm the information was reviewed. She stated if residents refused grooming, CNAs were to notify the nurse that shift. She stated the potential risk to residents with long, untrimmed nails included injury to self by cutting their skin with the nail. She stated that could lead to possible infection.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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's environment was as free from accident hazards as possible for 2 of 8 residents (Resident # 24 and Resident # 29) reviewed for accidents. The facility failed to properly dispose of a shaving razor in sharps container for Resident # 24 and # 29. This deficient practice could place residents at risk of injury and contribute to avoidable accidents. The findings included:Resident # 24 Record review of Resident 24's admission record dated 02/18/26 revealed a [AGE] year-old male admitted on [DATE]. Record review of Resident #24's History and Physical dated 01/15/2026 revealed a diagnosis of dementia (decline in mental ability). Record review of Resident #24's MDS assessment dated [DATE] revealed a BIMS score of 05 indicating severe cognitive impairment. Record review of Resident #24's care plan revised on 12/08/2025 revealed Resident #24 had a memory/recall problem related to cognitive loss/dementia, interventions included redirecting resident when entering unsafe areas. An observation on 2/15/26 at 12:50 pm of Resident # 24's room revealed two disposable shaving razors sitting in the slot of the sharp's container. Resident #29 Record review of Resident #29's admission Record dated 02/18/2026 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Record review of Resident # 29's History and Physical dated 02/17/2026 revealed a diagnosis of dementia (decline in mental ability). Record review of Resident # 29's MDS assessment dated [DATE] revealed a BIMS score of 10 indicating a moderate cognitive impairment. Record review of Resident #29's care plan revised on 11/26/25 revealed Resident #29 had moderate cognitive memory/ recall problem r/t dementia interventions included redirecting resident when entering unsafe areas.An observation on 2/15/26 at 12:50 pm of Resident # 29's room revealed two disposable shaving razors sitting in the slot of the sharp's container. In an interview on 2/17/2026 at 11:15 a.m., CNA N revealed razors were to be disposed of in the sharps container because it was considered a sharp and could hurt the resident if left within reach. She stated that the sharps were supposed to be disposed completely in the bin and not left in the slot. She stated that if the sharps were left in the slot, the resident could potentially hurt themselves if they happen to reach in or staff members could also get hurt when disposing of other sharp items. She stated that it was the responsibility of whoever was disposing of the object to ensure that it was completely in the bin and not in the slot. She stated that the last training over proper sharps disposal was upon hire. In an interview on 02/17/2026 at 1:17 PM, RN I revealed razors were to be disposed In the sharps container because it was considered a sharp and could hurt the resident if left with reach. She stated that it was the responsibility of the nurse to ensure all sharps were disposed of properly. She stated that she could not recall a recent Inservice or training over proper disposal of sharps, she stated that the last one she remembered was given upon hire. In an interview on 02/18/2026 at 3:42 p.m., the DON revealed that razors were to be disposed of in the sharps container so that residents would not get to them and accidently cut themselves. She stated that when staff were disposing of any sharp, they were to ensure that it was in the bin and not left in the slot. She stated that it was the responsibility of all staff to ensure that there weren't any sharps in the slot. She stated that she did not recall the last Inservice done about proper disposal of sharps. Review of facility policy titled Safety and Health Policy and Procedures read in part . The policy for management of biohazards wastes is designed to help protect patients/ residents, personnel, visitors, employees and community from exposure to biohazardous wastes. Biohazardous waste shall include the following categories: Sharps- all discarded sharps including hypodermic needles, syringes, and scalpel blades.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 3 (Resident #23, Resident #62, and Resident #67) of 12 residents observed for oxygen management.The facility failed to clean the oxygen concentrator air filter for Resident #23 and Resident #67 while the oxygen was in use; concentrators were observed with air filters with dust, and lint collected on them on.The facility failed to ensure Resident #62's nasal canula was properly stored while oxygen was not in use.This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. The findings include:Resident #23Record review of Resident #23's face sheet dated 2/18/2026 revealed an [AGE] year-old female admitted on [DATE].Record review of Resident #23's history and physical dated 11/25/2025 revealed Resident #23 was diagnosed with vascular dementia (a group of symptoms affecting memory, thinking, emotional regulation and social abilities) and chronic respiratory failure with hypoxia (damaged lungs cannot properly transfer oxygen into the blood).Record review of Resident #23's comprehensive MDS dated [DATE] revealed Resident #23 had a BIMS of 3 which signified severe cognitive impairment. Under section O, Resident #23 was coded to receive oxygen therapy while a resident at the facility.Record review of Resident #23's care plan dated 2/2/2026 revealed Resident #23 had an intervention in place of Licensed Nurse to monitor vital signs including temperature, blood pressure, pulse, respirations, and oxygen saturation weekly in reference to therapeutic treatment from medications. No additional goals/problems were identified in the care plan regarding respiratory therapy or oxygen concentrator.Record review of Resident #23's physician's orders dated 11/26/2025 revealed the resident was to receive 2 liters per minute of oxygen.In an observation on 1/15/2025 at 1:55 PM it was revealed Resident #23 had an oxygen concentrator in her room with the filter exposed with text that read, REPLACED 8.18.2021. Lint and dust build up were observed on the oxygen concentrator filter as well. Resident #23 could not participate in the interview because she was asleep. Follow-up visits were unsuccessful.Resident #62Record review of Resident #62's Face Sheet dated 02/18/2026 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE].Record review of Resident #62's history and physical dated 02/17/2026 revealed resident had a diagnosis of chronic obstructive pulmonary disease (airflow prevention to lungs causing breathing problems).Record review of Resident # 62's Quarterly MDS dated [DATE] revealed a BIMS score of 11 indicating mild cognitive impairment.Record review of Resident # 62's physician's orders revealed an order for oxygen at 2-5 liters per minute via nasal canula as needed. Start date of 01/02/2024.Record review of Resident #62's care plan revised 11/26/25 revealed that resident was at risk for respiratory distress/ shortness of breath due to diagnosis of chronic obstructive pulmonary disease. interventions included administering oxygen as ordered.Observation on 02/15/2026 at 08:58am revealed Resident #62's nasal canula sitting on top of the oxygen concentrator, not stored in a plastic bag while not being used. Resident #67Record review of Resident #67's face sheet dated 2/18/2026 revealed the resident was an [AGE] year-old female with an admission date on 9/20/2023.Record review of Resident #67's history and physical dated 10/11/2023 revealed the resident had a diagnosis of chronic congestive heart failure (heart is unable to pump blood efficiently), anemia of chronic disease (reduce capacity for oxygen in blood from long-term inflammation due to illnesses), and chronic respiratory failure with hypoxia (damaged lungs cannot properly transfer oxygen into the blood).Record review of Resident #67's quarterly MDS dated [DATE] revealed Resident 67 had a BIMS score of 99 which signifies the resident was unable to actively participate and complete in assessment and was coded for having moderate cognitive impairment. Under section O, Resident #67 was coded to receive oxygen therapy while a resident at the facility. Under section I, Resident #67 was coded for having a diagnosis of anemia (reduce capacity for oxygen in blood), respiratory failure, and heart failure. Under section J, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #67 was coded for experiencing shortness of breath when lying flat.Record review of Resident #67's care plan dated 2/12/2026 revealed Resident #67 had an intervention in place of Licensed Nurse to monitor vital signs including temperature, blood pressure, pulse, respirations, and oxygen saturation weekly in reference to therapeutic treatment from medications. Resident #67 care plan identified history of heart failure with interventions to administer medications as ordered per physician and monitor for signs of respiratory distress. Resident #67 care plan identified a category under respiratory interventions, oxygen at 2-5 liters per minute change oxygen tubing, cannula, humidification weekly .In an observation on 1/15/2026 at 2:26 PM revealed the Resident #67 had a noticeably dusty air filter with no date of last service.In an interview on 2/15/2026 at 1:35 PM with Resident #23's family members, revealed Resident #23 had never complained of dry sinuses or reported nasal bleeding. Family members were unable to recall when the oxygen concentrator was serviced. Family members declined to see staff enter the room to review the oxygen concentrator beyond providing a new cannula and humidifier.In an interview on 2/18/2026 at 9:24 AM Resident #67 stated staff checked her oxygen concentrator once a day. Resident #67 clarified she did not pay attention to what staff did when they reviewed or replaced parts on her concentrator. She stated she did not know when the last time the facility replaced the oxygen concentrator filter.In an interview on 02/17/2026 at 2:10 PM with CNA B revealed that nasal cannulas were to be stored in the plastic bag while not in use to prevent it from getting dirty or contaminated. She stated that if the nasal canula was found on the floor or exposed on a surface, it was supposed to be thrown away and changed out for a clean one. She stated that it was the responsibility of the CNAs and the nurses to ensure that the nasal cannulas were stored properly. She stated that the risk of residents using dirty nasal cannulas would be introducing bacteria into the nose and the resident could possibly end up getting sick. She stated that oxygen concentrator filters were to be cleaned by the nurses. She stated that the risk of a dirty air filter could be the resident not receiving adequate oxygen. She stated that she was not sure how often the nurses were to clean them. She stated not remembering the last in-service held on oxygen concentrator filters and nasal canula storage.In an interview on 02/17/2026 at 2:42 PM with RN E revealed that nasal cannulas were to be stored in a plastic bag to prevent contamination. She stated that if a nasal canula was found on the floor or lying exposed on a surface, she would need to exchange it for a new one to prevent the resident from placing a dirty nasal canula on their face and in their nares preventing them from introducing pathogens into their respiratory tract. She stated that it was the responsibility of the nurses and CNAs to ensure the nasal canula was stored while not in use. She stated that oxygen concentrator filters were cleaned weekly on weekends by weekend nurses. She stated that a dirty filter could trigger allergies for the resident. She stated that it was the responsibility of the nurses to ensure that the concentrator filters were free of dust. She stated that all nurses were able to check upon rounds if filters were clean. She stated that the last in-service was held during summer 2025.In an interview on 2/18/2026 at 10:18 AM RN F stated the purpose of the oxygen concentrator was to deliver oxygen to residents who have low oxygen saturation levels (below 92%). He stated it required a physician's order to administer oxygen and the facility did not hire nor contract with a respiratory therapist. He stated that if there was a maintenance concern, the Administrator needed to be notified to request assistance from the contracted maintenance provider. He stated that if the oxygen concentrator began malfunctioning, it would begin alerting staff with an alarm. He stated there was no routine basis for maintenance on the concentrators, and direct care staff (CNA and nurses) were not responsible for maintenance (replacing filters). He stated a dirty air filter will set off the alarm on the concentrator causing the machine to fail and not allowing O2 saturation levels to be met for the resident. He stated central supply did the product replacement of filters, cannulas, and nebulizers. In an interview on 02/18/2026 at 3:42 pm with the DON revealed that nasal cannulas were supposed to be stored in the bag attached to the oxygen concentrator to be kept clean. She stated that was done to prevent infection in the residents. She stated that staff to include nurses and CNAs were to change the tubing if it was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed to be lying out on a surface because the tubing was considered contaminated at that point. She stated that all staff was responsible for ensuring the nasal cannulas were stored properly when not in use. She stated that oxygen concentrator filters were cleaned weekly by weekend nurses. She stated that it was the responsibility of all staff during morning rounds to look at the flites to ensure cleanliness. She stated that dirty oxygen filters could inhibit the proper oxygen flow to the resident. She stated the staff received yearly training over the topic. Review of facility policy titled Respiratory Treatment, Care and Services Program revised 05/2023 revealed in part . Infection control practices including standard and transmission- based precautions are followed during: handling of equipment, including cleaning, storage and disposal of regular and biohazardous waste .

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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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen.-The facility failed to maintain safe consumable produce as evident by 4 visibly molded tomatoes, observed on 02/15/2026.-The facility failed to properly seal carrots to limit exposure, observed on 02/15/2026.-The facility failed to properly label prepared food being stored in the walk-in refrigerator/freezer/cart shelves with prepared and use by dates, observed on 02/15/2026.-The facility failed to dispose of 23 pudding sherbert nectars that were created on 2/8/2026 and had a use by date on 2/10/2026, observed on 02/15/2026.-The facility failed to accurately complete temperature logs as evidenced by afternoon logs being signed as completed on the morning of 2/15/2026.-The facility failed to ensure the grease traps above the grill and fryer were clean and free of dust/grease, observed on 02/15/2026.-The facility failed to properly thaw poultry as evident by diced turkey cubes left on the counter, observed on 02/15/2026.-The facility failed to ensure Dietary aide K was properly restraining hair while serving food, observed on 02/15-17/2026.These failures could place all residents who received meals from the kitchen at risk of food-borne illnesses. Findings included:During observation on 2/15/2026 at 8:38 AM of initial kitchen tour, it was observed in the walk-in freezer at 8:42 AM 23 pudding sherbert was on the cart shelves with a preparation date of 2/8/2026 and a use by date of 2/10/2026. At 8:43 AM, none of the other cart shelves had labels for preparation and use by dates for the desserts and cold sides that were going to be served during the upcoming meal services. At 8:44 AM, a bag of approximately 15 carrots was discovered on the shelf without am opened and use by label and was exposed to air. At 8:45 AM, 4 tomatoes with visible mold touched other tomatoes without visible mold. At 8:48 AM, large frozen iceicles had developed on boxes of food resting on the first, second, and third shelves (top to bottom) directly underneath the fan and condenser. At 8:49 AM, a plastic baggie of chile rellenos (Mexican dish of pepper, cheese, and egg wash) was not labeled with a use by date and a bag of breaded mozzarella reflected use me under the use by box without a date. At 8:55 AM, the temperature log for the refrigerator and freezer had the afternoon temperature completed in advance by [NAME] C. At 8:59 AM, a bag of diced turkey cubes was left on the counter near the entrance to the walk-in refrigerator and was cool to touch but not frozen. At 9:05 AM, the grease traps above the grill and fryer were visibly dirty with grease and dust and the log reflected they were cleaned on 2/13/2026.Observations on 2/15/2026 at 12:32 PM during dining/meal service, on 2/16/2026 at 10:55 AM during kitchen follow-up, and on 2/17/2025 at 9:16 AM during meal preparation revealed. Dietary Aide K was observed preparing food, handling food, or in the kitchen without properly restraining facial hair from his beard, sideburns, and mustache. In an interview on 2/17/2026 at 10:03 AM Dietary Aide K stated he was responsible for preparing beverages, desserts, nectars, condiments, and prepared breakfast for the next day. He stated that all dietary staff oversaw labeling and reviewing the ingredients' integrity. He stated his chores for cleaning were to: clean the serving area, tables, coffee/tea brewers, condiments container, sweep/mop the dry storage, empty trash cans, wipe the ice machine, clean/organize the dietary aide refrigerator, cleaning the preparation tables, and the steam table. He stated that the logs needed to be signed off once they were completed and not in advance. He stated that if a task was time sensitive, the next shift was responsible for completing the fridge/freezer check on the next shift. He stated that it was falsification and there might be an issue that occurred. He added it could be unclear as to when the issue occurred if the temperature log was completed in advance. He stated that the Dietary Manager was responsible for reviewing the logs to make sure they were completed and accurate. He stated that they could expose residents to cross contamination and foodborne illness if produce was left spoiled or uncovered in the fridge. He stated that hairnets needed to be worn upon entry into the kitchen to prevent hair from falling into the serving area or the resident's plate. He stated the hairnet (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should cover the hairline crown from front to back and women needed to tie their hair up. He stated that beards and mustaches should be always covered with a beard net while working in the kitchen, and the Dietary Manager was responsible for reviewing employees for dress code compliance. He stated that the grease traps above the grill and fryer were dirty as evidence by the grease and dust and added that the grease traps appeared to be dirtier than 2 days since the chore was documented as completed. He stated that the Dietary Manager was responsible for ensuring that chores were completed. He stated that the last in-service for cleaning, food storage, dates, and serving was in December 2025.In an interview on 2/18/2026 at 1:22 PM the Dietary Manager stated proper storage of produce was important to prevent cross contamination. He stated kitchen reviews were completed on Mondays and sporadically during the week by himself. He added that the cooks and dietary organizer assisted in reviewing the walk-in fridge. He stated staff were trained to discard food that was visibly spoiled, not labeled, or past their use by date to prevent cross contamination. He added staff would notify him when large amounts of food was tainted and discarded. He stated that frozen items that were cooked and prepared in the kitchen (chile rellenos) had to be used in 3 days. He stated that any processed food that was not in its original packaging or opened, needed a use by date to ensure its freshness. He stated that the temperature log needed to be filled once by the morning shift and once by the afternoon shift. He stated if it was recorded before its intended time then the fridge/freezer could have failed, and staff would not have had knowledge of it malfunctioning resulting in spoiled food for the residents. He stated the diced turkey thawing on the preparation table needed to be stored on ice, in the fridge, or freezer when not being actively used or thawed. He stated the hazard to leaving diced turkey on the table was the poultry could be spoiled and served to the residents unknowingly. He stated if a resident was to consume spoiled food, they could potentially feel ill. He stated that the dietary department was responsible for completing the chores on the log to maintain the integrity of the kitchen. He identified himself as the individual responsible for overseeing the operation of chores, cleanliness, and food storage for the kitchen. He stated staff was expected to always have their hairnets on while in the kitchen, preparing food, and when placing food in the meal carts. He stated facial hair needed to be covered to include mustache and beard to prevent the food from being cross contaminated by hair.In an interview on 2/18/2026 at 2:32 PM [NAME] M stated her responsibilities as a cook were to maintain the fridge/freezer, cook meals, and serve meals. She stated she was responsible for taking the temperatures for the fridge/freezer in the afternoon and completing the temperature log accurately. She stated the temperature for the fridge needed to be below 40 F and for the freezer 0 F. She stated she was trained to fill out the log at the time of completion. She clarified she could not fill in the log in advance because it provided inaccurate information and there could be an issue that arises between the time she reviewed the fridge/freezer and when it potentially became faulty. She added that she was also responsible for making sure food was labeled, discarding spoiled/expired food, and rotating inventory in the fridge. She stated she would review produce for spotting, mold, firmness, and change of color in produce. She stated it needed to be done to prevent serving bad/raw/expired food to the residents. She stated food with those qualities possessed risk for the development of bacteria or food borne illnesses. She stated that thawing procedures needed to be adhered to, especially for meats, to prevent the growth of bacteria. She stated she used the practice of rotating the frozen item to the fridge and placed on the lowest shelf or submerged the frozen meat under cold water and had cold water continuously running over the meat. She stated she would return unused diced turkey in the freezer/fridge to prevent it from spoiling instead of leaving it on the counter. She stated items needed to be labeled so that staff were aware of the expiration date of the food. She stated she would not serve food or use ingredients that were unlabeled. She stated dietary staff had a chore list per position with cleaning objectives for the kitchen. She stated that for the grease traps they would usually clean 2 at a time due to time restraints. She stated all head/facial hair needed to be covered while in the kitchen because there was potential for hair to get in the food. She stated this rule applied to all dietary staff and kitchen (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visitors.Record review of facility's Nutritional Policies and Procedures, dated 10/15/2025, titled Dress Code, revealed in part: The Dietary Department employees will adhere to a facility dress code that facilitate safe, sanitary meal production and service, and will present a professional appearance. Dietary staff involved in food production adheres to the department dress code that includes Appropriate hair restraints (hair covers or nets, beard restraints) while involved in food production activities.Record review of facility's Nutritional Policies and Procedures, dated 10/15/2025, titled Safe Preparation, revealed in part: During the food production process, food will be handled by methods to minimize contamination and bacterial growth to prevent food borne illnesses .Thawing: Thawing food at room temperature is not acceptable . Recommended methods to safely thaw frozen TCS foods include: under refrigeration that maintains the food temperature at 40 F or less. Completely submerged under running water of a temperature of 70 F or lower, or per local policy. Thawed in a microwave if the food is immediately transferred to conventional cooking equipment to finish cooking. Thawed as part of a continous cooking process Record review of facility's Nutritional Policies and Procedures, dated 10/15/2025, titled Food Safety in Receiving and Storage, revealed in part: Food will be received and stored by methods to minimize contamination and bacterial growth Foods that have been thawed and then refrozen can be contaminated; check for large ice crystals, solid areas of ice, discolored or dried-out food, or mishappen items Dampness or mold can be signs of spoilage or bacterial growth Inappropriate odors, colors, or textures in cold foods. Check expiration dates and use-by dates to assure the dates are within acceptable parameters Do not refreeze thawed food unless it has been thoroughly cooked. Refrigerated, ready to eat TCS are properly covered, labeled, dated with a use-by date, and refrigerated immediately. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded. The day of preparation or day original container is opened shall be considered day 1. Follow USDA guidelines for food storage

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 5 steam table wells reviewed.The facility failed to ensure the furthest right steam table well was not used to hold food for breakfast and lunch due to it not being operational since 12/31/2025.This failure placed residents at risk for delay in meal service.Findings included:In an observation made on 2/15/2026 at 12:04 PM revealed [NAME] C was serving lunch from the steam table with 4 of 5 wells filled with food. The furthest right well was not hot to touch, did not emit any steam, and the electric knob was not illuminated to show it was on. [NAME] C and the Dietary Manager confirmed that the 5th well on the steam table was not operational.In an interview and observation on 2/18/2026 at 10:26 AM with [NAME] C stated the steam table well had not been working for 2 months because the previous shift had left it on all night. She stated that when she returned in the morning there were brown charring marks and white spots that took her hours to scrub clean. She stated since the steam table had not been fully operational, she had to use the steamer and oven to accommodate the missing well. She stated by holding food in the oven affected the food's appearance, taste, and texture. She stated she had reported it to the Dietary Manager on 12/31/2025 by word of mouth. [NAME] C provided image confirmation from her phone to confirm the timeline of the steam table malfunctioning. She identified the Dietary Manager was responsible for maintaining, documenting, and reporting faulty equipment to the Administrator or Maintenance Director. She stated having faulty equipment in the kitchen could potentially affect residents by influencing the quality of meal experience.In an interview on 2/18/2026 at 11:39 AM the Maintenance Director stated he was responsible for maintaining the building to the best of his ability and contract with vendors when specialty qualification was required. He stated staff provided work orders to him verbally as there was no documentation completed. He stated the documentation he had would only be for part orders or vendor invoices. He stated he was notified of the steam table 3 weeks ago by the Dietary Manager, verbally. He stated he had repaired the steam table but a week after its repair it became faulty again on the second week of February 2026. He stated any staff member could report equipment not properly functioning to him. He identified himself as the individual responsible for assessing equipment and contacting vendors when it was beyond his capability of repair. He stated one of the steam table wells not working did not affect the residents because staff was still able to complete their responsibilities with 4 wells. He denied having any documentation in place for the steam table work order besides a part order invoice from 2/16/2026 and was unable to recall specific timeline/dates for the steam table becoming inoperable from the well.In an interview on 2/18/2026 at 1:50 PM the Dietary Manager stated there was a binder at the nurse's station for staff/residents to file a work order request. He stated the steam table well had not been operational for 2-3 weeks and added that he notified the Maintenance Director verbally when it initially broke. He stated the Maintenance Director replaced a part on the steam table; however it did not resolve the issue permanently. He stated they had been trying to find out what the name of the part was and found the specific model and specific part recently. He stated if the part did not resolve the issue the whole 5th well for the steam table would need to be replaced. He stated the steam table not working has not affected staff's ability to complete their tasks because the facility census was low. He stated the steam table not being fully operational had not affected residents and he did not foresee it affecting residents. He stated he could keep the food warm on 2 electric wells that could be connected to the wall or hotel chafing platters (catering [NAME] burners). He stated that staff was trained to notify him if equipment was faulty by verbal notification, over the phone, or could directly notify the Administrator, or the director of dietary at a sister facility.In an interview on 2/18/2026 at 2:08 PM Dietary Aide P stated the equipment she used was operating correctly and she had no concerns. She stated she did not interact with the steam table at all as this was the cook's duty (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	station. She stated she was aware the steam table became broken in December 2025 and was unable to recall if the Maintenance Director or Dietary Manager made repair attempts. She stated the cooks and the dietary aides had not been affected by the steam table not fully operating. She stated by not having the 5th well, the food's temperature could not be held at the appropriate temperature. She stated if the 5th well remained inoperable, there was potential for the kitchen to be backed up on meal orders and result in a delay in meal service for residents. She stated if she noticed malfunctioning equipment she would report it to her supervisor or Maintenance Director immediately so that it could be restored as soon as possible. She stated she would additionally write it down in the maintenance work order binder located in the nurse's station. She identified the Maintenance Director was responsible for ensuring kitchen equipment was operational or progressing repairs. Record review of facility's Nutritional Policies and Procedures, dated 10/15/2025, titled Safe Employee Work Practices, revealed in part: The maintenance department is responsible for a preventative maintenance program to avoid unnecessary breakdowns and hazards, as well as for routine inspections of items such as fans, vents, ducts, and large equipment .The CDM notified the maintenance department of any safety hazards or equipment breakdowns.Record review of an invoice submitted to a parts supplier by the Dietary Manager revealed 2 electrical components were ordered on 2/16/2026 at 3:51 PM with an additional note from the Dietary Manager, Please overnight air ship this order. Thank you.

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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** 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 quality of life for one (Resident #14) of eight residents reviewed for dignity.CMA H failed to feed Resident #14 at eye-level on 02/15/26.This failure could place the residents at risk of poor self-esteem and decrease self-worth.Findings include:Record review of Resident #14's face sheet dated 02/18/2026 revealed an [AGE] year-old male with initial admission date 07/30/2019 and readmission date 03/23/2025.Record review of Resident #14's health and physical dated 02/17/2026 revealed a medical history of Dementia (a syndrome characterized by decline in cognitive function, memory and ability to complete daily tasks), and Dysphagia (difficulty swallowing).Record review of Resident #14's Comprehensive MDS dated [DATE] revealed Resident #14 was unable to complete the BIMS interview. Section C-Cognitive Patterns revealed Resident #14 had a Memory problem with Short-term and Long-term Memory and was noted as severely impaired for Daily Decision Making. Section GG-Functional Abilities revealed Resident #14 required Supervision or touching assistance with Eating, meaning the helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity.Record review of Resident #14's care plan revealed resident required ADL assistance with the intervention of 1 staff member to assist with eating through supervision or touching assistance.An observation was made on 02/15/2026 at CMA H fed Resident #14 a spoon of Jello while still standing.In an interview on 02/15/2026 at 2:25 PM, CMA H, stated she was not assigned with feeding but wanted to help the CNA's who were to feed the residents. CMA H stated that staff standing when assisting with feeding the residents was not correct. She stated there was no chair or stool for her to sit and assist during lunch which was why she stood. She stated she was to look for a stool or chair to sit when feeding the resident. CMA H stated the risks of assisting with feeding residents while they sit could be a sign of disrespect and was a dignity issue for residents. She stated nurses who were overseeing the meal service, were responsible for monitoring all staff providing and assisting residents appropriately. In an interview on 02/17/2026 at 1:30 PM, RN I stated staff were to assist with feeding residents while sitting down and at an eye-level with residents. RN I stated it was to make residents more comfortable. RN I stated potential risks of assisting with feeding, while the staff stands and residents sit, included the possibility of residents becoming agitated or threatened. She stated nurses were responsible for overseeing the dining room and ensure staff feed residents at eye-level.In an interview on 02/18/2026 at 4:01 PM, the DON, stated that staff were trained to feed residents while sitting. She stated CNA's assisted residents with feeding during mealtimes, and the nurses were responsible for monitoring the dining room to ensure residents were assisted correctly. She stated the risk to residents feeling inferior to staff if staff stood over them when assisting.Record review of the facility's Nursing Policies and Procedures, titled Activities of Daily Living, Optimal Function, read in part: Definition: Activities of Daily Living (ADLs), refer to tasks related to . eating . and Policy: The Facility provides care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, hygiene.

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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. **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, and the residents' choices for two (Resident #26 and Resident #79) of 10 residents reviewed for quality of care, in that:RN O signed the TAR for treatment for Resident #26's treatment completion despite the treatment not being completed on 01/31/2026.The Wound Care Nurse failed to label Resident #79's wound dressing observed on her left ankle on 02/15/2026.These failures affected one resident and placed 72 additional residents who resided in the facility at risk of not receiving prompt medical interventions. The findings included:Record review of Resident #26's face sheet dated 02/16/2026 revealed an [AGE] year-old female with admission date 01/22/2026.Record review of Resident #26's history and physical dated 02/12/2026 revealed a medical history of the following: Chronic Kidney Disease (a condition meaning damage to the kidneys causing it to not filter the waste in the blood), Type II Diabetes Mellitus (metabolic condition that causes the body to become resistant to insulin or the pancreas fails to produce enough insulin), and had wounds on both legs.Record review of Resident #26's Discharge MDS dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact.Record review of Resident #26's care plan with revision date of 02/04/2026 revealed Resident #26 had a wound/disruption of skin surface, left lower leg venous ulcer. Interventions for staff included to provide wound care as ordered, and to use aseptic techniques.Record review of Resident #26's Wound Care Order dated with start date 01/24/2026 and discharge date [DATE], noted: Daily wound treatment: Left lower Lateral Distal Leg: Clean with Normal Saline or wound cleanser, apply thin layer of Mupirocin ointment () followed by a small piece of Hydrofera Blue MUST be moistened with Normal Saline, cover with a 4x4 gauze, ABD () pad, and roll gauze. Cover foot and leg with Tubigrip (a multi-purpose elasticated tubular bandage that provides uniform compression and support for wound dressings) from just below toes to just below the knee.Record review Wound Care Order dated 02/17/2026 noted with start date 02/04/2026, read: Daily wound treatment: Left lower Lateral Distal Leg: Clean with Normal Saline or wound cleanser, nickel thick layer of Santyl (an ointment used to treat chronic skin ulcers) followed by calcium alginate, apply ABD pad, and wrap roll gauze. Cover foot and leg with Tubigrip from just below toes to just below the knee.Record review of Resident #26's Wound Care Administration history record dated 02/17/2026 from 01/01/2026-01/31/2026 revealed wound care was marked as completed on Saturday 01/31/2026 between 6 AM to 10 PM.Record review of Resident #26's Wound Management Detail Report dated 02/18/2026 noted resident was seen on 02/03/2026 by the Wound Care Physician. The report noted a Venous Ulcer on the left shin lateral distal measured at 2 centimeters long, 1 centimeter wide, and 0.3 centimeters in depth. It was noted that the discharge was pale red to pink, thin, and watery. It was noted that the wound healing was stable. On 02/10/2026, the wound was noted as 1.8 centimeters long, 1 centimeter wide, and 0.3 centimeters in depth. The wound discharge was pale red to pink, thin, and watery. The wound healing was noted as stable.Record review of Resident #79's face sheet dated 02/16/2026 revealed a [AGE] year-old female with admission date 02/03/2026.Record review of Resident #79's history and physical dated 02/04/2026 noted the following medical history: Diabetes Mellitus, left eye prosthetic, right eye legal blindness. It also noted that the resident had a fall at home which resulted in a left trimalleolar fracture (happens when you break your lower leg sections that form your ankle joint and help you move your foot and ankle) that required a procedure and Resident #79 had a closed reduction and external fixation (closed reduction is a non-surgical procedure to realign broken bones, while external fixation involves stabilizing fractures using an external frame).Record review of Resident #79's Comprehensive MDS dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact. Section I-Active Diagnoses noted Resident #79's primary medical condition that best described the primary (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reason of admission was Fractures and other Multiple Trauma and Presence of other medical devices. Under Section M- Skin Conditions, it did not include surgical wound care or pressure ulcer wound care.Record review of Resident #79's care plan with revision date 02/09/2026, did not include the resident's wound care or the external fixator.Record review of Resident #79's wound care order with start date 02/05/2026, noted daily wound treatment: Left medial ankle (refers to the inner side of the left ankle) blister: Clean gently with Normal Saline or wound cleanser, pat dry, apply betadine and leave open to air.In an observation and interview on 02/15/2026 at 11:08 AM, revealed Resident #79's left lower leg with a wound care dressing on her left ankle not dated or labeled with staff initials. Resident #79 stated she was provided wound care for her blister on her left ankle, which the Physician and team advised for it to rupture naturally, and it had ruptured with discharge which was why she got wound care. She stated she had wound care completed the day before on 02/14/2026.In a phone interview on 02/17/2026 at 11:33 AM, Resident #24's family member stated she was with Resident #24 on Sunday 02/01/2026. She stated she observed Resident #24's left foot red as a tomato, with brown discharge, and mentioned the socks Resident #24 was wearing was also brown. She stated she reported it to RN O. She stated RN O provided wound care at that time and she requested a change in ointment and for Resident #24 to have soak baths for both of her feet. She stated Resident #24 had the wound for a long time and she was familiar on how to care for the resident's wound. She stated she went to visit Resident #24 on Monday 02/02/2026, and Resident #24 reported to her that wound care was not completed on Saturday 01/31/2026. She stated she immediately notified the Wound Care Nurse and the DON. She stated the DON had reported reviewing the wound care notes for Resident #24 and it noted wound care was given that day. She stated she advised the DON to speak with Resident #24 about the allegation. She stated the DON stated Resident #24 was alert and oriented and reported not receiving any wound care on 01/31/2026. She stated the DON notified her of speaking with RN O, and RN O admitted to the DON that she did not provide wound care on 01/31/2026. She stated she wanted to make sure RN O did not do this with other residents.In a phone interview on 02/17/2026 at 3:14 PM, RN O stated she recalled Resident #24's allegation of not providing wound care on Saturday 01/31/2026. She stated she was to provide wound care that day as Resident #24 had daily wound care ordered, but she stated she did not have Normal Saline () that she needed for wound care that Saturday night. She stated it was approximately 9 PM when she was to provide Resident #26 with wound care. She stated she was trained to call the DON to notify the need for supplies but she did not. In a follow up phone interview on 02/18/2026 at 12:42 PM, RN O stated she did not notify any staff of not having supplies needed for wound care that night. RN O stated she did not provide wound care because she was tired as it was the end of her shift and she stated she thought she would be able to complete wound care the following morning as she worked double weekends.In an interview on 02/17/2026 at 3:36 PM with RN E, she stated wound dressings were to be dated and initialed by the nurse doing the dressing change. She stated that nurses would be responsible for not labeling dressing changes. She stated the purpose of dating wound dressings was to keep track of when the dressing was changed. She stated a potential risk of not labeling wound dressings included infection and sepsis (serious condition in which the body responds improperly to an infection). She stated the ADONs and the DON monitored wound dressings on a weekly basis.In an interview and observation on 02/18/2026 at 6:00 AM, the Wound Care Nurse, stated she was the Wound Care Nurse during the weekdays, Monday to Friday, and the floor nurses provided wound care on the weekends. She stated that the supplies were in the treatment cart and in the supply room. An observation of the treatment cart with the Wound care Nurse revealed multiple bottles of Normal Saline. She stated nurses were trained to notify the ADON and DON if there was a need for supplies if there was not any available on site. She stated the potential risks of not providing wound care as ordered included infection to residents. She stated Resident #24's family member reported to her on Monday 02/02/2026, the allegation of Resident #24 not receiving wound care on Saturday 01/31/2026. She stated that the family member notified the DON right away, while she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for monitoring wound dressings, including confirming it was labeled correctly. She stated the potential risk of not labeling wound dressings would be a delay in care for residents.Record review of the facility's Leadership Policies and Procedures titled Abuse, Neglect, Exploitation, or Mistreatment, with no date, read in part: Under Policy, it stated The facility's leadership prohibits neglect, mental, physical, and/or verbal abuse . ensures that alleged violations involving abuse, neglect, exploitation, or mistreatment . are reported immediately.Record review of facility's Nursing Policy and Procedures, dated 05/15/2023, titled Infection Prevention and Control Program and Plan, read revealed in part: Purpose: To establish a facility wide program that incorporates a system for preventing, identifying reporting, investigating, and controlling infections and communicate diseases. Under Procedures, it read revealed in part: 4.G. Appropriate personnel, environment, ventilation needs, supplies, and equipment are in place to provide infection prevention and control practices for the facility population.Record review of the facility's Nursing Policy and Procedures titled Wound Care evaluation did not have information regarding wound care labeling expectations.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 2 of 3 (Resident #67 and Resident #72) residents reviewed for urinary catheters. The facility failed to ensure Resident #72's Foley bag was off the floor and failed to ensure Resident #67 Foley tubing was draining urine into the Foley bag. This failure placed residents who had a urinary Foley at risk of contracting a UTI.Findings include:Record review of Resident #67's face sheet dated 2/18/2026 revealed the resident was an [AGE] year-old female with an admission date on 9/20/2023. Record review of Resident #67's of history and physical dated 10/11/2023 revealed the resident had a diagnosis of chronic congestive heart failure (heart is unable to pump blood efficiently), Age-related physical debility (muscular weakness because of age), and acute renal failure (rapid loss of kidney function). Record review of Resident #67's quarterly MDS dated [DATE] revealed Resident 67 had a BIMS score of 99 which signifies the resident was unable to actively participate and complete in assessment and was coded for having moderate cognitive impairment. Under Section GG, Resident #67 was coded for being dependent on staff for toileting hygiene. Under section H, Residency #67 was coded for having an indwelling catheter. Under section I, Resident #67 was coded for an active diagnosis of Obstructive Uropathy (blockage that prevents normal flow of urine).Record review of Resident #67's care plan dated 2/12/2026 revealed Resident #67 had an indwelling urinary catheter administered since 8/30/2024 with a goal to assist/provide catheter care as ordered. Resident #67's care plan revealed the resident contracted a UTI on 8/29/2025 with a goal to for the resident to achieve normal urinary elimination pattern with an absence of urinary disorders (infection).Record review of Resident #67's physician orders dated 5/15/2025 revealed the resident was prescribed an indwelling Foley catheter 18 French (6.0 mm) with a 10cc [NAME] for a diagnosis of obstructive and reflux uropathy unspecified. Record review of Resident #72's face sheet dated 2/18/2026 revealed the resident was an [AGE] year-old female with an initial admission date on 9/18/2024 and a readmission date on 5/12/2025.Record review of Resident #72's history and physical dated 9/19/2024 revealed Resident #72 was diagnosed with generalized weakness, UTI, dementia with behavioral disturbances/anxiety (a group of symptoms affecting memory, thinking, emotional regulation and social abilities), obstructive reflux uropathy (blockage that prevents normal flow of urine), and chronic kidney disease (progressive, long-term condition where kidneys are damaged).Record review of Resident #72's quarterly MDS dated [DATE] revealed Resident #72 had a BIMS score of 99 which signifies the resident was unable to actively participate and complete in assessment and was coded for having severe cognitive impairment. Under Section GG, Resident #72 was coded for being dependent on staff for toileting hygiene, personal hygiene, and lower body dressing. Under Section H, Resident #72 was coded for having an indwelling catheter. Under Section I, Resident #72 was coded for an active diagnosis of obstructive uropathy.Record review of Resident #72's care plan dated 2/16/2026 revealed Resident #72 required enhanced barrier precautions. Resident #72 had a care plan to address indwelling catheter with an approach to, always use appropriate infection precaution during care and assist/provide catheter care as ordered. Record review of Resident #72's physician orders dated 12/04/2025 revealed the resident was prescribed an indwelling Foley catheter 16 French (6.0 mm) with a 10cc [NAME] for a diagnosis of obstructive and reflux uropathy, unspecified.In an observation on 2/15/2026 at 10:08 AM, Resident #72 was observed in her bed in the fetal position with her Foley bag on the bed rail where it contacted the floor. Resident #72 was unable to participate in an interview and could not be redirected. In a follow-up observation on 2/15/2026 at 2:39 PM, Resident #72 was observed back in her bed with the Foley bag contacted with the floor laying nearly flat. In an observation on 2/15/2026 at 11:37 AM, Resident (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#67's Foley tubing was observed to have a urine and white film pooling in the line and not properly draining into the Foley bag as the tubing was below the height of the Foley bag. In a follow-up observation on 2/15/2026 at 1:01 PM, revealed Resident #67's Foley tubing still had urine and white film pooling and not properly draining into the Foley bag. In an interview on 02/15/2026 at 11:38 AM, Resident #67 stated she had 2 UTIs since she had been at the facility. She was unable to recall when and what treatment she received to address her previous UTIs. She stated she did not feel any pain, discomfort or burning at the moment. She stated her Foley tubing was secured to her thigh with a Velcro strap, and she did not feel any pulling at her urethra. Resident #67 did not appear to be in distress. She stated staff reviewed her Foley bag, tubing, and emptied it approximately 5 times per day. In an observation on 2/15/2026 at 2:17 PM, revealed CNA B entered Resident #67's room and did not adjust the Foley placement to remove urine build up in the Foley tubing. In an interview on 2/17/2026 at 2:43 PM with CNA J, he stated a catheter and Foley bag was used to extract the urine from the bladder or when a resident had skin issues in the area to prevent agitation to the skin. He stated that CNAs were responsible for measuring urine output, preventing overflow/backflow, reviewing leakage, and noting color. He stated he checked a resident's Foley tubing and bag every round which was about every 2 hours. He stated all staff were responsible for picking the Foley bag up off the floor and preventing it from lying flat. He added that correcting the Foley tubing was something CNAs could address as long as it was not an invasive correction. He stated if the Foley was on the floor, it could be stepped on or be an infection control issue. He added that the Foley catheter tube not draining into the Foley bag posed a risk to the resident by potentially contracting a UTI. He added the urine could back fill into the bladder for not draining properly, or the resident/visitor could trip on their tubing or bag if the Foley bag was left on the floor. He stated that CNAs were responsible for notifying the nurse for Foley catheter/bag concerns that exceeded CNAs capability. He stated the ADON and DON were responsible for making sure staff were reviewing and completing standard tasks for residents with catheters. He stated the last in- service he received for Foley catheter/bag care was January 2026. In an interview on 2/17/2026 at 3:05 PM with RN F, he stated the purpose of the subpubic Foley catheter was to remove urine from the bladder. He stated CNAs were responsible for emptying and adjusting the Foley bag and tubing if it was not invasive or had to deal with the orifice. He stated whoever was making the rounds was responsible for reviewing the Foley bag/catheter to ensure it was off the floor and draining properly. He stated it needed to be monitored because it could become clogged, pulled out, and there was a high risk for residents to develop an infection. He stated that a UTI affected residents by potentially causing pain, altered mental status, septic, and fever. He was provided an image of Resident #72's Foley bag on the floor and stated the Foley bag on the floor was the only place for the bag because the bed was in the lowest position. He was provided an image of Resident #62's Foley tubing pooling with urine and stated the urine in the tubing would eventually flow into the Foley bag because it was below the resident's bladder. He stated the ADON and DON were responsible for overseeing nurses and ensuring care standards were being completed. He stated there had been recent in-services but could not recall the last one for Foley tubing or Foley [NAME] an interview on 2/18/2026 at 4:27 PM with the DON, she stated the Foley bag could not be on the floor because it was an infection control issue. She stated urine pooling in the tubing and not draining into the Foley bag was not acceptable because it could cause an obstruction resulting in an infection for the resident. She stated the nurse and CNAs were responsible for ensuring the Foley bag and tubing are in their proper place and functioning correctly. She stated her staff reviewed residents' Foley catheters/bags whenever they made their rounds, measured the resident's intake and output, and when responding to call lights. She stated the clinical team (DON, ADON, clinical consulting nurse) and administration provided annual competency training to nurses and CNAs. She stated she was unaware if there was a return demonstration during annual competency for Foley catheters/bag. She stated that a Foley bag left on the floor or urine pooling in the tubing had potential to cause harm to the resident by infection or obstruction. She (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated there was further potential for the resident to become hospitalized if a resident contracted an infection. She identified clinical team was responsible for ensuring the nurses were competent to complete their task. Record review of facility's Nursing Policy and Procedures, dated 05/15/2023, titled Infection Prevention and Control Program and Plan, read in part: Purpose: To establish a facility wide program that incorporates a system for preventing, identifying reporting, investigating, and controlling infections and communicate diseases. Under Procedures, read in part: 4A. Written standards and practice guidelines that comply with federal, state, local and The Joint Commision if the facility is accredited, infection prevention and control requirements .5. The infection prevention and control program consists of currently acceptable infection controsl standards, practices, and activities. Examples of these are 5B. Periodic environmental surveillance 6E-9 staff is provided with information and training on care of invasive devices, such as vascular access, urinary catheter

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility was labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 residents (Resident #4) reviewed for pharmacy services enteral feedings .The facility failed to label Resident #4's enteral feeding (also known as tube feeding, is a method of delivering nutrition directly into the stomach when a person cannot eat safely or adequately by mouth) with staff initials and the date on 02/15/26.This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects.The findings include:Record review of Resident #4's face sheet dated 02/16/2026 revealed a [AGE] year-old female with initial admission date 04/23/2018 and readmission date 01/11/2026.Record review of Resident #4's history and physical dated 02/17/2026 revealed a medical history of CVA, dysphagia (difficulty swallowing) and Type II Diabetes Mellitus. It noted that Resident #4 was on an NPO (Nothing By Mouth) diet related to her dysphagia and was receiving nutrition through a Gastric tube (also known as tube feeding, is a method of delivering nutrition directly into the stomach when a person cannot eat safely or adequately by mouth).Record review of Resident #4's Discharge MDS dated [DATE] revealed the resident was unable to complete the BIMS interview. Section K-Swallowing/Nutritional status noted Resident #14 received nutrition via feeding tube.Record review of Resident #4's care plan with revision date 02/10/2026, revealed resident was at Nutrition Risk related to her dysphagia. Staff interventions included for staff to Administer feeding via gastric tube as ordered: Jevity 1.2 at 70 ml/hour for 22 hours.Record review of Resident #4's General Order dated 01/14/2026 noted: Enteral feeding-Formula Jevity 1.2 rate 70 ml/hour via feeding pump per Gastric-tube.In an observation on 02/15/2026 at 9:30 AM of Resident #4 resting in her bed with an enteral feeding infusing via feeding pump at bedside. The feeding bad had no date or name labeled observed noted.In an interview on 02/17/2026 at 1:37 PM with RN I, she stated nurses were responsible for administering enteral feedings for residents. She stated nurses were trained to label each feeding, including initials of the nurse and the date. She stated enteral feedings without a label should be disposed of. RN I stated the possible risks of having enteral feedings without a label included residents being bloated, or diarrhea risks. She stated the enteral feedings were milk-based and it was at risk for being spoiled which could cause residents to become sick. She stated the night shift nurses were responsible for hanging a new enteral feeding during their shift, and morning nurses were to confirm the feeding was labeled during the day shift.In an interview on 02/18/2026 at 4:46 PM with the ADON, she stated nurses were responsible for administering enteral feedings. She stated that enteral feedings were only good to administer for 24 hours. She stated the possible risk to residents with unlabeled enteral feedings included delay of care. She stated that the nurse who administered the enteral feeding was responsible, and it was typically the night shift. She stated that the DON and other department supervisors conducted Angel Rounds, which included identifying any concerns.In an interview on 02/18/2026 at 4:05PM with the DON, she stated nurses were responsible for labeling enteral feedings when they were to administer and start the feeding. She stated nurses were expected to label it, including date, so staff could be aware of expiration and when a new feeding was needed. She stated that the nurse starting the feeding was responsible for labeling it. She stated that the ADONs and herself as the DON, were responsible for monitoring potential concerns. She stated Angel rounds were done daily, which were the supervisors rounding on residents. She stated not labeling the enteral feedings could possibly cause residents to become sick as it was an infection control issue.Record review of facility's Nursing Policy and Procedures with revision date 05/05/2023, titled Gastronomy (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tubes, revealed in part: Gastronomy tubes may be used for residents who require enteral feedings to maintain nutrition the patient/resident will maintain acceptable parameters of nutritional status to include usual body weight or desirable body weight . The policy did not specify labeling or dating the enteral feeding.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 of 4 residents (Resident #26) whose medical records were reviewed in that:The facility failed to accurately document on Resident #26's wound care on her Treatment Administration Record (TAR).This deficient practice affected one former resident and could place 14 residents with pressure sores at risk of inaccurate records.Record review of Resident #26's face sheet dated 02/16/2026 revealed an [AGE] year-old female with admission date 01/22/2026.Record review of Resident #26's history and physical dated 02/12/2026 revealed a medical history of the following: Chronic Kidney Disease (a condition meaning damage to the kidneys causing it to not filter the waste in the blood), Type II Diabetes Mellitus (metabolic condition that causes the body to become resistant to insulin or the pancreas fails to produce enough insulin), and had wounds on both legs.Record review of Resident #26's Discharge MDS dated [DATE] revealed a BIMS score of 15, indicating resident cognitively intact.Record review of Resident #26's care plan with revision date 02/04/2026 revealed Resident #26 had a wound/disruption of skin surface, left lower leg venous ulcer. Interventions for staff included to provide wound care as ordered, and to use aseptic techniques.Record review of Resident #26's Wound Care Order dated with start date 01/24/2026 and discharge date [DATE], revealed: Daily wound treatment: Left lower Lateral Distal Leg: Clean with Normal Saline or wound cleanser, apply thin layer of Mupirocin ointment (an antibiotic ointment) followed by a small piece of Hydrofera Blue (an antibacterial foam wound dressing that promotes healing by removing bacteria) MUST be moistened with Normal Saline (solution in water, commonly used in medicine for hydration, intravenous therapy, and wound care), cover with a 4x4 gauze, ABD pad (a specialized medical dressing designed for managing moderate to heavily exuding wounds), and roll gauze. Cover foot and leg with Tubigrip (a multi-purpose elasticated tubular bandage that provides uniform compression and support for wound dressings) from just below toes to just below the knee.Record review of Resident #26's Wound Care Order dated 02/17/2026 noted with start date 02/04/2026, revealed: Daily wound treatment: Left lower Lateral (a position away from the midline of the body) Distal (a position further from the point of attachment or the center of the body) Leg: Clean with Normal Saline or wound cleanser, nickel thick layer of Santyl (an ointment used to treat chronic skin ulcers) followed by calcium alginate, apply ABD pad, and wrap roll gauze. Cover foot and leg with Tubigrip from just below toes to just below the knee.Record review of Resident #26's Wound Care Administration history record dated 02/17/2026 from 01/01/2026-01/31/2026 revealed wound care was marked as completed on Saturday 01/31/2026 between 6 AM to 10 PM.Record Review of Resident #26's Wound Management Detail Report dated 02/18/2026 revealed resident was seen on 02/03/2026 by the Wound Care Physician. The report reflected a venous ulcer on the left shin lateral distal measured at 2 centimeters long, 1 centimeter wide, and 0.3 centimeters in depth. It was noted that the discharge was pale, red to pink, thin, and watery. It was noted that the wound healing was stable. On 02/10/2026, the wound was noted as 1.8 centimeters long, 1 centimeter wide, and 0.3 centimeters in depth. The wound discharge was pale, red to pink, thin, and watery. The wound healing was noted as stable.In a phone interview on 02/17/2026 at 11:33 AM, Resident #24's family member stated she was with Resident #24 on Sunday 02/01/2026. She stated she observed Resident #24's left foot red as a tomato, with brown discharge, and mentioned the socks Resident #24 was wearing were also brown. Resident #24's family member stated Resident #24 had an ulcer wound on her leg but was dressed in a wrapping around her leg to the resident's foot under the ankle. She stated the ulcer wound's discharge was dripping down to Resident #24's foot, causing it to be inflamed and red. She stated she reported this observation to RN O. She stated RN O provided wound care at that time and she requested a change in ointment and for Resident #24 to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have soak baths for both of her feet. She stated Resident #24 had the wound for a long time, and she was familiar with how to care for the resident's wound. She stated she went to visit Resident #24 on Monday 02/02/2026, and Resident #24 reported to her that wound care was not completed on Saturday 01/31/2026. She stated she immediately notified the Wound Care Nurse and the DON. She stated the DON had reported reviewing the wound care notes for Resident #24 and it was noted wound care was given that day. She stated she advised the DON to speak with Resident #24 about the allegation. She stated that Resident #24 was alert and oriented and reported not receiving any wound care on 01/31/2026. She stated the DON notified her of speaking with RN O, and RN O admitted to the DON that she did not provide wound care on 01/31/2026. She stated she wanted to make sure RN O did not do that with other residents.In a phone interview on 02/17/2026 at 3:14 PM, RN O stated she recalled Resident #24's allegation of not providing wound care on Saturday 01/31/2026. She stated she was to provide wound care that day as Resident #24 had daily wound care ordered, but she stated she did not have normal saline that she needed for wound care that Saturday night. She stated it was approximately 9 PM when she was to provide Resident #26 with wound care. She stated she was trained to call the DON to notify for the need for supplies, but she did not. In a follow up phone interview on 02/18/2026 at 12:42 PM, RN O stated she did not notify any staff of not having supplies needed for wound care that night. RN O stated she did not provide wound care because she was tired as it was the end of her shift and she stated she thought she would be able to complete wound care the following morning as she worked double weekends.In an interview and observation on 02/18/2026 at 6:05 AM with the Wound Care Nurse, she stated she was the Wound Care Nurse during the weekdays, Monday to Friday, and the floor nurses provided wound care on the weekends. She stated that the supplies were in the treatment cart and in the supply room. An observation of the treatment cart with the Wound care Nurse revealed multiple bottles of normal saline. She stated nurses were trained to notify the ADON and DON if there was a need for supplies if there was not any available on site. She stated the potential risks of not providing wound care as ordered included infection to residents. She stated Resident #24's family member reported to her on Monday 02/02/2026, the allegation of Resident #24 not receiving wound care on Saturday 01/31/2026. She stated that the family member notified the DON right away, while she spoke to Resident #24. She stated there was redness to Resident #24's left foot. She stated there was pale, pink to clear, thin and watery discharge, and had no odor. She stated the family member had requested a change in ointment and soak baths that Sunday 02/01/2026, and the plan of care was to continue that wound care per family request. She stated wound care was done daily until Resident #24's discharge, and there were no signs of infection or complications. In an interview on 02/18/2026 at 10:59 AM with RN F, he stated he worked weekends mostly and performed wound care during those shifts. He stated that if wound care supplies were not available in the wound care cart or supply closet, staff are to contact the physician for new wound care orders. He reported that the keys to the treatment cart were to be located on the side of the cart.In a phone interview on 02/18/2026 at 11:03 AM with Resident #24's Physician, he stated he was notified of an RN not providing Resident #24 with wound care that following Monday 02/02/2026 by facility staff. He stated he was not reported of any signs or symptoms of infection, and the plan of care was to continue with daily wound care. He stated Resident #24 was monitored and was not reported with infections or negative outcomes during their stay at the facility and when discharged . He stated the facility followed up, and it was identified as a sole incident.In a phone interview on 02/18/2026 at 1:40 PM with RN Q, she stated she worked weekends and provided wound care to residents as needed. She stated there were wound care supplies in the treatment cart and the supply room. She stated if there were no supplies, she would notify the DON and Central Supply right away, as they provide supplies as needed. She stated the facility was also able to pull supplies from sister facilities as needed. She stated that not providing wound care per physician's orders could put the resident at risk of infection.In an interview on 02/18/2026 at 3:36 PM with the DON, she stated she spoke with Resident #24's family member on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monday 02/02/2026, and the family member had reported Resident #24's allegation of wound care not being provided on Saturday 01/31/2026. She stated she reviewed the treatment record which noted wound care was provided on 01/31/2026 at 9 PM. The DON stated she spoke with Resident #24 who reported the same allegation, and Resident #24 was alert and oriented. She stated she called RN O and she confirmed she did not provide wound care to Resident #24 on 01/31/2026, even though she marked it on the treatment record. The DON stated that RN O reported she did not provide wound care that day because there were not enough supplies, and RN O reported to the DON, that she thought she could do it twice the following day. She stated that the treatment cart and supply room were reviewed on 02/02/2026 and there were enough supplies on-site. She stated nurses were trained to notify the ADON or the DON if there was a need for supplies to complete their tasks, as the facility can get supplies from sister facilities if needed. She stated an investigation was done by the facility and RN O was terminated. She stated the Physician and Wound Care Physician were notified. She stated that the Wound Care Physician assessed Resident #24 on 02/03/2026 and there were no signs of infection. She stated Resident #24 was monitored and provided wound care until discharge from the facility, and the wound was stable with no complications. The DON stated Resident #24 had that wound for a prolonged period. She stated potential risk to residents that did not have accurate documentation depended on the type of charting, such as this case with wound care would be risk of infection. She stated the nurse doing the documentation was responsible, and she reviewed reports weekly.Record review of the facility's Nursing Policy and Procedures titled Documentation, with no date, read revealed in part: The facility will maintain complete and accurate documentation for each resident on all appropriate clinical records.