STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676431	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at El Paso	7441 Paseo Del Norte El Paso, TX 79911

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 4 of 7 residents (Resident #56, #65, #96, and #109) reviewed for accommodation of needs. The facility failed to ensure resident call light was within reach for Resident #56, #65, #96, and #109 on 05/04/2026. This failure could place residents at risk of having their needs unmet when they were unable to contact staff.1. Record review of Resident #56's face-sheet, dated 05/06/2026, revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Record review of Resident #56's Quarterly MDS assessment, dated 02/20/2026, revealed a BIMS score of 0, meaning severe cognitive impairment. Under Section GG- Functional Abilities, the resident was dependent on staff for assistance for eating, hygiene, showering, dressing, transfers, and repositioning. Under Section H- Bladder and Bowel, the resident was coded for having an indwelling catheter. Under Section K- Swallowing/Nutritional Status, the resident was coded for having a feeding tube in place. Record review of Resident #56's care plan, dated 02/21/2026, revealed the resident was at risk for falls and to prevent another fall the care plan instructed having the call light within reach for the resident. Another focus area was to monitor the resident due to seizure disorder with an intervention of keep call light within reach. Record review of Resident #56's physical and history, dated 05/04/2026, revealed diagnoses of history of falling, Anxiety (excessive, persistent fear or worry that interferes with daily life), dysphagia (difficulty swallowing), and muscle weakness (a perceived or actual lack of physical strength throughout the body). During an observation and interview on 05/04/2026 at 10:12 a.m., Resident #56's call light was draped across her bedside table that was located behind her due to her facing the right side of the bed. Resident #56 was unable to participate in an interview due to her inability to produce speech and limited comprehension to what was being asked. 2. Record review of Resident #65's face-sheet, dated 05/06/2026, revealed an [AGE] year-old male with an original admission date of 03/08/2024 and a readmission dated of 01/02/2026. Record review of Resident #65's Quarterly MDS assessment, dated 04/27/2026, revealed a BIMS score of 13, meaning cognitively intact. Under Section GG- Functional Abilities, the resident required substantial/maximal assistance for personal hygiene, transfers, toileting, and changing clothes. Record review of Resident #65's care plan, dated 02/23/2026, revealed the resident had an ADL (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-care performance deficit and intervention of required staff assistance for personal hygiene needs, transfers, incontinent changing, and repositioning. Record review of Resident #65's physical and history, dated 05/04/2026, revealed diagnoses of unspecified dementia (exhibits clear signs of cognitive decline—such as memory loss, confusion, and reduced reasoning) and muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased muscle mass and strength). During an observation and interview on 05/04/2026 at 10:52 a.m., Resident #65's call light was on the nightstand not within reach while he was seated in his bed at a 60-degree angle. He stated he did not know where his call light was and added if it was not on the bed, he would not be able to reach it. He stated that to get the staff's attention without his call light he would yell or scream for help. 3. Record review of Resident #96's face-sheet, dated 05/05/2026, revealed an [AGE] year-old female with an original admission date of 09/22/2018 and a readmission dated of 12/22/2022. Record review of Resident #96's Quarterly MDS assessment, dated 03/05/2026, revealed a BIMS score of 3, meaning the resident had severe cognitive impairment. Under Section GG- Functional Abilities, the resident was partial to moderate assistance on assistance for eating, hygiene, showering dressing, transfers, and reportioning. Record review of Resident #96's care plan, dated 03/15/2026, revealed the resident was at risk for falls and to prevent another fall the care plan instructed having the call light within reach for the resident. Record review of Resident #96's physical and history, dated 05/06/2026, revealed diagnosis of Alzheimer's (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform daily tasks), difficulty in walking, generalized anxiety (excessive, persistent fear or worry that interferes with daily life), and muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased muscle mass and strength). During an observation and interview on 05/04/2026 at 9:41 a.m., Resident #96's call light was observed clipped to the nightstand while the resident was seated in an upright position at a 70-degree angle. She stated she knew where her call light was and proceeded to extend the upper half of her body off the bed to reach the call light. She denied experiencing a history of falls while attempting to reach her call light. During an observation on 05/04/2026 at 2:09 p.m., Resident #96's call light was still clipped to the nightstand out of reasonable and safe reach for Resident #96. 4. Record review of Resident #109's face sheet, dated 05/04/2026, revealed an [AGE] year-old male with an original admission date of 04/07/2018 with a readmission date of 07/25/2023. Record review of Resident #109's Annual History and Physical, dated 04/20/2026, revealed diagnoses which included diabetes mellitus (high blood sugar), hypertension (high blood pressure), hyperlipidemia (high cholesterol), benign prostatic hyperplasia/BPH (enlarged prostate), gastroesophageal reflux disease/GERD (acid reflux), myasthenia gravis (a condition causing muscle (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weakness and fatigue), pulmonary hypertension (high blood pressure in the lungs), anemia (low red blood cell count), obstructive and reflux uropathy (blockage and backward flow of urine in the urinary tract), encephalopathy (brain dysfunction/confusion), generalized muscle weakness, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (weakness/paralysis on one side of the body after a stroke), unsteadiness on feet (difficulty maintaining balance), repeated falls, gait abnormalities (difficulty walking), cognitive impairment (memory/thinking problems), blindness to the left eye, and urinary retention (difficulty emptying the bladder). The H&P revealed the resident was wheelchair bound. Record review of Resident #109's quarterly MDS assessment, dated 02/17/2026, revealed Resident #109 had a BIMS score of 09 indicating the resident had moderately impaired cognition. Record review of Section GG, Functional Abilities and Goals, revealed Resident #109 required staff assistance with multiple ADLs consisting on bed mobility, transfers, toileting hygiene, personal hygiene, dressing, and eating setup assistance. The assessment revealed the resident was wheelchair dependent, had unsteady gait/balance issues, generalized muscle weakness, impaired mobility, and required staff assistance for safe movement and repositioning. Record review of the MDS revealed the resident had impaired vision, cognitive impairment, history of repeated falls, and muscle weakness which increased the resident's dependence on staff assistance and need for accessibility to personal items and the call light for safety and communication with staff. Record review of Resident #109's care plan, dated 04/10/2026, revealed the resident required one-person assistance to complete ADLs, except for meals with setup assistance. Interventions included staff assistance with dressing, personal hygiene, oral care, toileting, bed mobility, repositioning, transfers, and eating assistance to maximize the resident's independence. The care plan revealed the resident required assistance by two staff members with transfers and required ongoing assistance with incontinence care, peri-care, skin monitoring, and maintaining personal hygiene. Record review revealed the resident had a care plan for potential injury related to incontinence and gait/balance impairment. Interventions included instructing the resident to call for help before getting out of bed or chair, demonstrating the use of the call light, keeping the call light within reach and visible to the resident at all times, and ensuring the resident was informed of the call light's location and use. Additional interventions included keeping personal items within reach, maintaining the bed in the lowest position with brakes locked, providing a clutter-free environment, toileting assistance during rounds and as needed, and providing proper footwear to reduce the risk of falls and injuries. During an observation on 05/04/2026 at 10:05 a.m., Resident #109 was lying in bed. The call light was positioned behind the bed, hanging from the nightstand, and was not within reach. Resident #109 stated he was unable to reach the call light and reported that if he needed assistance, he would have to shout to call staff. During an observation and interview on 05/05/2026 at 11:15 a.m. in hallway 100, the Activities Director was observed going room to room. During the interview, the Activities Director stated residents could fall while attempting to reach a call light that was not within reach and stated that if Resident #109 had an emergency, he would not be able to call for help. The Activities Director stated call lights were required to remain within reach at all times and that it was the responsibility of all staff, including CNAs, LVNs, and RNs, to ensure compliance. During an interview on 05/05/2026 at 11:20 a.m. with CNA A, she stated call lights needed to remain within reach so residents could request assistance. She stated if the call light was not accessible, (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident would be unable to request help when needed. CNA A stated it was primarily the responsibility of CNAs, although all staff shared responsibility, to ensure call lights were within residents' reach. During an interview on 05/05/2026 at 2:50 PM, LVN F stated the call light was used by residents to call for assistance and inform staff if residents had an urgent matter. She stated that the call light needed to be within reach of the resident's hands. She stated a call light on the nightstand or draped across a bed side table would not be considered within reach. She stated that staff rounded on residents every 2 hours and should be reviewing the placement of the call light. She stated if a resident did not have their call light within reach, they could not have their needs met. She stated all employees who entered a residents room were responsible for ensuring the call light was in reach. She stated the last in service she received for call light placement was the last week of April 2026. She stated the ADON and DON were responsible for ensuring nursing staff were rounding on residents and reveiwing call light pacement. During an interview on 05/05/2026 at 11:41 a.m., the DON stated it was not acceptable for Resident #109's call light to be positioned behind the bed. She stated the resident could attempt to retrieve it and sustain a fall or remain unattended if assistance was needed. The DON stated that all residents needed to always have their call lights within reach while in their bedrooms. During an interview on 05/05/2026 at 11:58 a.m., CNA B stated call lights should be positioned within reach, either at the resident's side or secured to their clothing or lap. She stated leaving it behind the bed created a risk for falls and inability to request assistance. During an interview on 05/05/2026 at 3:99 p.m., RN C stated the location of the call light being behind Resident #109's bed was not appropriate because the resident would not be able to reach it to call for help if he needed assistance and stated Resident #109 could have a fall if he couldn't reach the call light. RN C stated there was also a risk of the resident went unattended for a prolonged period of time if he couldn't reach his call light. During an interview on 05/06/2026 at 1:50 p.m., LVN D stated call lights needed to be within the resident's reach, so they were able to call for assistance if needed. LVN D stated the call light placement for Resident # 109 was inappropriate because he would not be able to reach for it and if he attempted to get up from bed, he could sustain a fall and potentially injure himself. LVN D stated that there was also a potential risk of him not being attended in time because he would not be able to ask for help. During an interview on 05/06/2026 at 3:03 PM, the administrator stated the call light was used for residents to call for assistance. He stated it needed to be placed within resident arm's length to be considered within reach. He stated a call light out of reach affected residents because they could fall trying to get it or not receive assistance. He stated everyone who went into a resident's room was responsible for ensuring the call light was within reach. He stated that staff should be reviewing the call light's placement every time they provided care, entered residents' room, and every two hours when performing rounds on residents. Record review of the facility's policy and procedures, revised on 01/22/2025, titled, Call System, Residents, read in part: Residents are provided with a means to call staff for assistance through a communication system (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that directly calls a staff member or a centralized work station. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Call system communication may be audible or visual. The system may be wired or wireless. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan. The resident call system is routinely maintained and tested by the maintenance department. Calls for assistance are answered timely.

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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, interviews, and record review, the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 6 of 24 residents (Resident #13, Resident #15, Resident #54, Resident #65, Resident #128, Resident #129) reviewed for ADL care. The facility failed to ensure Resident #13's, Resident #15's, Resident #65's, nails were trimmed, cleaned, and filed on 05/04/2026.The facility failed to ensure Resident #54's, Resident #128's, and Resident #129's nails were trimmed and filed on 05/04/2026.The facility failed to ensure Resident #111's toenails were trimmed and filed on 05/04/2026. This failure could place residents at risk of loss of dignity, risk for infections, and a decreased quality of life.1.Record review of Resident #13's face-sheet, dated 05/06/2026, revealed an [AGE] year-old female, admitted [DATE] and readmitted [DATE]. Record review of Resident #13's Quarterly MDS assessment, dated 04/30/2026, revealed a BIMS score of 03, meaning severe cognitive impairment. Under Section GG- Functional Abilities, the resident required partial/moderate assistance for personal hygiene. Record review of Resident #13's care plan, dated 03/18/2026, revealed the resident required assistance with ADLs and was at risk for deterioration and intervention to set-up/assist with nail care per schedule or as needed. Record review of Resident #13's dated 04/29/2026 revealed diagnosis of unspecified dementia (exhibits clear signs of cognitive decline—such as memory loss, confusion, and reduced reasoning), muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased muscle mass and strength), other lack of coordination, and cognitive communication deficit (difficulty with verbal or nonverbal communication caused by underlying cognitive impairments). During observation and interview on 05/04/2026 at 1:57 p.m., Resident #13 stated her nails were currently long but this was not her preference because she like them shorter; her fingernails appeared to be less than half an inch in length, jagged, and black residue underneath them. She stated she had received a shower today but was not offered nail trimming services by staff during or after her shower. She denied experiencing pain or anguish from having long fingernails. She did not know if she had any injuries or infections related to long fingernails; no scratches or swelling were noted on her forearms, ankles, or face. 2. Record review of Resident #15's face-sheet, dated 05/06/2026, revealed an [AGE] year-old male, admitted [DATE]. Record review of Resident #15's Comprehensive MDS assessment, dated 03/24/2026, revealed a BIMS score of 03, meaning severe cognitive impairment. Under Section GG- Functional Abilities, the resident required setup or clean-up assistance for personal hygiene. Record review of Resident #15's care plan, dated 03/25/2026, revealed an ADL self-care performance deficit related to Alzheimer's with an intervention of assistance from staff with personal hygiene needs. Record review of Resident #15's physical and history, dated 04/15/2026, revealed diagnosis of Alzheimer's (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eventually the ability to perform daily tasks) and type 2 diabetes (chronic condition where the body resists insulin or fails to produce enough). During an observation and interview on 05/04/2026 at 1:21 PM, Resident #15 stated he had been at the facility for about two months and never received fingernail trimming. Resident #15's nails were observed to be extending beyond the finger and unkept with dark residue underneath. He stated he received assistance with bathing and was on a routine of three showers a week. He stated he received a shower on 05/01/2026 but was not offered the service by staff to cut his fingernails. He denied experiencing pain or anguish from having long fingernails. He stated he did not have skin injuries or infections in relation to his fingernails being long and dirty. 4. Record review of Resident #65's face-sheet, dated 05/06/2026, revealed an [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Record review of Resident #65's Quarterly MDS assessment, dated 04/27/2026, revealed a BIMS score of 13, meaning cognitively intact. Under Section GG- Functional Abilities, the resident required substantial/maximal assistance for personal hygiene. Record review of Resident #65's care plan, dated 02/23/2026, revealed an ADL self-care performance deficit and intervention of required staff assistance for personal hygiene needs. Record review of Resident #65's physical and history, dated 05/04/2026 revealed diagnoses of unspecified dementia (exhibits clear signs of cognitive decline—such as memory loss, confusion, and reduced reasoning) and muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased muscle mass and strength). During an observation and interview on 05/04/2026 at 10:52 a.m., Resident #65 had long dirty fingernails that he was dissatisfied with. He stated he would like the staff to cut them once they get long, but he usually had to request these services from the nurse because he was diabetic. He denied experiencing pain or anguish from having long fingernails. He denied having skin injuries or infections in relation to his fingernails being long and dirty. 3. Record review of Resident #54's face-sheet, dated 05/05/2026, revealed a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Record review of Resident #54's Health and Physical, dated 10/03/2025, revealed the following medical history: Guillian Barre Syndrome (a rare autoimmune disorder where the immune system attacks the peripheral nerves, leading to muscle weakness and paralysis), Paraplegia (the inability to voluntarily move or control the lower half of the body), Contracture of left hand (scarring of soft tissue causing the muscles to tighten or stiffen affecting the range of motion), and Dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). Record review of Resident #54's Comprehensive MDS assessment, dated 02/21/2026, revealed a BIMS score of 15, meaning cognitively intact. Under Section GG- Functional Abilities, Resident #54 required maximal/substantial assistance with personal hygiene, meaning the helper does more than half of the effort to complete the task. Record review of Resident #54's Care Plan, dated 08/08/2024, revealed an ADL self-care (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performance deficit and interventions included for staff to check nail length and trim and clean on bath day, and as necessary. 4. Record review of Resident #111's face sheet, dated 05/06/2027, revealed a [AGE] year-old male, admitted [DATE]. Record review of Resident #111's History and Physical, dated 08/25/2024, revealed diagnoses including hypertension (high blood pressure), hearing loss, repeated falls, acute pain (pain that starts suddenly and is usually linked to a specific injury), impaired gait and mobility (difficulty walking and moving safely), generalized weakness, sarcopenia (loss of muscle mass related to aging), and disuse myopathy (muscle weakness from lack of activity). The history and physical revealed the resident was transferred from the hospital following a ground level fall at home and required rehabilitation services including physical therapy and occupational therapy. Record review of Resident #111's quarterly MDS assessment, dated 02/20/2026, revealed a BIMS score of 8 which indicated moderately impaired cognition. The MDS revealed the resident had impaired thought processes and required cueing, supervision, and staff assistance with daily care needs. Record review of Section GG, Functional Abilities and Goals, revealed the resident required extensive staff assistance with ADLs. The assessment revealed Resident #111 had impaired mobility, generalized muscle weakness, repeated falls, difficulty walking, reduced mobility, and muscle wasting. The resident required staff assistance with transfers, toileting, dressing, hygiene, mobility, and other personal care tasks. Record review of Resident #111's care plan, dated 12/19/2025, revealed the resident had episodes of bowel and bladder incontinence with interventions that included staff checking the resident every two hours and as needed for incontinence care, washing and drying the resident after episodes, changing clothing as needed, maintaining unobstructed access to the bathroom, and assisting the resident with personal hygiene and ADLs. The care plan revealed Resident #111 preferred to wear open toe shoes without grip socks and revealed the resident would remain free of falls and injury from wearing open toe shoes. The care plan called for staff intervention in allowing the resident to make choices by wearing the footwear of his choosing and to provide weekly skin assessments to address any concerns caused by wearing open toe shoes. During an observation and interview on 05/04/2026 at 10:05 a.m., Resident #111 was sitting on his bed wearing sandals with his toenails exposed. The toenails were long with yellowish discoloration. Resident #111 stated he did not like his toenails long and did not have nail clippers. He stated staff helped in the past but did not recall the last time his toenails were trimmed. Resident #111 stated he had requested assistance to trim his toenails from CNAs but he had not been helped. During an observation on 05/04/2026 at 09:35 AM, Resident #54 was observed with nails a quarter inch from the nail bed and clean. Resident #54 stated it had been a while, since his nails were last groomed and he would like them to be trimmed. 5. Record review of Resident #128's admission record, dated 05/05/2026, revealed a [AGE] year old male, admitted [DATE]. Record review of Resident #128's History and Physical, dated 05/01/2026, revealed diagnoses of acute respiratory failure (a sudden inability of the lungs to oxygenate blood or remove carbon dioxide causing severe shortness of breath) and tracheostomy status(surgically created opening in their neck (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leading to the trachea to facilitate breathing). Record review of Resident #128's comprehensive MDS assessment, dated 04/21/2026, revealed a BIMS of 02 indicating severe cognitive impairment. Section GG- Functional Abilities coded Resident #128 as dependent meaning helper does all of the effort and the resident does none of the effort to complete the activity for personal hygiene. Record review of Resident #128's care plan, revised on 05/04/2026, revealed Resident #128 had an ADL self-care performance deficit. Interventions included assistance from staff with personal hygiene and oral care and to check nail length and trim and clean on bath day, and as necessary. Report any changes to the nurse. During an observation on 05/04/2026 at 9:30 a.m., Resident #128's fingernails were about a quarter inch from the nail bed and were clean. Resident #128 was not able to answer the surveyor's questions. 6. Record review of Resident #129's admission record, dated 05/06/2026, revealed a [AGE] year-old male admitted [DATE]. Record review of Resident #129's History and Physical, dated 04/30/2026, revealed a diagnosis of nontraumatic intracerebral hemorrhage in hemisphere (a sudden spontaneous bleeding into the brain tissue). Record review of Resident #129's Quarterly MDS assessment, dated 04/22/2026, revealed a BIMS of 03 indicating severe cognitive impairment. Section GG- Functional Abilities coded Resident #128 as dependent meaning the helper does all of the effort and the resident does none of the effort to complete the activity for personal hygiene. Record review of Resident #129's care plan, dated 05/04/2026, revealed Resident #128 had an ADL self-care performance deficit. Interventions included assistance from staff with personal hygiene and oral care and to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. During an observation on 05/04/2026 at 9:15 a.m., Resident #129's fingernails were about a quarter inch from nail bed and clean. Resident #129 was not able to answer the surveyor's questions. During an interview on 05/05/2026 at 11:23 a.m., CNA A stated CNAs could trim or file toenails if the resident was not diabetic. CNA A stated if she observed long toenails, she would offer assistance to the resident. CNA A stated untrimmed toenails could result in injury, bleeding, discomfort, and infection. CNA A stated Resident #111's toenails were long and unclean and it was not acceptable to leave the resident without trimming his toenails. During an interview on 05/05/2026 at 11:43 AM, the DON stated CNAs could trim toenails for non-diabetic residents. She stated if staff were unable to provide care, they were expected to notify the charge nurse or DON so arrangements could be made. The DON stated it was not acceptable for the resident's toenails to remain in that condition and identified risks such as ingrown toenails, pain, and discomfort which could lead to bleeding and infection. (continued on next page)

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Avir at El Paso	7441 Paseo Del Norte El Paso, TX 79911

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/05/2026 at 12:01 PM, CNA B stated it was the responsibility of CNAs to monitor residents and ensure hygiene needs were met. CNA B stated untrimmed toenails could lead to injury when putting on socks or shoes, including tearing, bleeding, and infection. During an interview on 05/06/2026 at 2:30 p.m., the DON stated the facility did not have a specific policy addressing toenail care. During an interview on 05/06/2026 at 2:30 p.m., the Administrator stated it was the responsibility of all CNAs, LVNs and RNs who worked with the resident to monitor hygiene to include toenail care. The Administrator stated it was not acceptable for Resident #111 to have long toenails because he preferred to wear sandals or open toe shoes and he could potentially hit his foot on a surface and break a toenail, injuring himself, causing bleeding and infection. During an interview on 05/05/2026 at 3:30 p.m., RN C stated there was a possibility for Resident #111 breaking his toenails if he bumped his toes against a bed or a door due to him preferring to wear open toe shoes. RN C stated there was a potential for injury and ingrown toenails, which could lead to bleeding and infection, and stated it was not acceptable for the resident to have long and yellowish toenails and stated Resident #111 needed attention to include trimming his toenails. During an interview on 05/05/2026 at 3:33 PM, CNA O stated all nursing staff were responsible for monitoring residents' nails. She stated residents' fingernails were looked at daily during initial rounds. She stated CNAs trim and clean residents' nails, and nurses monitor them daily. She stated the potential risk of residents having long nails included resident scratching self and possibly cutting self. She stated the cutting of the skin could be a risk for infection if the residents have dirty nails. During an interview on 05/05/2026 at 3:48 PM, CNA G stated that a resident who was dependent on staff received personal care, changing, transfer, and repositioning on a regular basis or as needed. She stated t the Activities department, CNAs, and nurses provided fingernail trimming for nondiabetic residents. She stated usually she provided nail care when she noticed they were long. She stated she reviewed nails whenever she provided showers which was three times a week. She stated it affected residents because they would not receive the services they wanted or needed. She stated residents could scratch themselves, create skin integrity issues, and potentially get infected if their nails were dirty. She stated CNAs and nurses were responsible for ensuring the resident's nails were being trimmed and cleaned to their preference. She stated the ADON and DON were responsible for ensuring staff were providing ADLs to residents. She stated the last in service she received for ADLs was the last week of April 2026. During an interview on 05/06/2026 at 2:03 p.m., the DON stated fingernails should be checked with every shower and trimmed those days or when needed. She stated that the CNAs and the nurse were responsible for ensuring the residents' nails were trimmed. She stated CNAs could cut the fingernails of nondiabetic residents. She stated the residents with long fingernails were at risk of breaking the skin and introducing bacteria into the skin, leading to infection. During an interview on 05/06/2026 at 2:39 PM, the Administrator stated nursing staff were responsible for residents' nails. He stated CNAs were responsible for routine nail care, including cleanliness and trimming. He stated the DON was responsible for monitoring and ensuring residents' nails were groomed appropriately. He stated the potential risks for residents having long nails included residents scratching self and causing injury. The Administrator stated there was also a potential risk for infection if the residents' fingernails were dirty. (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 the facility's Resident Rights policy, dated 02/2021, read in part: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: 1. a dignified existence.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure biologicals were stored in locked compartments and accessed by authorized personnel for 3 (Resident #3, Resident #74, and Resident #89) of 24 residents reviewed for medication storage.The facility failed to dispose of a dixie cup on 05/04/2026 by leaving a dixie cup with Zinc Oxide pomade (skin ointment) at Resident #3's, Resident #74's, and Resident #89's bedside, exposed and within reach of other residents.The facility failed to ensure a medication cart was locked when unattended.This failure could place residents at risk of access to medications not approved for administration by their physician. Findings included: 3. Record review of Resident #89's face sheet dated 05/04/2026 revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE] and 02/22/2026. Record review of Resident #89's Annual History and Physical, dated 07/08/2025, revealed the resident had diagnoses which included Non-Alzheimer's dementia (a decline in memory, thinking, and daily functioning that is caused by something other than Alzheimer's disease decline in memory, thinking, and daily functioning that is caused by something other than Alzheimer's disease), hypertension (high blood pressure), hyperlipidemia (high cholesterol), delirium (acute confusion), hypothyroidism (underactive thyroid), decreased mobility, and dependence on a wheelchair for mobility. The history and physical revealed the resident had a history of altered mental status, catatonic symptoms, confusion, and cognitive impairment. Record review of Resident #89's quarterly MDS assessment, dated 04/09/2026, revealed a BIMS score of 00 out of 15, which indicated severe cognitive impairment. The MDS revealed the resident had severely impaired decision-making abilities, memory deficits, impaired communication, and required extensive staff supervision and assistance. Record review of Section B, Hearing, Speech, and Vision, revealed the resident was usually unable to make needs known, had impaired hearing, and had severely impaired vision. Record review of Section GG, Functional Abilities and Goals, revealed the resident required substantial or maximal staff assistance with ADLs including mobility, transfers, hygiene, and personal care tasks. Resident #89 was dependent on lower body dressing and toileting. Record review of Resident #89's care plan dated 04/09/2026 revealed the resident had cognitive impairment with impaired decision-making, difficulty expressing needs, memory deficits, and impaired safety awareness. The care plan was initiated on 02/05/2021 and revised on 03/07/2025. Interventions included explaining procedures in simple terms, repeating information as needed, allowing additional time for responses, involving the resident in care to maintain independence, and ensuring the resident's needs and preferences were anticipated and met by staff. The care plan also revealed the resident was at risk for injury related to cognitive impairment, gait and balance impairment, history of falls, and impaired safety awareness. Interventions included keeping frequently used items within reach, maintaining the bed in the lowest position with brakes locked, ensuring staff awareness of the resident's safety needs, and providing supervision and assistance with transfers and mobility. The care plan revealed the resident required medications as ordered, ongoing monitoring by licensed nursing staff, and staff assistance with hydration, nutrition, and activities of daily living. During an observation on 05/04/2026 at 9:55 AM, a small (nurse only) medication cart was left (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlocked and unattended as evidenced by the cylinder lock being fully extended out with its red tab visible and the cabinets were accessible by the surveyor when force was applied. There were eight residents in wheelchairs approximately 15 feet away from the medication cart and RN C was assisting with care in a resident's room. An unidentified resident was observed passing in front of the medication cart and using it as a sturdy surface to propel herself forward; the unidentified resident did not make any effort to investigate or open the medication drawers. RN C returned to his cart at 9:57 AM and reapplied the locking mechanism. During an interview on 05/04/2026 at 9:58 AM, RN C stated it was not okay to leave the medication cart unlocked and unattended because residents or unauthorized employees could access it. He stated only the nurse on duty should have access to the medication cart. He stated he was responsible for ensuring it was locked when he was not using it or when it was out of his immediate reach. He stated he did not know how long he stepped away from the medication cart and approximated it to be a minute. He stated it was not within his line of site and did not have knowledge if anyone accessed his medication cart during the time he could not see it. He stated the ADON and DON were responsible for ensuring that the nurses were adhering to medication storage policy. He stated the last in service he received for medication storage was within the past year. He stated the contents of his medication cart included syringes, injectable medication (example: haloperidol and insulin), over the counter medication (example: vitamins and Tylenol). He stated it affected residents if they obtained a syringe, vial medication and injected themselves or others or if a resident's insulin went missing because someone accessed the cart and took it. He stated the items in his cart had potential for residents to harm themselves or others. During an interview on 05/05/2026 at 2:55 PM, LVN F stated the small (nurse only) medication cart contained a glucose reading instrument, insulin vials, intravenous medications, medications that only a nurse could administer, syringes, haloperidol, Vitamin C, and Tylenol. She stated only the nurse on shift had access to the small medication cart. She stated when she was not in arms reach of the medication cart, it needed to be locked. She stated it was not acceptable for a nurse to leave the cart unlocked because of the potential for a resident, visitor, or staff member to access it. She stated it was a safety issue because a resident could harm themselves, stab themselves, or administer medication not intended for them. She stated the nurse on shift was responsible for ensuring it was locked at all times. She stated it required a key to unlock the cylinder and when the red tab on the cylinder was extended, it signified that it was open. She stated there were residents in the hallway with dementia, habits of wandering, and accessing items that did not belong to them. She stated the last in service for medication storage was last week of April 2026. She stated the ADON and DON were responsible for ensuring nurses were locking the small medication cart when not in use. She stated staff should discard dixie cups with ointment after use and not leave them at bedside because a resident could eat it or access it. She stated whoever used it whether the nurse or CNA was responsible for discarding it after care was provided. She stated it was an infection control issue if it was already used and left at the residents' bedside. During an interview on 05/06/2026 at 2:06 PM, the DON stated the facility's methods of protecting medication was to adhere to medication storage policy by utilizing medication carts, central supply areas, and applying locking mechanisms to prevent access to unauthorized individuals. She stated nurses and CMAs were the only staff members who had access to medication storage room and medication carts. She stated the small medication carts were reserved only for the nurses on shift to have access to it. She stated medication was stored securely to ensure there was no misuse of medication. She stated if the nurse was not in front of the small medication cart it needed to be locked. She stated anytime the small medication cart was out of the nurses reach it needed to be (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	locked. She stated the contents of the small medication cart included: lancers, insulin vials, syringes, gastric tube medications, liquid base medications, ointments, and anything a CMA could not administer to a resident. She stated there were many outcomes for potential for harm to residents and staff if it was left unlocked and unattended but could not further elaborate how it was harmful. She stated the last in service for medication storage practices was two months ago. During an interview on 05/06/2026 at 2:42 PM, the Administrator stated that facility's methods for protecting medication was to adhere to medication storage policy by utilizing locking mechanisms for carts/storage rooms and limiting access to only the nurses and CMAs. He stated that the small medication cart needed to be locked all the times when it was not in the nurse's reach or being used. He stated that the nurses were responsible for locking the small medication carts. He stated if it was not locked medications/narcotics could go missing and injectables/syringes could pose harm to residents and staff. He stated it affected residents because medications could be stolen, misplaced, or ingested without staff's knowledge. He stated the DON was responsible for ensuring nurses were locking the medication carts when they were away from them. During an observation was on 05/04/2026 at 9:52 AM, a medication cup that contained a thick white ointment open to air was on Resident #74's nightstand located next to the head of the bed and within the resident's reach. Resident #74 was observed in bed with her eyes closed. This State Surveyor attempted to speak with Resident #74, but she continued to rest with her eyes closed. During an observation and interview on 05/04/2026 at 11:01 a.m. in Resident #89's room, a dixie cup was observed on the nightstand containing white cream. The medication was uncovered and exposed. The surveyor attempted to interview Resident #89; however, she was confused and did not respond to any questions asked by the surveyor. During an interview on 5/5/26 at 11:32 AM, CNA A stated it was not acceptable to leave medication in an open cup. She stated the cream could become contaminated and pose a risk for infection if applied. She stated another resident could ingest the medication and become ill. During an interview on 5/5/26 at 11:47 AM, the DON stated it was not acceptable to leave medication exposed. She stated residents who were not alert and oriented could mistake it for food and ingest it, which could cause nausea or illness. She stated it was the responsibility of the nurse or wound care nurse to dispose of leftover medication. During an interview on 5/5/26 at 12:04 PM, CNA B stated the cream should not have been left at bedside. She stated contamination could occur if debris entered the cup and could create an infection risk if applied to a wound. She stated staff were responsible for discarding leftover medication after use. During an interview on 5/5/26 at 3:99 p.m., RN C stated whenever a medication has been supervised, if there are leftover medications such as powder with apple sauce from those residents who get their medications crushed, or ointment in a cup, it had to be immediately disposed of in the trash bag located in the med carts to later be thrown away as biohazard waste. RN C stated there was a potential for infection control if a confused resident wondered into the room and mistakenly ingested the contents on the cup which could make them sick to their stomach, or depending on the ointment or medication, if it was contaminated for being left exposed and it was administered to the resident, they could get an infection. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/2026 at 2:30 p.m., the Administrator stated leftover medications needed to be immediately discarded in the trash bag. The Administrator stated leaving medications or ointments exposed at bedside created a potential infection control concern and presented a risk that a confused resident could accidentally ingest the contents, which could result in illness or adverse effects. He further stated medications or ointments left exposed could become contaminated and, if later administered or contacted by a resident, could potentially lead to infection or other health complications. Record review of an in-service sheet titled, TOPIC: Locking Med Carts, dated 01/22/2026, revealed RN C signed for acknowledgement of in-service. Record review of the facility policy titled Medication Label and Storage undated read in part, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access keys (Medication Storage) (2) The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner (3) Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others Record review of the facility policy titled, Medication Label and Storage, April 2019, read in part, Medications are administered in a safe and timely manner, and as prescribed. (policy interpretation and implementation) (1) Only persons licenses or permitted by this state to prepare, administer and document the administration of medications may do so (24) Topical medications used in treatment are recorded on the resident's treatment record (TAR). (25) Staff follows established facility infection control procedures (example given, handwashing, antiseptic technique, gloves, isolation precaution, etc.) for the administration of medications, as applicable 2. Record review of Resident #74's face sheet, dated 05/06/2026, revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Record review of Resident #74's Annual History and Physical, dated 05/05/2026, revealed the following medical history: Congestive Heart Failure (a chronic condition where the heart is unable to pump blood to meet the body's need for blood and oxygen). Record review of Resident #74's Quarterly MDS, dated [DATE], revealed a BIMS of 13, meaning resident was cognitively intact. Record review of Resident #74's care plan, with revision date 01/25/2026, had impaired cognitive function/impaired thought processes related to resident's Dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). 1. Record review of Resident #3's admission record, dated 05/04/2026, revealed a [AGE] year old female, admitted [DATE]. Record review of Resident # 3's history and physical, dated 05/06/2026, revealed a diagnosis of type 2 diabetes (a chronic metabolic condition where the body resists insulin or fails to produce enough of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it leading to high blood glucose levels). Record review of Resident #3's Quarterly MDS assessment, dated 02/27/2026, revealed a BIMS of 15 indicating intact cognitive function. Record review of Resident #3's physician orders, dated 05/04/2026, revealed an active order with a start date of 12/24/2025 of zinc oxide mixed with collagen particles with every brief change, as needed. Record review of Resident #3's care plan, dated 05/04/2026, revealed an ADL Self Care Performance Deficit. Interventions included assistance from staff with all toileting and incontinent care needs. During an observation on 05/04/2026 at 10:00 a.m., a plastic medicine cup containing an unknown white substance on the bedside table. There were no residents present in the room at this time.

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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 observations, interviews, and record review, the facility failed to distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. -The facility failed on 05/04/2026 to ensure employee sodas were not stored in the walk-in refrigerator.-The facility failed on 05/04/2026 to ensure a turkey in the walk-in freezer was labeled with a receive and use by date.-The facility failed on 05/04/2026 to ensure Dietary Aide E and Dietary Aide M did not grabbed drinking cups from the opening with barehand 13 times.-The facility failed on 05/04/2026 to ensure [NAME] J did not grabbed 5 bowls with bare hands by the interior portion of the bowl.-The facility failed on 05/04/2026 to ensure Dietary Aide L stored approximately 75 peanut butter and jelly halved sandwiches in the dry storage area after completion for approximately 30 minutes. This failure could place residents at risk for foodborne illness.Findings included: During initial kitchen tour observation and interview on 05/04/2026 at 8:35 AM with the Dietary Director, it was observed that a case of sodas that was only intended for employees (verified with Dietary Director) was being stored in the walk-in refrigerator because there was no space in the employee designated refrigerator. At 8:48 AM, an unlabeled turkey was in the walk-in freezer; as per Dietary Director, they had received it in December 2025 but could not confirm an exact date. A follow-up observation during meal service from 12:07 PM to 12:17 PM, it was observed Dietary Aide E and M were transferring drinking cups with bare hands encountering the opening of uncovered cups 13 times. At 12:23 PM, [NAME] J was observed transferring 5 bowls from the dishwasher area to the serving line with bare hands grabbing the bowls by the interior portion of the bowl. At approximately 12:05 PM, Dietary Aide L had finished preparing approximately 75 peanut butter and jelly halved sandwiches and proceeded to prepare beverages; At 12:35 PM, 75 peanut butter jelly halved sandwiches were in the dry storage pantry. In an interview on 05/04/2026 at 12:36 PM, Dietary Aide L stated she had finished preparing the peanut butter jelly sandwiches about 30 minutes prior and placed them in the dry storage pantry. She stated the peanut butter jelly sandwiches needed to be stored in the refrigerator, but she was unable to put them in there because a cart was blocking the snack and beverage fridge. She stated she did not think about moving the cart or placing them in the walk-in refrigerator and added that she was busy completing other tasks. She stated that she was going to transfer them to the fridge after lunch was done being served; all meals had already been served, and there was no observation of Dietary Aide L retrieving and relocating the peanut butter jelly sandwiches to cold storage without surveyor prompting. She stated peanut butter jelly sandwiches needed to be stored below 41 F to ensure they did not spoil. She stated if spoiled food was served to residents, they could become sick from a food borne illness. She stated the peanut butter jelly sandwiches were going to be saved at the nurse's stations as a snack for residents. During an interview and observation on 05/06/2026 at 10:51 AM, Dietary Aide I stated her responsibilities were to prepare desserts and drinks, answer the kitchen door, review meal tickets, transport meals to the hallways, and assist the line as needed. Using an empty cup and bowl from the kitchen, she provided a demonstration of how to properly grab and transfer bowls and cups; no concerns noted during return demonstration. She stated drinking cups needed to be grabbed from the bottom, otherwise it could contaminate the cups for residents when they drink out of them. She stated it was cross-contamination if staff put their bare hands in the bowl. She stated that it did not affect residents because the staff washed their hands constantly. She stated the method of grabbing the bowels was cross contamination and staff needed to use a tray when transporting more than 2 bowls. She stated that the items in the freezer and fridge needed to be labeled when it was received, to monitor how long they had to use it. She stated that a label needed to be present on the turkey to identify when it was received. She was responsible for ensuring the labels for the food, and everyone was responsible for preventing cross contamination. She stated the peanut butter jelly sandwiches (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed to be refrigerated immediately after preparation. She stated it was not appropriate for them to be stored in the dry storage pantry. She stated that nothing would happen to the sandwiches in 30-minutes but it was the dietary aide's responsibility to put them in the fridge immediately. She stated it was not appropriate for employee sodas to be stored in the walk-in fridge because it was only intended for the residents. She stated that there was a separate storage space for employee beverages. She stated the last in-service was in December 2025. During an interview and observation on 05/06/2026 at 12:17 PM, [NAME] K provided a demonstration of how to properly grab and transfer bowls and cups using empty drinkware and plateware from the kitchen; no concerns noted during return demonstration. He stated he would grab the bowl from the bottom and if he was transporting more than 2 bowls, he would use a tray. He stated this needed to be done because the interior portion was where residents' food would go. He stated if bare hands touched the interior of the bowl it would create cross contamination. He stated the cup needed to be grabbed from the bottom away from the opening because it was cross contamination if care hands encountered it. He stated if these practices were continued, it could affect the residents by making them sick and contaminating their food and drinks. He stated the Dietary Director was responsible for ensuring dietary staff were adhering to cross contamination prevention practices. He stated that items in the walk-in refrigerator that were not in their original box needed a label for when it was open or received. He stated that the turkey needed to be labeled so that staff was aware when it arrived and how long it would be good for. He stated that everyone who grabbed an ingredient or removed an item needed to ensure they put a label on it. He stated that the peanut butter jelly sandwiches needed to be placed in the refrigerator once they were prepared. He stated it was not appropriate for the peanut butter jelly sandwiches to be stored in the pantry and they could spoil if left there for too long. He stated that employee sodas could not be stored in the walk-in fridge because that space was reserved for the residents and added there was a separate storage area for employees' beverages. He stated the last in service for food safety and storage was in December 2025. During an interview and observation on 05/06/2026 at 12:32 PM, The Dietary Director provided a demonstration of how to properly grab and transfer bowls and cups using empty drinkware and plateware from the kitchen; no concerns noted during return demonstration. She stated that the bowls and cups needed to be grabbed from the bottom. She stated staff needed to adhere to this standard because they could contaminate the portion that the residents eats or drinks from. She stated a resident could eat cross-contaminated food and potentially sick with symptoms of vomiting, fever, upset stomach, and diarrhea. She stated she was responsible for ensuring drink and serving plates were not cross contaminated by dietary staff. She stated that peanut butter jelly sandwiches needed to be stored in the refrigerator immediately after preparation. She stated it was not appropriate for the peanut butter jelly sandwiches to be stored in dry storage pantry and added they would need to be thrown away. She stated that the peanut butter jelly sandwiches were not thrown away on 05/04/2026 because she was not aware they were stored in the dry storage pantry for approximately 30 minutes. She stated that all consumables and seasonings needed a label in the kitchen. She stated this gave staff a time for when it needed to be used by and inform staff how long it had been there for. She stated that a label would help staff know the exact date when the kitchen received it. She stated herself and dietary staff were responsible for ensuring that all items in the kitchen had an appropriate label. She stated that sodas and all other employee consumables cannot be stored in the walk-in refrigerator because that area was only intended for the ingredients used for resident meals. She stated the last in service to her staff was in November 2025. In an interview on 05/06/2026 at 3:00 PM, The Administrator stated a turkey without a label, employee sodas in the walk-in refrigerator, peanut butter and jelly sandwiches, and dietary staff's bare hands contacting cups and bowls in/near the opening was not appropriate cross-contamination prevention practices. He stated peanut butter and jelly sandwiches needed to be stored in the refrigerator to prevent food-borne illness. He stated it affected residents because it could cause food-borne illness. He stated he and the Dietary Director were responsible for ensuring staff were (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adhering to safe food handling procedures and facility policy. Record review of the facility's policy titled, Food Preparation and Service revised November 2022 read in part, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices (General Guidelines) (2)Cross-contamination can occur when harmful substances, in example, chemical or disease-causing microorganisms are transferred to food by hands, food contact surfaces. (3) Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness (Food preparation, cooking and holding time/temperature)(1) The ?danger zone' for food temperature is above 41 F and below 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness (Food distribution and Service) (7) Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks (10) snacks are not left on trays or countertops beyond the established safe time and temperature requirements (12) Food that has been served to residents without temperature controls (example give, trays, snacks, etc.) will be discarded if not eaten within two hours (Special events) (1) Food safety requirements apply to facility-sponsored events regardless of where the food was prepared or where it was served Record review of the facility's policy titled, Food Receiving and Storage revised November 2022 read in part, Food shall be received and stored in a manner that complies with safe food handling practices (Refrigerated/Frozen storage) (1) All foods stored in the refrigerator or freezer are covered, labeled and dated (?use by' date) (Food and Snacks Kept on Nursing Units) (1) All food items to be kept at or below 41 F are placed in the refrigerator located at the nurse's station and labeled with a use by date

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly for 2 of 2 dumpsters (Dumpster #1 and #2) reviewed for garbage disposal . -The facility failed to ensure the dumpster #1 and #2 was closed on 05/04/2026.-The facility failed to properly dispose/save 2 bed frames (1 nonrepairable), air conditioning unit, and lamp post light housing that was left outside the facility laundry room on 05/04/2026 thru 05/06/2026.- The facility failed to ensure dumpster #1 and was closed on 05/05/2026. This failure could place residents at risk of infestation of rodents and insects.Findings included:During initial kitchen tour on 05/04/2026 at 9:00 AM with the Dietary Director, it was observed dumpster #1 and #2 were left open by the dumpster access doors on both sides. At 9:03 AM, 2 bed frames, an air conditioning unit, and lamp post light housing was observed in a patio area outside the facility laundry room. A follow-up observation on 05/05/2026 at 1:35 PM revealed that the inoperable equipment outside the facility laundry room was still present. At 1:38 PM Dumpster #1 and #2 were left open by the dumpster access doors on 1 side. A follow-up observation on 05/06/2026 at 8:44 AM revealed that the refusal outside the facility laundry room was still present.In an interview on 05/05/2026 at 3:33 PM, Housekeeper H stated housekeeping, nursing, maintenance, dietary, and physical therapy used the facility dumpsters. She stated that it was expected for staff to close the dumpsters and the corral gate when not in use. She stated it needed to be closed to ensure germs don't spread, minimize odor, limit access, and prevent infestation of rodents and insects. She stated that whoever used it last was responsible for ensuring it was closed at all times. She stated it could irritate the residents if the dumpster was not closed by producing odors and an unappealing appearance. She stated she was aware of the items outside the facility laundry room and described it was beds and boxes put there by the Maintenance Director approximately three weeks ago. She stated she did not think it was an appropriate place for refusal because it looked junky . She stated that the Maintenance Director was responsible for organizing refusals and contacting vendors to pick up refusals that were not appropriate for the dumpster. She stated she did not remember the last in service she received for proper waste and refusal removal. In an interview on 05/05/2026 at 3:48 PM, CNA G stated she used the dumpsters in the back to discard waste at the end of every shift. She stated the process was to take trash in the bin with gloves, open the corral doors, close the bags, throw the trash in the dumpster, discard the gloves, and close the dumpster. She stated the dumpster needed to be closed to contain anything in there, and prevent access for cats, rats, roaches, and flies. She stated whoever used the dumpster last was responsible for ensuring it was closed afterward. She stated the beds and boxes outside the facility's laundry room were not an appropriate location for them because it posed a hazard to anyone walking by. She stated The Maintenance Director was responsible for disposing the beds and refusal ensuring they were not left there. She stated the last in service for waste disposal was a week or two ago. She stated refusal placed outside the facility laundry room affected residents by potentially causing an accident or fall to happen. She stated the dumpster being left open affected residents by potentially creating an infestation of pests that could migrate to the facility. In an interview on 05/06/2026 at 11:05 AM, Dietary Aide I stated that the process to discard trash was to take the rolling barrels to the dumpster, throw them away and close the corral door. She stated that the dumpster needed to be closed after every use and when not in use. She stated that it needed to be closed to limit access and to prevent infestation of pests. She stated that cockroaches, mice, flies, and cats could access the trash if it was left open. She stated that if the trash was left open and infested then staff could unintentionally introduce the pest into the building. She stated housekeeping were responsible for closing when not in use and reviewing it throughout the day. She stated that she does not know how long the beds and refusal in front of the facility laundry room had been there. She stated if it had been there for a long time, it was not appropriate. She stated that maintenance was responsible for calling someone to dispose of or repair the refusal that was left in front of the facility laundry room. In an (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 05/06/2026 at 11:27 AM, The Maintenance Director stated the dumpster should be closed when not in use. He stated that all staff needed to close the dumpster after they disposed of something. He stated that it was an infection control guideline. He stated rodents, flies, and roaches had easy access to a dumpster left open. He stated that infestation could begin if the dumpster was left open throughout the day. He stated it affected residents because it could create an infestation near the building and expose the residents to pests. He stated whenever he passes by it, he stops by and checks it to ensure it's closed when not in use. He stated he had 2 bed frames (1 repairable), an air conditioning unit (used for spare parts), and a light lamppost housing (waste). He stated that the ac unit and beds had been placed in front of the facility laundry room approximately 6 weeks ago. He stated the light lamppost housing had been there since before he became the maintenance director in October 2025. He stated it was the best spot he could find to store long-term items and added it was not the appropriate place for waste and refuse. He stated he had no work orders for pick-ups with contractors and added he was going to take them in his personal truck to a local waste/refusal site. In an interview on 05/06/2026 at 12:45 PM, Dietary Director stated during initial observation on 05/04/2026 the dumpster was open and was not appropriate since it was not in use. She stated it needed to be closed to prevent infestations of mice, cockroaches, flies, and cats. She stated that if there was an infestation in the dumpster, residents could get sick because the infestation could migrate to the building. She stated the beds and air conditioning unit had been there for approximately a month or less. She stated if the items were not working and there was no intent to fix it, they needed to be disposed of properly. She stated the maintenance person was responsible for ensuring the refusal was discarded appropriately. She stated who ever used the trash last was responsible for ensuring it was closed after use. In an interview on 05/06/2026 at 2:57 PM, The Administrator stated the top lids and side doors to the dumpster should be closed when not in use and everyone was responsible for ensuring it was done. He stated it was to prevent the dumpster from being accessible to pests. He stated it affected residents because the pests could enter the facility and create a problem. He stated that the equipment in front of the facility laundry room was being repaired by the Maintenance Director, but if it was not repairable, then the items needed to be discarded properly. He stated the Maintenance Director was responsible for discarding items that were beyond repair. Record review of the facility policy titled Sanitization revised November 2022 read in part, (14) Garbage and refuse containers are in good condition without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). (15) Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pests

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident # 1 and Resident #39) of 8 resident's reviewed for infection control. The facility failed to ensure Resident #39's nasal canula was properly stored while oxygen was not in use.The facility failed on 05/04/2026 to properly monitor and store Resident #1's dentures and did not placed them in a denture cup, and they were left exposed in a see through plastic clear cup without a lid on it. These failure could place residents at risk of cross contamination resulting in acquired infection or illness. Findings included: Record review of Resident #1's face sheet revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. The face sheet revealed the resident's original admission date was 06/24/2021 with a readmission date of 11/21/2023.Record review of Resident #1's History and Physical dated 06/25/2021 revealed the resident was admitted following hospitalization related to generalized weakness, hyponatremia (low sodium levels), hypoglycemia (low blood sugar), and intra-abdominal sepsis (serious infection in the abdomen). Diagnoses included hypertension (high blood pressure), diabetes mellitus type II (high blood sugar), benign prostatic hyperplasia/BPH (enlarged prostate), generalized weakness, dehydration, hypothyroidism (underactive thyroid), gout (arthritis caused by uric acid buildup), coronary artery disease/CAD (heart disease), osteopenia (decreased bone density), and chronic kidney disease stage III (decreased kidney function). The physical assessment revealed the resident required PT, OT, and speech therapy services.Record review of Resident #1's MDS quarterly assessment dated [DATE] revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Record review of Section GG, Functional Abilities and Goals revealed Resident #1 required moderate staff assistance with activities of daily living, oral hygiene to include the use of suitable items to clean teeth or dentures, ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with us of equipment, mobility, transfers, personal care, and eating-related tasks.Record review of Resident #1's care plan revealed the resident received a therapeutic mechanical ground texture diet with thin liquids due to nutritional risk and swallowing-related concerns. Interventions included allowing ample time for the resident to participate in activities of daily living, attempting to alleviate barriers to self-performance of ADLs, determining the resident's level of self-feeding impairment, and providing assistance with ADLs to the extent necessary to complete tasks. The care plan also included dental evaluation and intervention as needed and interventions related to eating assistance and monitoring for choking or coughing episodes. The care plan revealed the resident required staff assistance with ADLs and personal care tasks associated with oral hygiene and denture management.During an observation on 05/04/2026 at 10:05 a.m. in Resident #1's room, dentures were observed inside a clear plastic cup on the side table without a lid. Another denture cup containing liquid was observed on the dresser, uncovered and exposed.During an observation and interview on 05/04/2026 at 10:20 a.m., the Speech Therapist was present in the room. The dentures remained exposed while inside the plastic cup. The Speech Therapist stated dentures should not be left uncovered due to the risk of contamination and potential infection if used without proper cleaning. She also stated there was a risk the dentures could fall and break. Resident #1 nodded when asked if he was doing well.During an interview on 5/5/26 at 11:36 AM with CNA A, she stated Resident #1's dentures should be cleaned, disinfected, and stored in a designated container. She stated leaving them exposed created a risk for cross-contamination and infection and potentially damage if the cup with his dentures was to fall to the floor.During an interview on 5/5/26 at 11:52 AM with the DON, she stated dentures should be stored in a denture cup with a disinfecting solution. She stated leaving Resident #1's dentures exposed created a risk for contamination, accidental use by other residents, and illness. She stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dentures could also be lost, which could affect Resident #1's eating intake and weight.During an interview on 5/5/26 at 12:08 PM with CNA B, she stated dentures should be properly washed and stored. She stated leaving Resident #1's dentures exposed created a risk for infection, damage, or loss, which could impact eating and self-esteem.During an interview on 5/5/26 at 3:99 p.m. with RN C, stated there was a potential for cross contamination and infection for leaving the dentures exposed. RN C stated the dentures could break and be lost, which could impact Resident #1's ability to eat right which could potentially result in loss of weight.During an interview on 05/06/2026 at 2:30 p.m. with the Administrator, he stated that dentures that are not being worn by a resident needed to be stored in the denture cup after washing them, to keep them free of dust or debris which could damage the dentures and could potentially make the resident ill if there was something in the dentures that contaminated them. The Administrator stated that all staff who worked with Resident #1 were responsible for reminding the resident of the risks of leaving is dentures without properly storing them which could potentially lead for them to be lost or broken.Record review of Resident #39's face sheet, dated 01/24/2026, revealed a [AGE] year-old female, admitted [DATE]and readmitteed 12/01/2023.Record review of Resident #39's annual history and physical, dated 07/08/2025, revealed the resident was a [AGE] year-old female with diagnoses of hypothyroidism (underactive thyroid), hypertension (high blood pressure), allergic rhinitis (nasal allergies) and insomnia (difficulty sleeping). The history and physical revealed Resident #39 required supplemental oxygen to be given as needed via nasal cannula to maintain oxygen at 90%. Record review of Resident #39's MDS quarterly assessment, dated 03/30/2026, revealed a BIMS score of 9 indicating moderately impaired cognitive skills. Record review of Section GG, Functional Abilities and Goals, revealed the resident required extensive staff assistance with activities of daily living, mobility, transfers, hygiene, and personal care tasks. Record review of Resident #39's care plan, dated 12/19/2025, revealed the resident had potential for altered respiratory status and difficulty breathing with history of pneumonia and revealed interventions by staff were to notify the nurse for an assessment if there was a respiratory change in Resident #39, to maintain a clear airway and encouraging the resident to clear own secretions with effective coughing, to monitor signs of respiratory distress and report it to the doctor and check for decreased pulse with oximetry (a test used to measure how much oxygen is in a person's blood). The care plan revealed the resident was allergic to dust.During an interview and observation on 05/04/2026 at 10:40 a.m., Resident #39 was lying in bed. Her nasal cannula was hanging behind her from the bed's headboard, touching the floor, and the concentrator was on. Resident #39 stated she did not remember when she had last worn her cannula and stated she wanted to put it on, and she needed assistance with her clothes. Resident #39 was confused and could not provide more details and was talking incoherently.During an interview on 5/5/26 at 11:34 AM, CNA A stated when a nasal cannula was not in use, it should be stored in a plastic bag to prevent contamination. She stated leaving it exposed was not acceptable and could result in the residents becoming ill or developing an infection in their nose or lungs.During an interview on 5/5/26 at 11:49 AM, the DON stated the cannula should be stored in a clean plastic bag and not placed on the floor. She stated this created an infection control concern due to exposure to dust and germs and could lead to respiratory infection.During an interview on 5/5/26 at 12:04 PM, CNA B stated the cannula should be disinfected and stored properly when not in use. She stated improper storage created a risk of infection if reused.During an interview on 5/5/26 at 3:99 p.m., RN C stated residents who were in oxygen therapy needed to have their equipment, such as the nasal cannulas, cleaned, bagged, labeled and stored, if they were not in use by the resident. RN C stated it was not acceptable that the cannula was touching the floor because if the resident was confused and put the cannula on without cleaning it, there was a potential risk of the resident aspirating (when food or liquids accidentally goes into the airway or lungs instead of going down the esophagus into the stomach) lint or debris which could potentially make Resident #39 sick.During an interview on 05/06/2026 at 2:30 p.m., the Administrator stated it was not acceptable to leave a nasal cannula (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	handing by a resident's bed and directly touching the floor. The Administrator stated there was a potential risk of contamination that would make the resident sick from her lungs if she was to aspirate lint or dust if it got into the cannula and the resident put it on without properly disinfecting it prior to using it.Record review of the facility's policies and procedures with a revision dated of 2016, titled Dental Services, read in part: Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures.Dentures will be protected from loss or damage, to the extent practicable, while being stored.Lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures.If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay.Record review of the facility's policy and procedures, revised October 2010, titled, Oxygen Administration, read in part: PurposeThe purpose of this procedure is to provide guidelines for safe oxygen administrationPreparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders, facility protocol for oxygen administration.2. Review the resident's care plan to assess any special needs of the resident.3. Assemble the equipment and supplies as needed. General Guidelines 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure:2. Nasal cannula, nasal catheter, mask (as ordered);Steps in Procedure9. Place an appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter).10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.Weekly DocumentationOxygen/nebulizer tubing/masks to be changed by nursing department, weekly, and documented in the electronic health record.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **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 room was equipped to assure full privacy for each resident by providing ceiling suspended curtain that extended around the bed for 1 of 5 (Resident #75) residents reviewed for privacy. -The facility failed on 05/04/2026 to 05/06/2026 to provide a privacy curtain to Resident #75 in a shared room. This failure placed the resident at risk for not having privacy to his side of the room, experiencing embarrassment, and a decreased sense of self-esteem. Findings included: Resident #75 Record review of Resident #75's admission sheet dated 05/06/2026 revealed an [AGE] year-old male with an admission date on 05/14/2024. Record review of Resident #75's comprehensive MDS dated [DATE] revealed under Section C (Cognitive patterns) revealed the resident had a BIMS score of 3 with the significance being the resident had severe cognitive impairment. Under Section GG (Functional Abilities) the resident was coded for substantial/maximal assistance for toileting, showering, upper/lower body dressing, and personal hygiene. Under Section H (Bladder and Bowel) the resident was coded as frequently incontinent (inability to retain bladder and bowel movements) for urinary and bowel continence. Record review of Resident #75's care plan dated 04/01/2026 revealed the resident had a focus area to address Alzheimer's Dementia with an intervention of provide a homelike environment. An additional focus area of bowel and bladder incontinence with intervention to use disposable briefs and change as needed and check for incontinence every 2 hours. Record review of Resident #75's physical and health dated 06/11/2024 revealed the resident was diagnosed with Dementia (a decline in cognitive function-including memory, language, problem-solving, and thinking-severe enough to interfere with daily life) and physical debility (a state of severe physical weakness, fatigue, or loss of strength, often resulting from illness, injury, aging, or prolonged inactivity). In an observation on 05/04/2026 at 10:45 AM, revealed Resident #75 did not have a privacy curtain in his room; Resident #75 was not in his room at this time to participate in interview. Resident #75 shared a room with Resident #16 who had a privacy curtain. Resident #16 was unable to be interviewed due to severe cognitive impairment. A follow up observation on 05/04/2026 at 2:08 PM revealed no change. Resident #75 was still not in room at this time. A follow-up observation on 05/05/2026 at 3:04 PM, revealed that LVN F entered the room and did not acknowledge Resident #75's privacy curtain was missing until prompted by surveyor In an interview and follow-up observation on 05/06/2026 at 11:47 AM, Resident #75's family member was at bedside and stated the Maintenance Director that morning to applied hooks for the curtain. He stated he did not know how long the privacy curtain had been off because he was visiting from out of town. He stated he had not noticed the privacy curtain was missing until he saw the Maintenance Director working on it. He stated Resident #75 would not be able to remember when it was removed and for how long due to difficulty remembering events. Resident #75 was asleep during interview with family member. In an interview on 05/05/2026 at 3:05 PM, LVN F stated Resident #75 and #16 shared a room. She stated the facility utilized privacy curtains when providing incontinent care, clothes change, repositioning, and transfers to residents. She stated she was not aware of any discrepancies in Resident #75's room. She entered the room and denied there being present concern in Resident #75 and #16's room. She stated Resident #75's privacy curtain was missing after resuming interview. She stated she was previously in Resident #75's room before the surveyor and did not notice the privacy curtain missing. She stated the privacy curtain did not pose a hazard risk to Resident #75 and there was no documentation in progress notes or care plan regarding the privacy curtain posing a potential risk to Resident #75 and needing to be removed. She stated that staff use the privacy curtain every time they provided care throughout the shift and could be noted as missing by any staff member. She stated she would put in a work order with the Maintenance Director to reapply the privacy curtain. She stated she did not know what staff members could remove or change privacy curtains. She stated any staff member could report it to the (continued on next page)

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	676431	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at El Paso	7441 Paseo Del Norte El Paso, TX 79911

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's nurse or leadership to have a new privacy curtain applied in the resident's room. She stated it was a dignity issue if a resident did not have their privacy curtain. She stated the ADON and DON were responsible for ensuring direct care staff were completing rounds and inspecting residents' environment. She stated she did not know for how long the privacy curtain had been missing for. In an interview on 05/05/2026 at 3:43 PM, CNA G stated she provided privacy to the resident by closing the door and drawing the curtain when she provided care. She stated privacy curtains were located in every resident's room. She stated if a resident did not have a privacy curtain she would notify the shift nurse and Maintenance Director. She stated she was not sure who was supposed to monitor and review resident's rooms to ensure there was a privacy curtain in place. She stated the process for the privacy curtains she was familiar with was to notify housekeeping if the curtain was dirty, wrinkled, or missing. She stated that all staff members who entered a resident's room were responsible for ensuring they had a privacy curtain. She stated it affected a residents' dignity, respect, and privacy if they did not have a privacy curtain for 2 days. She stated that a resident who was being dressed, changed, transferring required a privacy curtain when those services were provided. She stated the shift nurse and ADON and DON were responsible for ensuring that residents had privacy curtains at all times. In an interview on 05/06/2026 at 11:27 AM, The Maintenance Director stated that himself and housekeeping were able to take down privacy curtains and replace them as needed. He stated that the curtain was provided to add privacy between roommates during changing, care services, or when a resident wanted to be left alone. He stated he did not have any work orders prior to 5/5/2026 for Resident #75's privacy curtain. He stated he did not remove Resident #75's privacy curtain and he did not know how long the curtain was missing. He stated CNAs and nurses could report work orders to him verbally or on the facility software for any repairs or concerns noted in a resident's room. He stated he did a thorough room check on residents' rooms once every 2 months. He stated this was a full inspection where he reviewed the privacy curtain, door handles, bed, windows, restrooms, etc. He stated in addition to direct care staff rounding on residents every 2 hours that the facility had angel rounds in the morning and they usually conducted environmental inspections while talking with the resident. He stated a resident should always have a privacy curtain. He stated that if staff were to remove the privacy curtain, it was the expectation to replace or notify someone to change it immediately or before removing the original privacy curtain. In an interview on 05/06/2026 at 11:50 AM, Housekeeper H stated Resident #75's privacy curtain had been missing for approximately a week because it was missing additional hooks on the track. She stated she was not allowed to reapply the curtain if there was a maintenance issue. She stated she notified The Housekeeping Director with the expectation that she would notify the Maintenance Director. She stated it affected Resident #75 by not providing a private setting for changing and care. She stated a week was a long time for Resident #75 to go without his privacy curtain. She stated that the curtain hooks or an alternative should have been provided to the resident during the week he did not have a privacy curtain. She stated that housekeeping was responsible for ensuring the residents had a privacy curtain since they washed and reapplied them. She stated the last in service was in April 2026 for resident rights to privacy. In an interview on 05/06/2026 at 12:04 PM, Business Office Manager stated she was the angel round representative for Resident #75's room and she had worked on 05/04/2026 and 05/05/2026. She stated her responsibilities during angel rounds included talking with residents, making sure beds were made, placing call lights within reach, removing leftover food, and reviewing residents' environment. She stated she did not complete her angel round on 05/04/2026 because she was caught up with another resident who needed their concerns addressed with the nurse. She stated she did rounds on 05/05/2026 and did not note any concerns with Resident #75 or his room. She stated she did not remember if Resident #75 had a privacy curtain on 05/04/2026 and 05/05/2026 and could not recall if Resident #75 privacy curtain was missing the week prior. She stated that if a privacy curtain was missing it would be obvious that it's not there. She stated it could affect a resident's dignity and privacy to care if they do not have a privacy curtain. She stated she does not remember when (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #75 privacy curtain was removed. She stated the privacy curtain or an alternative needed to be placed right away before removing the original curtain. She stated that everyone was responsible for ensuring that residents had privacy curtains at all times. She stated that she could not recall the last in service she received for residents' rights or dignity. In an interview on 05/06/2026 at 2:10 PM, DON stated her direct care staff provided privacy to residents by drawing the privacy curtain, closing the door, and stepping out of the restroom while a resident was using it. She stated residents in a shared room should have a privacy curtain. She stated that the DON, ADON, and Administrator do weekly walkthroughs, but they had not completed their weekly walkthrough on 04/27/2026 to 05/01/2026. She stated privacy curtains were replaced when they were dirty, used in a quarantine/contaminated room, or needed repair. She stated there should been a replacement immediately if the staff were going to change or replace Resident #75's curtain. She stated that the housekeeping and Maintenance Director were the only staff members that could replace it. She stated that it affected a resident's privacy to change, care, and transfers if they were left without a privacy curtain. She stated that care should not be provided without the privacy curtain being used. She stated that a privacy curtain was obvious and could be easily identified as missing. In an interview on 05/06/2026 at 2:46 PM, The Administrator stated the facility utilized privacy curtains and closing resident's doors to provide privacy. He stated that privacy curtains were used anytime the staff provided service to a resident for incontinent care, clothe change, and transfers. He stated that all residents who shared a room with another resident should have a privacy curtain. He stated that the curtain should be applied immediately if it was removed by the Maintenance Director and housekeeping staff. He stated housekeeping staff and Maintenance Director were responsible for replacing the privacy curtain. He stated that it affected Resident #75 because they did not have privacy during care. He stated that all staff members should check the residents' environment whenever they were in their room and report any concerns. Record review of the facility's maintenance work order #456 revealed it was created on 05/06/2026 at 7:20 AM in relation to Resident #75's bedroom. The work order revealed it was resolved and noted as completed at 11:56 AM by the Maintenance Director by replacing the hooks to the curtain track. Record review of the facility's policy titled Resident Rights revised February 2021 read in part, Employees shall treat all residents with kindness, respect and dignity (1) Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the resident right to: (a) a dignified existence; (b) be treated with respect, kindness, and dignity; (t) privacy and confidentiality Record review of the facility's policy titled Dignity revised February 2021 read in part, Each resident shall be care for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem (1) Residents are treated with dignity and respect at all times (5) when assisting with care, residents are supported in exercising their rights (11) Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interview the facility failed to maintain an effective training program for all new and existing staff providing services for 2 of 7 employees (CNA A and Dietary Aide E) reviewed for training completions. -The facility failed to ensure CNA A received annual training for 6 training subjects reviewed on 05/06/2026.-The facility failed to ensure Dietary Aide E received annual training for 4 training subjects reviewed on 05/06/2026. This failure places residents at risk to receive services or care from a staff member who was not informed on procedures.Findings included: Record review on 05/06/2026 at 1:07 PM, HR Coordinator provided a completed document of 7 employees sampled for personnel files review. The document revealed that CNA A had a hire date of December 2024 and was missing the following trainings: communication, infection control, compliance and ethics, HIV, restraint reduction, and prevention of falls. Dietary Aide E had a hire date of December 2023 and was missing the following trainings: communication, infection control, HIV, and restraint reduction; amounting to a total of 10 incomplete trainings from CNA A and Dietary Aide E. In an interview on 05/06/2026 at 1:27 PM, HR Coordinator stated she did not have documentation of completed trainings for CNA A and Dietary Aide E. She stated the trainings missing were communication, HIV, infection control, compliance and ethics (CNA A only), restrain reduction, fall prevention (CNA A only). She stated it was not acceptable for staff to be working without completed annual training. She stated that the training needed to be completed annually to ensure staff were refreshed and competent on the regulations and policies of the facility. She stated it affected residents if staff were not up to date on their training because it posed a risk on the care they provided and staff's knowledge of their actions, decisions, and procedures. She stated that staff could get comfortable and fall into a routine that does not adhere to standards. She stated annual training kept employees informed on regulations and requirements. She stated department heads to whom employees reported to were responsible for ensuring employees were up to date on training. She stated that every Monday the Administrator runs the scheduled training modules and if a staff member had not completed the training, they would get removed from the schedule until completion. She stated that the Administrator was made aware today that the 2 employees were not up to date in the training. She stated she had not completed a training audit because the training software was new and initiated facility wide in November 2025. She stated Corporate HR would have to unlock the training and assign them to staff if the training was scheduled for a future date. She stated that corporate HR had not been notified yet to unlock the training since she was aware of CNA A and Dietary Aide E missing training today. She stated there was no policy for training and provided an Employee Handbook in its place. In an interview on 05/06/2026 at 2:16 PM, The DON stated that every day during morning meeting a list was printed of employees with missing trainings who were not in compliance. She stated if the training was incomplete for more than a month, the employee would be relieved of duties until completion of said training. She stated CNA A and Dietary Aide E needed to be pulled from the schedule because they did not have their completed trainings. She stated the trainings included videos, readings, and a test at the end to ensure comprehension. She stated if a staff member did not have completed training, they might not be knowledgeable as to what the procedures were in response to a situation (for example: infection control, falls, restraints). She stated it affected residents because staff may not be equipped with the proper knowledge on how to handle the residents. She stated it was a requirement for the employee to have their training schedule up to date with confirmation of completion within the past year. She stated herself, the HR Coordinator and Administrator were responsible for ensuring that employees had completed all training. In an interview on 05/06/2026 at 2:50 PM, The Administrator stated that the Corporate HR was responsible for unlocking and scheduling trainings to the staff. He stated that the facility monitored training completion by reviewing the software's scheduled training report daily during (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning meetings with department heads. He stated this was completed to ensure staff were up to date on training. He stated the software report showed scheduled trainings that were coming up but did not provide a report on all the trainings employees could still pending completion. He stated it affected residents because staff could be uninformed on policy and procedures that pertain to resident safety and wellbeing. He stated if the employee did not completed scheduled trainings within the month, they would be removed from the schedule and not be permitted to return to work until completion. He stated himself and HR Coordinator were responsible for ensuring training was up to date and completed for employees. He stated that training was scheduled every month, and different classes were scheduled by the Corporate HR coordinator on the facility software. He stated HR Coordinator and himself did not have access to the software to assign training for CNA A and Dietary Aide E and they would need to contact Corporate HR. He stated there was no alternative method for training besides the software the facility used. He stated all staff needed to have their training record up to date. Record review of Dietary Aide E's training scheduled revealed Infection Prevention and Control Guidelines with a scheduled due date by 05/31/2026. HIV antibody Testing and Post-Exposure completed with a scheduled course availability date of 08/01/2026 and due date of 08/31/2026. Use of Restraints with a scheduled course availability date of 10/01/2026 and due date of 10/31/2026. Hazard Communication Program with a scheduled due date by 05/31/2026. Record review revealed there were no completed trainings on file for Dietary Aide E for the 4 training subjects reviewed. Record review of CNA A's training scheduled revealed Infection Prevention and Control Guidelines with a scheduled due date by 05/31/2026. HIV antibody Testing and Post-Exposure with a scheduled course availability date of 08/01/2026 and due date of 08/31/2026. Use of Restraints with a scheduled course availability date of 10/01/2026 and due date of 10/31/2026. Hazard Communication Program with a scheduled due date by 05/31/2026. Fall Incident Prevention with a scheduled course availability date of 10/01/2026 and due date of 10/31/2026. Annual Compliance and Training with a scheduled course availability date of 07/01/2026 and due date of 07/31/2026. Record review revealed there was no completed trainings on file for CNA A for the 6 training subjects reviewed under. Record review of the facility's Employee Handbook dated December 2025 read in part, (Employment Ethics and Conduct, page 10-11) The company considers its obligations to comply with all state and federal laws seriously. As such, The Company has a Corporate Compliance Plan designed to assist with compliance with those rules and regulations this Program has been designed to establish the framework by which the organization will use reasonable effort to ensure compliance with all such laws. It is the responsibility of all employees to comply with the Code of Ethics and to use all reasonable efforts to ensure that the organization is in compliance with all applicable laws It is important that an individual reporting to Corporate Compliance misconduct must be able to provide accurate and sufficient detail in order for the Corporate Compliance Officer to evaluate the potential problem. Ongoing training is made available to all employees. Please refer to your Corporate Compliance Plan and/or Administrator for further details The Compliance Process has been created to teach, support, and monitor the commitments of individual employees and The Company. It provides the standards, principles, tools, and the training needed to meet The Company's legal, ethical, and professional responsibilities Each employee is responsible for supporting the Compliance Process in all aspects of his/her individual position. To ensure that each employee has full understanding of The Company's expectations for his/her conduct, each employee will attend a training session covering the Code of Conduct, will read the Code and sign the last page indicating understanding, and acknowledging his/her responsibility along with his/her commitment to the Code of Conduct. In addition, annual training will be conducted. Your signed acknowledgement form and a record of all supplemental training are retained as a permanent part of your employee record