STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Patriot		STREET ADDRESS, CITY, STATE, ZIP CODE 11490 Gateway North Blvd El Paso, TX 79934	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician and representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of (Resident #1) 13 residents reviewed for changes in condition.The facility failed to notify Resident #1's physician Resident #1 was complaining of abdominal pain on 2/20/26 and 2/22/26.This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. The findings included:Closed record review of the Face Sheet dated 02/25/26 for Resident #1 revealed an original admission date of 1/14/26.Review of a Medical Visit dated 1/22/26 for Resident #1 revealed, History of Present Illness: The patient has a history of DM, HTN, PVD, CAD and recent left foot osteomyelitis and gangrene, status post left below-knee amputation.Review of the admission MDS for Resident #1 dated 1/18/26 revealed: Date of admission [DATE] from acute hospital. BIMS Summary Score: 15 Cognitively Intact. Active Diagnoses: Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Post Procedural Pain, Aftercare following surgical amputation, left below knee amputation High-Risk Drug Classes: Opioid. Discharge Plan already occurring for the resident to return to the community.Review of the Care Plan for Resident #1 dated 1/15/26 revealed:-The resident has Diabetes Mellitus. Approaches: Diabetes Medication as ordered by doctor. Monitor/document for side effects and effectiveness. Educate resident/family as to the correct protocol for glucose monitoring. Monitor/document/report PRN any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Monitor for signs and symptoms of infection to any open areas: redness, pain, heat, swelling, or pus formation.-The resident is on pain medication therapy. Administer Analgesic medications as ordered by the physician. Monitor/Document side effects and effectiveness Q Shift. Monitor/Document/Report PRN adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, urinary retention. Review. For pain medication efficacy. Therapeutic regiment followed, but pain control not adequate, changes required.-The resident has potential for pain r/t Amputation Left leg below knee. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify previous responses to analgesia, including pain relief, side effects, and impact on function. Monitor/Document for side effects of pain medications. Observe for constipation, new onset of increased agitation, restlessness, confusion, hallucination, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician. Monitor/Record/Report to nurse loss of appetite, refusal to eat and weight loss. Monitor/record/report to Nurse resident complaints of pain or request for pain treatment. Notify physician if interventions are unsuccessful or a recurrent complaint is a significant change from residents past experience of pain.Review of the New Prescription Summary dated 1/15/26 for Resident #1 written by attending physician revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg give 1 tablet by mouth every 6 hours as needed for severe Pain. Diagnosis Z89512 - (ICD-10) Phantom Pain.Review of a Medical Visit dated 2/18/26 written by attending physician revealed Reason for Visit: New c/o Abd pain and diarrhea. History: reporting new Abd pain and diarrhea with low appetite today. Plan: us Abd, basic labs including amylase and lipase ordered Lomotil.Review of the Radiology Report dated 02/18/26 for Resident #1 revealed, Date of Exam: 02/18/26. History: Unspecified abdominal pain. KUB X-Ray Kidney, Ureter, Bladder: Findings: There is no evidence to suggest bowel obstruction. Impression: No bowel obstruction or ileus. Reported to MD & NP 2/18/25 at 6:45 p.m.Review of the Radiology Report dated 02/18/26 for Resident #1 revealed, Date of Exam: 02/18/26. History: abdominal discomfort. US Abdomen Impression: No acute process. Reported to MD & NP 2/18/25 at 6:45 p.m.Review of the 24-Hour report Sheet dated 2/20/26 revealed:-2:03 a.m. written by LVN H documented Resident #1 Hydro 2/20 at 3 a.m. The DON said LVN H had not notified the attending physician and/or NP resident continued to complain of abdominal pain.Review of the 24-Hour report Sheet dated 2/22/26 revealed:-4:05 a.m. written by LVN H documented Tylenol, not working resident, is still in pain, refusing to eat. The DON said LVN H had not notified the attending physician and/or NP resident continued to complain of abdominal pain.Review of the Administration Noteated 2/22/26 at 5:56 a.m. for Resident #1 written by LVN H revealed PRN Administration was: Effective. Follow-up Pain Scale was: 0Review of the Administration Note dated 2/22/26 at 5:09 a.m. for Resident #1 written by LVN H revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of the Nurses Notesated 2/22/26 at 4:25 a.m. for Resident #1 written by LVN H revealed Resident observed crying and stated her stomach hurts and that she has not eaten in days. Lips noted to be dry. Pain medication offered and education provided on purpose and benefits; resident refused at this time.Review of the Administration Note dated 2/22/26 at 11:11 p.m. written by LVN H for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of the Administration Note dated 2/20/26 at 8:59 a.m. written by LVN C for Resident #1 revealed PRN Administration was: Effective. Follow-up Pain Scale was: 3Review of the Administration Note dated 2/20/26 at 8:10 a.m. written by LVN C for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of the Administration Note dated 2/20/26 at 3:13 a.m. written by LVN H for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of the Medication Administration Record dated February 2026 for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain was administered on:-2/22/26 at 5:09 a.m. for Pain Level 7 by LVN H-2/20/26 at 3:13 am for Pain Level 10 by LVN H-2/20/26 at 8:10 am for Pain Level 8 by LVN C-2/20/26 at 11:11 p.m. for Pain Level 7 by LVN HReview of the 24-Hour report Sheet dated 2/21/26 revealed: 6:28 p.m. written by LVN B documented Resident #1 stable. Tylenol, not working resident, is still in pain. DON said LVN B had not notified the attending physician and/or NP that resident continued to complain of abdominal pain.During an interview and Record on 2/24/26 at 10:30 a.m., 24-Hour Report Sheet with DON and ADON LVN C revealed:Review of the Physician Order Summary dated 2/25/26 for Resident #1 revealed: Order Date: 02/18/26 CBC w/Diff, Comprehensive Panel, Lipase, Amylase. Order Date: 02/18/26 Abdominal Ultrasound; Order Date: 02/18/26 KUB; Order Date: 02/20/26 Stool Culture. Pain assessment to be completed every shift. Pharmacy: Order Date: 02/20/26 Dicyclomine HCL 20 mg Give one tablet by mouth two times a day for GI. Order Date: 01/15/26 Hydrocodone-Acetaminophen 7.5-325 mg Give one tablet by mouth every six hours as needed for pain. Ondansetron HCl 4 mg give 1 tablet by mouth every 6 hours as needed for nausea. Order Date: 02/19/26 Pepto Bismol Oral Suspension give 30 ml by mouth every 6 hours as needed for upset stomach and loose stools.Interview and record review on 3/04/26 at 12:44 p.m. with the attending Medical Director/attending physician for Resident #1 revealed he had written on the prescription Hydrocodone 7.5 mg-acetaminophen 325 mg take 1 tablet by oral route every 6 hours as needed for pain PRN severe (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain for Diagnosis of Phantom pain. He said, The nurses should have called me to report the resident was having abdominal pain and I would have given them a new order. I would not have approved for the nurses to administer the Hydrocodone for abdominal pain because the resident was already complaining of abdominal pain and the Hydrocodone would have made it worse because it causes constipation. The nurses should have only administered the Hydrocodone for the phantom pain related to recent amputation of lower extremity. The problem is that whoever entered the medication order to the resident's electronic record, did not specify the Hydrocodone was ordered for Phantom Pain related to recent amputation of lower extremity.Review of facility policy and procedure on Change in a Resident's Condition or Status Revised April 2025 revealed: Policy Statement: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation: The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure efforts were made to resolve resident grievances, for 1 (Resident #2) of 13 resident reviewed for grievance resolution. The facility failed to follow their facility policy and procedure on Grievance/Complaints when Resident #2's family member voiced a concern on 01/30/26 to LVN M regarding the way that the staff combed the resident hair and concerns regarding food. This failure could place residents at risk of feeling that their voices were not being heard or taken seriously and could cause feelings of worthlessness. Findings included:Review of the Face Sheet dated 3/06/26 for Resident #2 revealed original admission date was 3/31/25 and re-admission date was 08/12/2025. Resident #2's diagnoses included: Dementia, Diabetes Mellitus, Hypertension, End Stage Renal Disease, and Adult Failure to Thrive.Review of the Quarterly MDS dated [DATE] for Resident #2 documented Date of Entry 08/13/2025. Clear speech sometimes makes self-understood, sometimes understands others; BIMS Score 2 (severely cognitively impaired); dependent with personal hygiene. Active Diagnoses: End Stage Renal Disease, Diabetes Mellitus, Non-Alzheimer's Dementia, Malnutrition. No weight loss. Therapeutic Diet. High-Risk Drug Classes: HypoglycemicReview of the Care Plan revealed: Review of Care Plan initiated 4/01/25 for Resident #2 documented ADL self-care performance deficit Approaches: The resident requires assistance with personal hygiene.- Review of the Care Plan initiated 4/02/25 Impaired Cognitive Function: Approaches: Ask yes/no questions. Communicate with resident/family regarding Residents, capabilities and needs.-Review of the Care Plan initiated 4/01/25 for Resident #2 documented: Resident has nutritional problems or potential nutritional problem r/t adult failure to thrive and protein calorie malnutrition. Approaches: Provide, serve diet as ordered. Monitor intake and record every meal. RD To evaluate and make diet change recommendations as needed.-Review of the Care Plan initiated 4/01/25 for Resident #2 documented Resident Receiving a therapeutic diet. Reduce concentrated sweets and Regular texture. Approaches: Administer snacks/Supplements as ordered/Desired within the restrictions. RD To review. Nutritional and hydration status, quarterly and as needed.-Resident has renal failure r/t end stage renal disease. Approaches: Assist wit ADLS as needed.Review of the Care Plan Conference dated 3/10/26 for Resident #2 revealed Meeting Time: 03/10/26 at 1:00 p.m. Attendance at Meeting: RN, Dietary, Social Worker, Family, and MDS Nurse. Quarterly Care Plan meeting. Nutrition: Renal regular diet thin liquids. Weight 106.7 labs; Eating 75-100%, mighty shake once at day. Summary of Care Plan: Resident's care plan reviewed with family member. Family requesting cookie protein supplement that is provided at dialysis to be given at facility. Agreed to have resident receive both extra protein and health shake for meals. Facility to continue looking for orange blanket. Family member requesting monthly care plan meetings moving forward. All questions answered. Family attended via phone and agree with plan of care. Dietitian participated in care plan meeting.Review of the Diet Slip for Resident #2 revealed RCS Regular House Shake, Regular Texture. Fortified meal plan.Review of the Menu dated 2025 Diet: Regular Thursday Loaded Baked Potato, Toss Salad, Dressing of Choice, Saltine Crackers, Frosted Cake, Milk and Beverages.Review of the Nutritional assessment dated [DATE] for Resident #2 revealed: RCS, Reg Text, Thin, eats 75% of meals and needs supervision with eating.Review of the Physician Order dated 3/06/26 for Resident #2 revealed: Liberal Renal Diet Regular Texture, Health Shake once a day, HS snack, Needs potassium rich foods for breakfast. Dialysis Monday-Wednesday-Friday.Review of Nurses Note dated 1/30/26 at 5:46 p.m. written by LVN M for Resident #2 revealed family member had called regarding how CNAs are preparing resident hair before she goes to appointments or dialysis, she verbalized I don't want them to be doing ponytails and putting flower clips, she's not a child and it looks like they are making fun of her, she's old and maybe she's not going to complain but at the other facility she would not agree to have ponytails and flower clips this nurse explained she (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will pass on report to CNAs and nurses.Review of Nurses Note dated 1/30/26 at 6:06 p.m. written by LVN M for Resident #2 revealed Dietary Manager was notified family had concerns regarding food.Review of the Grievance Binder revealed there was no Grievance report written for January 2026 to present regarding family members' concerns regarding the way CNAs combed the Resident #2's hair and/or concerns related to food that were reported to LVN M on the evening shift on 1/30/26.During an interview on 2/24/26 at 10:47 a.m. with LVN R revealed that she was not aware of any concerns related to how staff combed the Resident #2's hair or any concerns about the food. She said the resident was alert, oriented to person, place, situation, recognized familiar faces and recognized family members. She said the resident went to dialysis three times a week from 7:30 a.m. - 2:00 p.m. and they packed her a lunch for the resident to eat while at the dialysis center. She said, The never eats her lunch at the dialysis center. She said she checked the lunch box in the morning and always brings her lunch back untouched. She said the resident wants to eat when she returns to the facility from dialysis.During an interview on 2/24/26 at 10:50 a.m. with CNA U said the facility packed a lunch for those residents that went to dialysis in a blue lunch bag. She said Resident #2 never ate her lunch at the dialysis center and the nurses were aware that the resident did not eat while at dialysis because she got nauseated. She said LVN R Charge Nurse on the 400 Hall during the day shift had informed them approximately two weeks ago that the resident's family member did not want them to comb the resident's hair with ponytails, and not want us to put on ribbons, colored rubber bands and barrettes. She said the resident liked the way that they combed her hair because she got a lot of compliments from the staff at the dialysis center. She said the resident was very sad because her family member no longer allowed the staff to comb her hair like they used to.During an observation and interview on 2/24/26 at 10:52 a.m. with Resident #2 revealed, the resident was sitting in a wheelchair by the side of her bed, clean and well groomed. The resident's hair was combed and did not have any ponytails, colored rubber bands, ribbons, or hair barrettes. She said her family member worked and would occasionally come to visit her on the weekends. She said the family member did not like the way the girls combed my hair with ponytails, colored rubber bands, ribbons and little girl barrettes. She said she liked the way the girls combed her hair, but family member did not like it, so now they only brush her hair. The resident appeared to be sad and said she preferred to have her hair done the way they used to before the family member asked that the girls not to put anything on her hair and/or with ponytails. She said, I will do whatever my family member wants. The resident said the facility packed her lunch when she went to the dialysis center on Monday-Wednesday-Friday and did not eat at the dialysis center because she got nauseated while getting her dialysis treatment. She said she would not be able to eat lying down because she was afraid of choking. She said that upon return to the facility, the staff facility checked the blue bag to check if she ate and she reminded the staff that she did not like to eat while getting her dialysis treatment. She said she preferred not to eat upon return from dialysis and would wait for her dinner meal to be served.During a telephone interview on 2/20/26 at 10:56 a.m. with the family member for Resident #2 revealed a visit was made during dinner time on January 29, 2026, and noted the resident had been served a very small baked potato, small salad and ice cream. She said the resident was confused at times and could voice her needs. The family member said she had asked LVN M about the dinner that had been served to Resident #2 on that day. LVN M said they had already notified the Dietary manager that the menu was not followed on that day. The family member said she had reported her concerns about the food that was served to the Resident #2 for dinner on 1/29/26 to the Dietary manager and the DON on that day, and she said that she was not aware of what had been served to Resident #2 for dinner on that day. The family member said she had voiced concern to the evening nurse who was assigned to Resident #2 about how the staff combed the resident's hair like a little girl with bright color ties in her hair and Butterfly clips when she went to appointments and/or dialysis and she felt The staff was not treating the resident with dignity and respect. The family member said the facility sent the Resident #2 with a sack lunch when the resident went to dialysis on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse for 1 (Residents #3) of 13 residents reviewed for abuse. The failed to ensure allegations of abuse were immediately reported by the facility staff to the Administrator when Receptionist X witnessed when Resident #4 calling Resident #3 a cow.This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse.Findings include: -Resident #3Review of Face Sheet dated 3/09/26 for Resident #3 revealed an admission date of 10/24/22.Review of History & Physical dated 2/27/26 for Resident #3 documented [AGE] year-old female with progressive multiple sclerosis, obese, the resident is chairbound and receives assistance her with ADLs. Oriented to person, place, and time.Review of Quarterly MDS dated [DATE] for Resident #3 documented clear speech, makes self-understood and understands others. BIMS Score 15 (cognitively intact). Active Diagnoses: multiple sclerosis, morbid (severe) obesity due to excess calories. Weight 268 pounds.Review of the Care Plan dated 3/02/26 for Resident #3 revealed:-Resident has episodes of adverse behaviors: Fabricates facts/unreliable historian/manipulates staff/accusatory behavior towards staff. Approaches: Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, persons involved, and situation. Document behavior and potential causes.-Resident has a potential mood problem r/t incident with another resident calling her cow Approaches: Behavioral health consult as needed. Monitor/record to MD prn mood patterns signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. Recommendation for a room offered.During an observation and interview on 2/20/26 at 12:00 p.m. revealed Resident #3 was sitting in a wheelchair in her room watching television. Resident was alert, oriented to person, place, and time. She said Resident #4 yelled at others and called her a cow. She said her Spanish was limited and could not understand everything that he said to her. She said Resident #3 does not enter her room. She said, He just yells at me indirectly when he passes by my room. They said this made her feel very anxious and frustrated because the facility staff were not doing anything to stop him from calling her names and yelling at her.Resident #4Review of Face Sheet dated 2/20/26 for Resident #4 revealed admission date 10/27/22.Review of History & Physical dated 2/09/26 for Resident #4 revealed [AGE] year-old male with diabetes, physical debility, and hypertension. Alert and oriented to person and place, forgetful. Cooperative and appropriate mood.Review of the Quarterly MDS dated [DATE] for Resident #4 Entry Date: 10/27/22. Clear speech, makes self-understood, understands others. BIMS Score: 14 (Cognitively intact); Verbal aggression (e.g. threating others, screaming at others, cursing at others). Wheelchair. Active Diagnoses: Hypertension, Diabetes Mellitus. Antidepressant.Review of the Care Plan revealed:-Date initiated: Resident #4 impaired thought processes/Dementia.-Date initiated: 11/10/25 Resident #4 had potential to be verbally aggressive r/t called another resident the cow. Approaches: Trauma assessment completed. Contracted health provider evaluation.3/01/25 Female Resident stated, this resident called her inappropriate names.Review of IDT noted dated 11/23/25 at 8:58 p.m., written by LVN O, revealed nurse was informed by 300 Hall nurse that Resident #4 was asked to leave female resident's room in 300. He used foul language towards CNA, verbally aggressive, raising tone of voice and exhibiting hostile behavior.Review IDT Note dated 11/20/25 written by the contracted health provider 11/20/25 for Resident #4 revealed Encounter: New Evaluation - Psychiatric Evaluation: Reason for Follow-Up: Staff requested- evaluate due to prior physical altercation with another patient. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Patriot	11490 Gateway North Blvd El Paso, TX 79934

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate for aggressive behavior. Treatment Plan: At this time patient is not an acute danger to self or others. Do not engage in arguing with resident regarding unreasonable requests made by the resident. Behavioral interventions: Redirect as needed.-Review of Telehealth Psych dated 11/06/25 at 3:30 p.m., written by NP - revealed When Resident #4 asked about incident of him calling other residents names, he shook his head, began pushing his wheelchair back and did not answer questions. Said bye to NP on screen. Note written by the previous RN DON AA.-Review of IDT Note dated 11/03/25 for Resident #4 revealed resident altercation was reported to HHSC via Tulip Intake #1047552.- Review of IDT Note dated 1/15/26 for Resident #4 written by LVN N complaining of roommate having TV too loud.-Review of IDT note dated 1/05/26 written by LVN N revealed Resident #4 was arguing with roommate, calling him names due to TV being too loud and does not let him sleep. Roommate's TV volume was lowered. Resident calm down.-Review of contracted psychological care provider for Resident #4 revealed Diagnostic assessment dated [DATE] Reason for referral: Verbal Aggression. Patient has been observed insulting male peers. Pt. has been observed yelling at his roommate and another male peer, insulting them. Pt denied instigating conflict. Pt's mood disturbance may be related to interpersonal stress. Diagnoses: Anxiety Disorder, Depressive Disorder. Treatment Plan: Address anxiety, interpersonal problems, irritability. Completed by: Ph. D, Licensed Psychologist.-Review of contracted psychological care provider note for Resident #4 revealed Subsequent assessment dated [DATE] Reason for referral: Verbal Aggression. Mental Status Examination Oriented To: Person, Place, Day, Month, Year, Situation, Speech: Fluent, Mood: Neutral, Affect: Mood Congruent, Thought Process: Logical Linear, Associations: Intact Association, Thought Content: WNL, Suicidal Ideation: None; Homicidal Ideation: None Risk ofAggression: Verbal; Insight: Fair; Judgement: Fair; Attention: WNL; Short Term Memory: Intact; Long Term Memory:Psychiatric Assessment for Resident #4-Review of Psychological Services Progress for Resident #4 revealed: Date of Service: 3/4/2026Visit Type: Psychotherapy Note. Mental Status Examination. Appearance/Behaviors: Polite, well groomed, Sensorium: Alert. Orientation: Person, Place, TimeDuring an observation on 2/20/26 at 11:55 a.m. revealed Resident #4 was sitting in a wheelchair in the dining room area with other residents waiting for lunch to be served.During a telephone interview on 2/20/26 at 11:14 a.m. with a friend of Resident #3 revealed Resident #4 yells and calls Resident #3 a cow and this has been going on for a year and a half. She said Resident #4 had been moved to another hall and still goes to call Resident #3 a cow. She said these behaviors happen more on the weekends. She said the weekend Receptionist X had witnessed this on the weekends. She said Resident #4 yelled at his roommate, called people names and was nasty to everyone. The friend said she had reported this to the Administrator last year and nothing was done. She said that the administrator was aware that Resident #4 threatens to hit Resident #3 who has MS and she does not have a lot of strength in her arms to defend herself. She said Resident #3 had snapped at Resident #4 because she tries to stop this man from harassing her. She said Resident #4 was in a wheelchair and wheeled himself everywhere in the facility. She said the administrator was not handling the problem.During an interview on 2/24/26 at 10:44 a.m. with CNA Y revealed Resident #4 was alert and oriented to person, place, and time, required minimal assistance with ADLS, chairbound and propels his wheelchair with his hands all over thefacility. She said she had never seen him go into other resident rooms. She said she had never seen him yell, swear, or call names to other residents. She said he spends a lot of time playing dominoes with a female Resident.During an interview and record review on 2/24/26 at 9:25 a.m. with LVN T assigned to Resident #4 on the 6 a.m. -2 p.m. shift revealed resident was alert, oriented to person, place, and time. He was independent with ADLs and only required minimal assistance with bathing. She said that he never entered other resident rooms. She said that approximately 3 months ago, there was an incident that was reported by Resident#3 about Resident #4 calling her names. She said she did not know where the incident had occurred. She said Resident #4 had no previous incidents related to this incident. LVN T said there was a Progress Note in Resident #4's electronic record dated 1/05/26 regarding name calling with roommate. She said (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 was receiving psychological services from contracted health provider and came to see him on a weekly basis. She said his family rarely visited Resident #4. She said he spends most of his time playing dominoes with a female resident all over the facility.During an observation and interview on 02/24/26 at 9:40 a.m. withe Resident #4 was sitting in a wheelchair in his room. He was talking to himself in a loud tone of voice and was making loud noises. He was oriented to person, place, time and situation. He said he had never insulted any of the residents. He said that he got very bothered by the noise that the oxygen machine made, that was used by his roommate and had requested a new roommate. Resident was pleasant and cooperative.During an observation on 2/24/26 at 10:07 a.m. revealed Resident #4 as sitting in a wheelchair in the dining room speaking loudly to himself.During an interview on 2/24/26 at 10:09 a.m. CNA Z revealed Resident #4 was alert, oriented to person, place, and time. She said Resident #4 wheeled his wheelchair independently and never wandered into other resident rooms. She said he speaks in a very loud tone of voice. She said that Resident #4 made other residents very uncomfortable with his loud tone of voice. She said he played dominos with a female resident everywhere in the facility. She said she had not witnessed Resident #4 insulting or name calling any of the residents.During an observation on 2/24/26evealed Resident #4 was wheeling his wheelchair by the nurse's station towards his room talking to himself and making loud noises.During an interview on 3/11/26 at 1:05 p.m. with Receptionist X revealed Resident #3 was alert and oriented to person, place, and time. She said that approximately a month ago Resident #4 was in the Living Room playing dominoes with another resident and Resident #3 was in the reception area talking to her. She said he heard Resident # 4 call Resident # 3 the cow. She said Resident #4 had done this before and she had moved Resident # 3. She said, I went to ask Resident #4 why he had called Resident # 3 a cow. She said she had not reported this to anyone at the facility and had told Resident # 4 that if he did it again, she was going to report to the Administrator. She said she had been trained to immediately report verbal abuse to the administrator. She said, I asked Resident #3 if she wanted me to report it and she said no. I told her that if it happened again, I'm going to have to report it. She said she had received a training by Email on ANE 7/01/25 and they had been trained to immediately report any abuse to the administrator. She said that Resident #3 had told her Resident #4 makes a loud noises when he passed by Resident #3's room such as Whoa that was very annoying behavior and that he just did that to Resident #3.During an interview on 3/01/26 at 1:14 p.m. the Administrator said the facility had reported an allegation of Resident Abuse to state office December 2025 involving Resident # 3 and Resident #4. Resident #4 had called Resident #3 a cow. Resident #3 scratched Resident #4 on the chest. He said he had talked to Receptionist X and told her that she was expected to Immediately report to him any resident abuse. He said, I was not aware of this being an on-going problem of Resident #4 calling Resident #3 a cow. He said facility staff had witnessed Resident #4 calling out the cow when he wheeled down the 300 Hall to go to therapy. He said he had told Resident #4 that he needed to be respectful to other residents and told him not to be making remarks that made other residents feel bad. He said the facility staff had been trained to immediately report to him any allegation of abuse, neglect, and mistreatment. He said failure to immediately report any allegation of abuse placed the residents at risk of further abuse.Review of facility's policy and procedure on Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 2021 revealed: Policy Statement - Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident symptoms. Policy Interpretation and Implementation: The Resident Abuse, Neglect and Exploitation Prevention Program consist of a facility wide commitment and resource allocations to support the following objectives. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone, including facility staff, other residents, staff form other agencies, family members, friends, visitors and/or any other individual. Develop and implement policies to prevent and identify them: Abuse or mistreatment of residence; Neglect of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents; and/or Theft, exploitation, or misappropriation of resident property. Ensure adequate staffing and oversight/Support. To prevent burnout, stressful working situations and high turnover rates. Provide staff orientation and training/orientation Programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive behavior. Investigate and report any allegations within timeframes required by federal requirements. Protect residents from any further harm during investigation.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 1 of 13 residents (Resident #1) reviewed for quality of care.-The facility failed to immediately notify the physician and/or nurse practitioner on [DATE] at 6:06 p.m. when the laboratory called to report WBC critical results for Resident #1. -The facility failed to immediately notify the physician on [DATE] of Resident #1's worsening condition, continued abdominal pain, elevated blood glucose at 563 and became unresponsive. Resident #1 was transferred to the hospital emergency room and expired on [DATE].-The facility failed to monitor blood glucose on Resident #1 when she as admitted to the facility on [DATE] and was taking multiple oral hypoglycemic medications to treat Diabetes Mellitus.An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 2:47 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for minimum harm, due to the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of delayed treatment/intervention, decline in health and/or death.Findings included:Record review of Resident #1's Face Sheet dated [DATE] revealed and original admission date of [DATE].Record review of Resident #1's Hospital ED Triage Note dated [DATE] at 4:28 p.m. revealed Chief Complaint: Unresponsive. Diagnoses: Altered Mental Status. Vitals: Pulse Rate 91, blood pressure 87/60. At 4:13 p.m. EMS Blood Glucose Check 561, SPO2 less than 90%, pt arrived being bagged by EMS, chest compressions were performed; 4:50 p.m. family member revoked hospital DNR/DNI over the phone. Emergent intubation at this time. While preparing for intubation pt pulse is no longer palpable, CPR started; 4:43 p.m. Patient intubated due to respiratory failure. At 5:00 p.m.; 4:59 p.m. EKG Post ROSC has hyperkalemia (low levels of potassium in the blood), severe acidosis (A life-threating condition where the body fluids or blood contain too much acid, overwhelming the body's ability to balance its pH), and hypoxia (a dangerous condition where the body's tissues and organs do not receive enough oxygen to function properly); 5:45 p.m. patient noted to have agonal respirations (a sign of cardiac arrest and severe lack of oxygen) and a faint pulse is placed back on ventilator. At 5:28 p.m. patient is becoming bradycardic (having a slow heart rate), no pulse felt at this time, witnessed arrest. Family members wished to discontinue CPR and resuscitation efforts at this time. Time of death 5:45 p.m.Record review of Medical Visit dated [DATE] at 10:29 a.m. written by attending physician revealed Reason for Visit follow up: c/o Abd pain and diarrhea. History: new Abd pain and diarrhea with low appetite ordered amylase and lipase and Pepto started. No other medical concerns reported DOS [DATE]. Summary of Findings: Abdominal pain diarrhea. Plan: Start Bentyl & Zofran PRN.Record review of Medical Visit dated [DATE] written by attending physician revealed: Reason for Visit: New c/o Abd pain and diarrhea. History: reporting new Abd pain and diarrhea with low appetite today. Plan: us Abd, basic labs including amylase and lipase ordered Lomotil.Record review of Resident #1's Radiology Report dated [DATE] revealed: Date of Exam: [DATE]. History: Unspecified abdominal pain. KUB X-Ray Kidney, Ureter, Bladder: Findings: There is no evidence to suggest bowel obstruction. Impression: No bowel obstruction or ileus. Reported to MD & NP [DATE] at 6:45 p.m.Record review of Radiology Report dated [DATE] for Resident #1 revealed, Date of Exam: [DATE]. History: abdominal discomfort. US Abdomen Impression: No acute process. Reported to MD & NP [DATE] at 6:45 p.m.Record review of Resident #1's admission MDS dated [DATE] revealed: Date of admission [DATE] from acute hospital. BIMS Summary Score: 15 Cognitively Intact. Active Diagnoses: Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Post Procedural Pain, Aftercare following surgical amputation, left below knee amputation High-Risk Drug Classes: Opioid. Discharge Plan already occurring for the resident to return to the community.Record review of Resident #1's Care Plan dated [DATE] revealed: -The resident has (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Diabetes Mellitus. Approaches: Diabetes Medication as ordered by doctor. Monitor/document for side effects and effectiveness. Educate resident/family as to the correct protocol for glucose monitoring. Monitor/document/report PRN any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Monitor for signs and symptoms of infection to any open areas: redness, pain, heat, swelling, or pus formation.-The resident is on pain medication therapy. Administer Analgesic medications as ordered by the physician. Monitor/Document side effects and effectiveness Q Shift. Monitor/Document/Report PRN adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, urinary retention. Review. For pain medication efficacy. Therapeutic regiment followed, but pain control not adequate, changes required.-The resident has potential for pain r/t Amputation Left leg below knee. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify previous responses to analgesia, including pain relief, side effects, and impact on function. Monitor/Document for side effects of pain medications. Observe for constipation, new onset of increased agitation, restlessness, confusion, hallucination, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician. Monitor/Record/Report to nurse loss of appetite, refusal to eat and weight loss. Monitor/record/report to Nurse resident complaints of pain or request for pain treatment. Notify physician if interventions are unsuccessful or a recurrent complaint is a significant change from residents past experience of pain.Record review of Physician Order Summary dated [DATE] for Resident #1 revealed: Order Date: [DATE] CBC w/Diff, Comprehensive Panel, Lipase, Amylase Order Date: [DATE] Abdominal Ultrasound; Order Date: [DATE] KUB; Order Date: [DATE] Stool Culture. Pain assessment to be completed every shift. Pharmacy: Order Date: [DATE] Dicyclomine HCL 20 mg Give one tablet by mouth two times a day for GI. Order Date: [DATE] Hydrocodone-Acetaminophen 7.5-325 mg Give one tablet by mouth every six hours as needed for pain. Order Date: [DATE] Insulin Glargine Subcutaneous Solution 100 unit/ml Inject 10 units subcutaneously at bedtime for DM. Order Date: [DATE] Insulin Lispro Injection Solution 100 unit/ml Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 5 units; 251 - 300 = 7 units; 301 - 350 = 10 units; 351 - 399 = 12 units. If >400 administer 14 units and notify MD, subcutaneously before meals and at bedtime for DM. Order Date: [DATE] Metformin HCl 500 mg give 1 tablet by mouth two times a day for DM. Order Date: Ondansetron HCl 4 mg give 1 tablet by mouth every 6 hours as needed for nausea. Order Date: [DATE] Pepto Bismol Oral Suspension give 30 ml by mouth every 6 hours as needed for upset stomach and loose stools. Order Date: [DATE] Pioglitazone HCl 30 mg give 1 tablet by mouth one time a day for DM. Order Date: [DATE] Sitagliptin 25 mg give 1 tablet by mouth one time a day for DM.Review of Medication Administration Record dated [DATE] for Resident #1 revealed, Order Date: [DATE] Pioglitazone HCl 30 mg give 1 tablet by mouth one time a day at 9:00 a.m. for DM. Order Date: [DATE] Sitagliptin 25 mg give 1 tablet by mouth one time a day at 9:00 a.m. for DM. Order Date: [DATE] Metformin HCl 500 mg give 1 tablet by mouth two times a day at 9:00 a.m. and 5:00 p.m. for DM.Review of Medication Administration Record dated February 2026 for Resident #1 revealed, Order Date: [DATE] Pioglitazone HCl 30 mg give 1 tablet by mouth one time a day at 9:00 a.m. for DM. Order Date: [DATE] Sitagliptin 25 mg give 1 tablet by mouth one time a day at 9:00 a.m. for DM. Order Date: [DATE] Metformin HCl 500 mg give 1 tablet by mouth two times a day at 9:00 a.m. and 5:00 p.m. for DM. Record review of Resident #1's Laboratory Lab Monitoring Sheet, not dated, filed in the 200 Hall Lab Binder revealed, Resident #1 CBC, CMP, Lipase and Amylase collected [DATE] with lab staff initials. Review of Lab Results Report dated [DATE] for Resident #1 in the resident's clinical record revealed: Collection Date: [DATE] 8:19 a.m. (Eastern Time); Date Reported: [DATE] at 22:45 p.m. (Eastern Time) Clinic Information: Status: Completed Flag: Red Octagon (Report contains critical results in red text). CBC w/Diff - WBC Result: CRITICAL HIGH 30.9 Unit: K/uL Ref. Range: 3.8-10.8 Flag HH Final. There was no documentation on the lab report that results had been reported to MD (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and/or NP on [DATE].During an interview and record review on [DATE] at 10:30 a.m., of the 24-Hour Report Sheets dated [DATE] through [DATE] with DON and ADON LVN C on [DATE] at 10:30 a.m. revealed the following-[DATE] at 1:07 p.m. LVN C had not documented in the 24-Hour Report sheet new order for CBC w/Diff, Comprehensive Panel, Lipase, and Amylase were ordered [DATE] for Resident #1. -[DATE] LVN C on 6-2 shift had not documented follow up on labs ordered on [DATE] for Resident #1.-[DATE] LVN D on 2-10 shift had not documented follow up on labs ordered on [DATE] for Resident #1.-[DATE] LVN H on the 10-6 had not documented labs were done in the morning for Resident #1.-[DATE] LVN C on the 6-2 shift had not documented labs were completed on [DATE] 8:19 a.m. (Eastern Time) for Resident #1 and were pending results.-[DATE] LVN D on the 2-10 shift had not documented labs drawn in a.m. for Resident #1 and were pending results.Record review of Resident #1's Nurse Note dated [DATE] at 1:35 p.m. written by DON revealed: spoke to resident's family member by weekend supervisor family wants to leave AMA. Family was informed we could provide the care in-house and agreed for resident to be treated in the facility. DON then spoke to Medical Director over the phone with RN weekend supervisor per physician, initiate orders for blood glucose checks prior to meals and bedtime. Resident to be place on a medium dose insulin sliding scale. DON to report morning fasting glucose levels over next 24-48 hours for further review. Record review of Resident #1's Nurse Note dated [DATE] at 2:55 p.m. written by LVN B revealed: Upon doing rounds, pt was crying and stating pain to abdomen area, PRN Hydrocodone administered, pt stated pain decreased but 30 minutes later increased to 8/10. Family arrived, pt showed to be agitated and irritable. BS checked with reading of 473 mg/dl Family stated wanted to have pt leave AMA, notified DON and spoke to pt family and informed that if leaves AMA not able to come back. Family agreed to have pt. stay in facility. Notified attending physician by phone and ordered BS checks ac and Hs, with moderate sliding scale and to give Lispro 10 units STAT. Administered 10 units to back of left arm. Pt tolerated well. Rechecked BS 45 minutes later and BS increased to 515 mg/dl Pt clammy, and stated feels sleepy. Notified attending physician and ordered to D/C moderate sliding scale and start patient on high sliding scale and to give 14 units of Lispro STAT, and to give the Lantus 10 units as well. Administered both to back of right arm. Pt tolerated well. Educated family on purpose of each insulin. Will continue to monitor.Record review of Resident #1's Nurse Note dated [DATE] at 3:35 p.m. written by DON revealed LATE ENTRY: Informed by weekend supervisor labs pending review from Friday have not been reported to physician, DON informed RN to inform MD for further evaluation and review. CN reported lab values to physician and is awaiting orders. Resident's Glucose continues to trend up and is now 567, informed to encourage oral fluids, as per weekend supervisor resident has received 14 units of lispro and 10 units of Lantus, as per MD order. Resident to be encouraged to increase oral fluid intake.Record review of Resident #1's Nurse Note dated [DATE] at 3:45 p.m. written by DON revealed: LATE ENTRY: DON received a call from weekend supervisor, stating the resident's condition is starting to deteriorate aeb fixed pupils and resident is increasingly lethargic with little improvement, as per weekend supervisor attempts made to notify physician and NP, with no answer. DON notified supervisor to send resident out to the ER due to change in condition.Record review of Resident #1 eINTERACT SBAR Summary dated [DATE] at 4:00 p.n. written by LVN B revealed: Situation: Abdominal pain/Altered mental status. Pulse: 194, Respirations 12, Blood Glucose 563, Relevant Medical History: Diabetes. Review and Notify: Primary Care Clinician Notified: Yes [DATE] at 4:00 p.m.Record review of Resident #1's Nurse Note dated [DATE] at 4:03 p.m. written by LVN B revealed: Upon further assessment pt became unresponsive, clammy, HR elevated to 194, family at bedside, notified attending physician by phone, with no answer, sent group message to attending physician and FNP, no response, EMS activated via 911, decision to be sent to hospital based on symptoms above. Family concurred with decision to be sent to hospital. Review of Administration Note dated [DATE] at 5:56 a.m. for Resident #1 written by LVN H revealed PRN Administration was: Effective. Follow-up Pain Scale was: 0Review of Administration Note dated [DATE] at 5:09 a.m. for Resident #1 written by LVN H revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tablet by mouth every 6 hours as needed for Pain.Review of Nurses Notes dated [DATE] at 4:25 a.m. for Resident #1 written by LVN H revealed Resident observed crying and stated her stomach hurts and that she has not eaten in days. Lips noted to be dry. Pain medication offered and education provided on purpose and benefits; resident refused at this time.Review of Administration Note dated [DATE] at 4:13 a.m. written by LVN H for Resident #1 revealed PRN Administration was: Effective. Follow-up Pain Scale was: 0Review of Administration Note dated [DATE] at 11:11 p.m. written by LVN H for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of Administration Note dated [DATE] at 8:59 a.m. written by LVN C for Resident #1 revealed PRN Administration was: Effective. Follow-up Pain Scale was: 3Review of Administration Note dated [DATE] at 8:10 a.m. written by LVN C for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of Administration Note dated [DATE] at 4:13 a.m. written by LVN C for Resident #1 revealed PRN Administration was: Effective. Follow-up Pain Scale was: 0Review of Administration Note dated [DATE] at 3:13 a.m. written by LVN H for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain.Review of Medication Administration Record dated February 2025 for Resident #1 revealed Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for Pain was administered on:-[DATE] at 5:09 a.m. for Pain Level 7 by LVN H-[DATE] at 3:13 am for Pain Level 10 by LVN H-[DATE] at 8:10 am for Pain Level 8 by LVN C-[DATE] at 11:11 p.m. for Pain Level 7 by LVN HReview of Witness Statement dated [DATE] written by LVN F revealed, On February 20, 2026, I LVN F answered the phone at nurse's station for a critical lab result for Resident #1 for WBC at 30.9 and immediately reported it to nurse LVN D in hall 200 with lab information in a piece of paper which I gave to her in her hand and emphasized the critical lab result. I also encouraged her to double check on the portal as the lab guy had an accent. She acknowledged my statement and said okay. Who later failed to report results to MD. This event was witnessed by Med Aide J.Review of Witness Statement dated [DATE] written by LVN D revealed, on [DATE] I LVN D was LVN attending 200 Hall. I was attending Resident #1. As of this date, I do not recall receiving any critical lab results on [DATE].Record review of facility's camera video dated [DATE] provided by Administrator revealed LVN F answered the telephone at the nurse's stations, walked down the 200 Hall with a piece of paper in his right hand, and was seen talking to LVN D who was assigned to Resident #1 and handed her a piece of paper after the laboratory called the facility at 6:06 p.m. to report WBC Critical Lab values.Review of Witness Statement dated [DATE] written by DON revealed I was notified by the weekend supervisor on the date of [DATE] of a residents Blood Sugar of 470. I had the weekend supervisor on the phone and called the physician, on the call, the doctor was notified of how resident was presenting and the blood sugar being above 470, orders obtained by the physician to place resident on medium dose insulin sliding scale and to give 10 units of Lantus. Order place in PCC by weekend supervisor. I then received a call about an hour later the RN supervisor spoke to physician and orders received to give additional insulin, informed by supervisor that Blood Glucose is trending up and They (CN/supervisor) were unable to get ahold of physician. That's when I said to send resident via EMS to ER. At 4;36 physician contacted me stating during the week we would need to analyze the case as there were a couple of missed opportunities that we needed to address, was informed by physician labs were not reported to him on the 20th. Informed the physician that I would look into why it wasn't reported. Physician then stated if he would have known, based on the labs he would have sent her out.Review of Witness Statement dated [DATE] written by LVN B revealed, Upon arrival to patient's room, family had brought glucometer from home and checked pt. blood sugar on own with reading of 495 mg/dl. Pt was responsive and stated pain to abdomen area. Nurse notified RN Supervisor of results, then notified attending physician of results. Received phone order, and order was to start pt on Moderate Sliding Scale and give 10 units of Lispro STAT and to give Lantus 10 units every night and to recheck in about an hour and to report results. Nurse gave the units of Lispro (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and pt tolerated well. Rechecked at 2:30 p.m. and BS elevated to 517 mg/dl. Notified Attending physician by phone and ordered D/C Moderate Sliding Scale and to increase to High Sliding Scale and to give 14 units of Lispro STAT along Lantus 10 units STAT as well. Nurse found labs that had not reported which were in system and had a critical value 30.9 RN supervisor and Physician by sending photo text to physician with no new orders and did not respond. Rechecked BS at 3:35 PM with results of 563 mg/dl. Notified physician by phone and text with no response back. Pt. started to become excessively clammy and became unresponsive. Notified physician and FNP Q by phone and text with no response back through phone or by text. Due to pt symptoms activated EMS via 911, and family was in agreement to call 911. Upon arriving of EMS, Family left with EMS and was taken to hospital.During a telephone interview on [DATE] at 2:07 p.m. with a family member revealed Resident #1 had not been feeling well for approximately two weeks. The Family member said that a week prior to sending the resident to the hospital on [DATE] the resident was complaining of stomach pain, was throwing up, not eating and had diarrhea. The Family member said she had reported this to LVN D during the week and LVN D had said, The resident has dementia and is making it up and she did not go to assess the resident. The Family member said they had visited the resident on Friday [DATE] and took her out to eat and she ate very little. The Family member said they visited the resident on Saturday [DATE] and she was very sleepy and was not eating. The Family member said on Sunday [DATE] when several family members went to visit the resident at the nursing home at approximately 9:00 -9:30 a.m., the resident was still complaining of abdominal pain, nausea and she looked very weak. The Family member said that on Sunday [DATE] when they went to visit the resident, one of the family members took the resident's glucometer from home to the nursing home, because they were concerned about the resident's condition and suspected the nurses were not checking the resident's blood sugar. The Family member said the family took care of the resident at home and checked her blood sugar once a day in the morning. The Family member said they wanted to take the resident home on [DATE] because the resident's blood sugar checks had not been done since she was admitted to the nursing home on [DATE] and the nursing home staff were not providing the resident with the necessary care to treat her symptoms. The Family member said RN A weekend supervisor, had provided her with the AMA form and had signed the AMA form. The Family member said she had started to prepare to take the resident home in her private vehicle when she was informed by the DON that if they took the resident AMA, Medicare/Medicaid would not pay for the resident's care at the nursing home and the family would be responsible for paying for all the care and services provided to the resident at the facility. The Family member said the DON told them that it would take 2-3 days for them to get medical clearance from the physician for them to take the resident home. The Family member said the DON told her that there was no need to send resident to the hospital, because they were able to treat the resident at the nursing home. The Family member said At 1:00 p.m., on that day the resident looked very sick, so I checked her blood sugar, and it was at 451. The Family member told the surveyor she had a picture of the glucometer to show that family member had checked resident's blood glucose two times on [DATE] because the resident's condition appeared to be worsening. The Family member said they could not remember who had informed them on [DATE] that the nurses had not reported to physician the resident's lab results done on [DATE]. The Family member said LVN B had notified the physician [DATE] of the resident's blood sugar level of 451 and had given an order to administer insulin. The Family member said LVN B and RN A had used a vial of insulin that had pharmacy label for another resident when they administered the insulin to Resident #1 on [DATE]. The Family member said the family member had rechecked the resident's blood glucose 45 minutes after the insulin was administered and the blood sugar was at 517. The Family member said they were concerned because the blood sugar was higher after the insulin had been administered. She said LVN B rechecked the resident's blood sugar for the second time and it was higher after the insulin had been administered. The Family member said resident was still conscious and kept saying that she felt like she was dying. The Family member said EMS was finally (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	called by the nurses and when EMS arrived at the facility Resident #1 was already unresponsive. The Family member said Resident #1 had coded twice in the emergency room at the hospital and died due to ketoacidosis (a life threating emergency complication of diabetes, occurring when the body lacks enough insulin to use glucose for energy). During an interview on [DATE] at 2:25 p.m. with the DON revealed Resident #1 was sent to the hospital via EMS on [DATE] due to high blood glucose and was unresponsive and had expired in the hospital on that day. He said RN A Weekend supervisor had reported to him on [DATE] that LVN B had reported to her Resident #1's blood sugar was at 473, MD was notified and gave a new order for Moderate Dose Sliding Scale coverage, and blood glucose checks ac meals and HS. He said the physician had also given a new order to start the resident on Lantus. The DON said the residents' blood continued to increase above 500 on that day and they had made multiple attempts to contact the physician and NP on [DATE] and they did not answer their group text messages and/or telephone calls. The DON said the attending physician who was also the facility's Medical Director was out of town on vacation on [DATE], So, I instructed the nurse to call EMS and send the resident to the hospital. He said LVN B had called EMS right away and the resident was transported to hospital. He said the resident's family was at the facility with the resident on that day, until the resident was sent to the hospital. The DON said the resident had started to complain of abdominal pain, diarrhea on [DATE] and the physician had ordered a KUB, ultrasound of the abdomen and labs. He said KUB and Ultrasound of the abdomen did not show abnormal results. The DON said the family wanted to take her home on [DATE] in their private vehicle and RN A had given the family the AMA form to sign. He said the family was upset because the resident's condition continued to decline and then they decided to leave her at the facility. He said he was not aware labs were drawn on [DATE] until [DATE] when LVN B notified him after the resident had been sent to the hospital that Critical Lab results were showing in the resident's electronic under Lab Results Critical Lab results received on [DATE] were showing as pending review. He said, That meant Critical Lab results had not been reported to the physician and/or NP on [DATE]. He said Critical Lab values must be immediately reported to the physician and/or NP and notification show be documented in the resident's electronic record.During an interview on [DATE] at 2:42 p.m., with the Administrator, DON and ADON C revealed Resident #1 had been sick for several days complaining of abdominal pain, nausea, and vomiting. The DON said the physician had been called on [DATE] and gave orders for a KUB, ultrasound of the abdomen and labs. The surveyor asked DON and ADON if they were aware that Critical Lab values for WBC had not been reported to the physician and/or NP on [DATE]. The DON said, Yes, LVN B called me on Sunday [DATE] to report that he was reviewing the resident's clinical record after Resident #1 had been sent to the hospital on that day and had noted that the Critical Lab results received on [DATE] were pending review in the resident's electronic record. That meant that the lab results had not been reported to the attending physician and/or NP. The DON said he had called their Corporate RN on [DATE] to inform her that Critical Lab values for Resident #1 had not been reported to the attending physician on [DATE]. The DON said the Corporate Nurse had instructed him to audit labs on all residents to ensure they were drawn, and results had been reported to the physician and/or NP. The DON said the corporate nurse also requested in-service training for the licensed staff on notification of changes in condition to physician and responsible party, documentation of AMS, labs and decline in condition. The DON said they had discussed the missed labs with the Administrator, ADONs, Medical Director, who was Resident #1 attending physician FNP, ADONs and MDS Nurses on [DATE]. The DON said they had in-serviced the staff on reporting changes in condition, reporting lab results and documentation in the resident's clinical record on [DATE]. The surveyor requested copies of the lab audits initiated on [DATE] and copies of in-service records. ADON E said, We started the lab audits on [DATE] and have not completed the lab audit as of today [DATE]. The state surveyor requested a copy of the audits started on [DATE]. The ADON E said We will complete the lab audits today [DATE] as soon and give you a copy. ADON C said Licensed Staff had been trained to call 911 and send the resident to the emergency room for critical (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	change of condition if they could not get a whole of the physician and/or NP and then notify the physician and/or NP after the resident had been sent to the hospital. She said she did not know if LVN B had notified the physician and/or the nurse practitioner the resident was sent to the ER via EMS. She said the DON had informed Resident #1's attending that the nurses had called and sent a group text to him and his NP and that neither had answered their group text messages and/or telephone calls, so the DON had instructed LVN B to call 911 and send resident to the ER via ambulance. She said she did not know if LVN B had documented the notification in the resident's electronic record.During a Telephone interview on [DATE] at 11:18 a.m. with LVN B revealed Resident #1 complained of abdominal pain on [DATE] and had administered PRN Hydrocodone. He said blood glucose check had been done by resident's family on [DATE] at 2:55 p.m. and the physician was notified and ordered blood glucose checks ac meals and HS and had started the resident on Moderate Sliding Scale coverage. He said he had administered 10 units of the Lispro stat and could not remember the time the insulin was administered. He said he had rechecked the resident's blood glucose again 45 minutes later after the insulin was administered and it when up to 517 and the resident complained of being sleepy. He said he had notified the physician a second time, and the physician gave orders to discontinue the Moderate Sliding Scale coverage and to start the resident on High Sliding Scale coverage and to administer 14 units of Lispro and to also administer10 units of Lantus. He said he had not documented the actual times the blood glucose checks were done or when the insulin was administered in the resident's electronic record. He said they had been trained to document the date and times when blood glucose checks were done and administered insulin according to physician's orders. He said they did not have Lantus in the Insulin Ekit and RN A weekend supervisor had borrowed a vial from another resident. He said that at approximately 4:03 p.m., the resident became clammy, unresponsive Heart Rate was 194, family was in the room with the resident. He said he had called the physician and NP, and they had not answered his call. He said he sent the physician/NP a group text message and had not responded so he called the DON to report the situation and he instructed him to call 911 and send the resident to the Emergency Room. The state surveyor requested a screen shot of the text message.During an interview on [DATE] at 11:18 a.m. with RN A Weekend Supervisor revealed LVN C worked on [DATE] during the morning shift. She said, LVNtold me the family member had checked the resident's blood glucose, and I told him to notify the physician and DON to see what they wanted to do. The family member told LVN B they wanted to take the resident to the hospital. She said, I notified the DON and LVN B that I had notified the physician. That is when the doctor ordered blood glucose checks ac and HS and new orders for insulin. She said the DON talked to the family and he informed the physician that the family wanted to take the resident to the hospital. The DON told her the physician wanted to start the resident on insulin and to keep her at the facility. She said LVN B had rechecked the blood glucose after the first dose of insulin was administered and notified the physician that the blood glucose was higher and physician gave a new order for insulin.During a telephone interview on [DATE] at 11:34 a.m. with LVN B revealed he could not remember which family member had told him that they wanted to take the resident to the hospital. He said he had checked the resident's blood glucose after the resident's family member informed him that they had checked the resident's blood glucose. They said the first blood glucose was 473 and he had notified the physician and got new orders for blood glucose checks and HS and to start the resident on Moderate Sliding Scale coverage. He said he had rechecked the resident's blood glucose at 2:20 p.m. and blood glucose had i

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure another physician supervises the medical care of residents when their attending physician is unavailable for 1 (Resident #1) of 13 residents reviewed for physician services.The facility failed to ensure another physician was available to supervise the medical care for Resident #1's when her condition continued to worsen, continued abdominal pain, elevated blood glucose at 563 and became unresponsive. Resident #1 was transferred to the hospital emergency room and expired on [DATE].This failure could place residents at risk of delayed treatment/intervention, decline in health and/or death.Findings included:Closed record review of the Face Sheet dated [DATE] for Resident #1 revealed, original admission date [DATE].Review of admission MDS for Resident #1 dated [DATE] revealed: Date of admission [DATE] from acute hospital. BIMS Summary Score: 15 Cognitively Intact. Active Diagnoses: Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Post Procedural Pain, Aftercare following surgical amputation, left below knee amputation High-Risk Drug Classes: Opioid. Discharge Plan already occurring for the resident to return to the community.Review of Care Plan for Resident #1 dated [DATE] revealed:-The resident has Diabetes Mellitus. Approaches: Diabetes Medication as ordered by doctor. Monitor/document for side effects and effectiveness. Educate resident/family as to the correct protocol for glucose monitoring. Monitor/document/report PRN any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Monitor for signs and symptoms of infection to any open areas: redness, pain, heat, swelling, or pus formation.-Resident has infection diagnosis of Gangrene. Pain medication therapy. Monitor/Document/Report to MD signs and symptoms of delirium, changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness, agitation. altered sleep cycle.-The resident is on pain medication therapy. Administer Analgesic medications as ordered by the physician. Monitor/Document side effects and effectiveness Q Shift. Monitor/Document/Report PRN adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, urinary retention. Review. For pain medication efficacy. Therapeutic regiment followed, but pain control not adequate, changes required.-The resident has potential for pain r/t Amputation Left leg below knee. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify previous responses to analgesia, including pain relief, side effects, and impact on function. Monitor/Document for side effects of pain medications. Observe for constipation, new onset of increased agitation, restlessness, confusion, hallucination, dysphoria, nausea, vomiting, dizziness and falls. Report occurrences to the physician. Monitor/Record/Report to nurse loss of appetite, refusal to eat and weight loss. Monitor/record/report to Nurse resident complaints of pain or request for pain treatment. Notify physician if interventions are unsuccessful or a recurrent complaint is a significant change from residents past experience of pain.Review of Medical Visit dated [DATE] written by attending physician revealed Reason for Visit: New c/o Abd pain and diarrhea. History: reporting new Abd pain and diarrhea with low appetite today. Plan: us Abd, basic labs including amylase and lipase ordered Lomotil.Review of Radiology Report dated [DATE] for Resident #1 revealed, Date of Exam: [DATE]. History: Unspecified abdominal pain. KUB X-Ray Kidney, Ureter, Bladder: Findings: There is no evidence to suggest bowel obstruction. Impression: No bowel obstruction or ileus. Reported to MD & NP [DATE] at 6:45 p.m.Review of Radiology Report dated [DATE] for Resident #1 revealed, Date of Exam: [DATE]. History: abdominal discomfort. US Abdomen Impression: No acute process. Reported to MD & NP [DATE] at 6:45 p.m.Review of Medical Visit dated [DATE] at 10:29 a.m. written by attending physician revealed Reason for Visit follow up: c/o Abd pain and diarrhea. History: new Abd (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain and diarrhea with low appetite ordered amylase and lipase and Pepto started. No other medical concerns reported DOS [DATE]. Summary of Findings: Abdominal pain diarrhea. Plan: Start Bentyl & Zofran PRN.Review of the Hospital ED Triage Note dated [DATE] at 4:28 p.m. for Resident #1 revealed Chief Complaint: Unresponsive. Diagnoses: Altered Mental Status. Vitals: Pulse Rate 91, blood pressure 87/60. At 4:13 p.m. EMS Blood Glucose Check 561, SPO2 less than 90%, pt arrived being bagged by EMS, chest compressions were performed; 4:50 p.m. family member revoked hospital DNR/DNI over the phone. Emergent intubation at this time. While preparing for intubation pt pulse is no longer palpable, CPR started; 4:43 p.m. Patient intubated due to respiratory failure. At 5:00 p.m.; 4:59 p.m. EKG Post ROSC has hyperkalemia, severe acidosis, and hypoxia; 5:45 p.m. patient noted to have agonal respirations, and a faint pulse is placed back on ventilator. At 5:28 p.m. patient is becoming bradycardic, no pulse felt at this time, witnessed arrest. Family members wished to discontinue CPR and resuscitation efforts at this time. Time of death 5:45 p.m.Review of Nurse Note dated [DATE] for Resident #1 at 4:03 p.m. written by LVN B revealed Upon further assessment pt became unresponsive, clammy, HR elevated to 194, family at bedside, notified attending physician by phone, with no answer, sent group message to attending physician and FNP, no response, EMS activated via 911, decision to be sent to hospital based on symptoms above. Family concurred with decision to be sent to hospital.Review of eINTERACT SBAR Summary dated [DATE] for Resident #1 at 4:00 p.m. written by LVN B revealed Situation: Abdominal pain/Altered mental status. Pulse: 194, Respirations 12, Blood Glucose 563, Relevant Medical History: Diabetes. Primary Care Clinician Notified: Yes [DATE] at 4:00 p.m.Review of Nurse Note dated [DATE] for Resident #1 at 3:45 p.m. written by DON revealed LATE ENTRY: DON received a call from weekend supervisor, stating the resident's condition is starting to deteriorate aeb fixed pupils and resident is increasingly lethargic with little improvement, as per weekend supervisor attempts made to notify physician and NP, with no answer. DON notified supervisor to send resident out to the ER due to change in condition.Review of Physician Order Summary dated [DATE] Resident #1 revealed: Order Date: [DATE] CBC w/Diff, Comprehensive Panel, Lipase, Amylase Order Date: [DATE] Abdominal Ultrasound; Order Date: [DATE] KUB; Order Date: [DATE] Stool Culture. Pain assessment to be completed every shift. Pharmacy: Order Date: [DATE] Dicyclomine HCL 20 mg Give one tablet by mouth two times a day for GI. Order Date: [DATE] Hydrocodone-Acetaminophen 7.5-325 mg Give one tablet by mouth every six hours as needed for pain. Order Date: [DATE] Insulin Glargine Subcutaneous Solution 100 unit/ml Inject 10 units subcutaneously at bedtime for DM. Order Date: [DATE] Insulin Lispro Injection Solution 100 unit/ml Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 5 units; 251 - 300 = 7 units; 301 - 350 = 10 units; 351 - 399 = 12 units. If >400 administer 14 units and notify MD, subcutaneously before meals and at bedtime for DM. Order Date: [DATE] Metformin HCl 500 mg give 1 tablet by mouth two times a day for DM. Order Date: Ondansetron HCl 4 mg give 1 tablet by mouth every 6 hours as needed for nausea. Order Date: [DATE] Pepto Bismol Oral Suspension give 30 ml by mouth every 6 hours as needed for upset stomach and loose stools. Order Date: [DATE] Pioglitazone HCl 30 mg give 1 tablet by mouth one time a day for DM. Order Date: [DATE] Sitagliptin 25 mg give 1 tablet by mouth one time a day for DM.Review of Witness Statement dated [DATE] written by DON revealed I was notified by the weekend supervisor on the date of [DATE] of a residents Blood Sugar of 470. I had the weekend supervisor on the phone and called the physician, on the call, the doctor was notified of how resident was presenting and the blood sugar being above 470, orders obtained by the physician to place resident on medium dose insulin sliding scale and to give 10 units of Lantus. Order place in PCC by weekend supervisor. I then received a call about an hour later the RN supervisor spoke to physician and orders received to give additional insulin, informed by supervisor that Blood Glucose is trending up and They (CN/supervisor) were unable to get ahold of physician. That's when I said to send resident via EMS to ER. At 4;36 physician contacted me stating during the week we would need to analyze the case as there were a couple of missed opportunities that we needed to address, was informed by physician labs were not reported to him on the 20th. Informed the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avir at Patriot		STREET ADDRESS, CITY, STATE, ZIP CODE 11490 Gateway North Blvd El Paso, TX 79934	

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician that I would look into why it wasn't reported. Physician then stated if he would have known, based on the labs he would have sent her out.Review of Witness Statement dated [DATE] written by LVN B revealed, Upon arrival to patient's room, family had brought glucometer from home and checked pt. blood sugar on own with reading of 495 mg/dl. Pt was responsive and stated pain to abdomen area. Nurse notified RN Supervisor of results, then notified attending physician of results. Received phone order, and order was to start pt on Moderate Sliding Scale and give 10 units of Lispro STAT and to give Lantus 10 units every night and to recheck in about an hour and to report results. Nurse gave the units of Lispro and pt tolerated well. Rechecked at 2:30 p.m. and BS elevated to 517 mg/dl. Notified Attending physician by phone and ordered D/C Moderate Sliding Scale and to increase to High Sliding Scale and to give 14 units of Lispro STAT along Lantus 10 units STAT as well. Nurse found labs that had not reported which were in system and had a critical value 30.9 RN supervisor and Physician by sending photo text to physician with no new orders and did not respond. Rechecked BS at 3:35 PM with results of 563 mg/dl. Notified physician by phone and text with no response back. Pt. started to become excessively clammy and became unresponsive. Notified physician and FNP Q by phone and text with no response back through phone or by text. Due to pt symptoms activated EMS via 911, and family was in agreement to call 911. Upon arriving of EMS, Family left with EMS and was taken to hospital. During an interview on [DATE] at 2:25 p.m. with DON revealed Resident #1 was sent to the hospital via EMS on [DATE] due to high blood glucose and was unresponsive and had expired in the hospital on that day. He said RN A Weekend supervisor had reported to him on [DATE] that LVN B had reported to her Resident #1's blood sugar was at 473, MD was notified and gave a new order for Moderate Dose Sliding Scale coverage, and blood glucose checks ac meals and HS. He said the physician had also given a new order to start the resident on Lantus. The DON said the residents' blood continued to increase above 500 on that day and they had made multiple attempts to contact the physician and NP on [DATE] and they did not answer their group text messages and/or telephone calls. The DON said the attending physician who was also the facility's Medical Director was out of town on vacation on [DATE] and the physician's NP assigned to the facility did not answer the telephone call and/or text messages So, I instructed the nurse to call EMS and send the resident to the hospital. He said LVN B had called EMS right away and the resident was transported to hospital.During an interview on [DATE] at 2:42 p.m., with Administrator, DON and ADON C revealed Resident #1 had been sick for several days complaining of abdominal pain, nausea, and vomiting. The DON said the physician had been called on [DATE] and gave orders for a KUB, ultrasound of the abdomen and labs. The surveyor asked DON and ADON if they were aware that Critical Lab values for WBC had not been reported to the physician and/or NP on [DATE]. The DON said, Yes, LVN B called me on Sunday [DATE] to report that he was reviewing the resident's clinical record after Resident #1 had been sent to the hospital on that day and had noted that the Critical Lab results received on [DATE] were pending review in the resident's electronic record. That meant that the lab results had not been reported to the attending physician and/or NP. ADON C said Licensed Staff had been trained to call 911 and send the resident to the emergency room for critical change of condition if they could not get a whole of the physician and/or NP and then notify the physician and/or NP after the resident had been sent to the hospital. She said she did not know if LVN B had notified the physician and/or the nurse practitioner the resident was sent to the ER via EMS. She said the DON had informed Resident #1's attending physician that the nurses had called and sent a group text to him and his NP and that neither had answered their group text messages and/or telephone calls, so the DON had instructed LVB B to immediately call called 911 and send resident to the ER via ambulance. She said she did not know if LVN B had documented the notification in the resident's electronic record.During a Telephone interview on [DATE] at 11:18 a.m. with LVN B revealed Resident #1 complained of abdominal pain on [DATE] and had administered PRN Hydrocodone. He said blood glucose check had been done by resident's family on [DATE] at 2:55 p.m. and the physician was notified and ordered blood glucose checks ac meals and HS and had started the resident on Moderate Sliding Scale (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coverage. He said he had administered 10 units of the Lispro stat and could not remember the time the insulin was administered. He said he had rechecked the resident's blood glucose again 45 minutes later after the insulin was administered and it when up to 517 and the resident complained of being sleepy. He said he had notified the physician a second time, and the physician gave orders to discontinue the Moderate Sliding Scale coverage and to start the resident on High Sliding Scale coverage and to administer 14 units of Lispro and to also administer10 units of Lantus. He said he had not documented the actual times the blood glucose checks were done or when the insulin was administered in the resident's electronic record. He said they had been trained to document the date and times when blood glucose checks were done and administered insulin according to physician's orders. He said they did not have Lantus in the Insulin Ekit and RN A weekend supervisor had borrowed a vial from another resident. He said that at approximately 4:03 p.m., the resident became clammy, unresponsive Heart Rate was 194, family was in the room with the resident. He said he had called the physician and NP, and they had not answered his call. He said he sent the physician/NP a group text message and had not responded so he called the DON to report the situation and he instructed him to call 911 and send the resident to the Emergency Room. The state surveyor requested a screen shot of the text message.Review of a copy of a screen shot sent to surveyor on [DATE] at 11:16 a.m. by LVN B revealed call placed to NP for Resident #1 Sunday at 1:23 PM 12 seconds to physician/NP. Call placed to attending physician Sunday [DATE] at 1:25 PM by LVN B to physician cancelled call. Outgoing Call [DATE] at 2:45 PM to physician 1 minute by LVN B. Incoming Call Sunday [DATE] at 3:38 PM by DON to LVN B 2 minutes. Outgoing Call [DATE] at 3:43 PM to NP/Attending Physician 5 seconds. Outgoing Call Sunday 3:44 PM 911 3 minutes.Review of a copy of text message screen shot sent to surveyor on [DATE] at 11:16 a.m. by LVN B revealed: Sunday at 4:00 PM to physician by LVN B Resident sent to hospital, HR 194, BS elevated to 563, pt became unresponsive. Sunday 3:37 PM sent by LVN B Just rechecked BS gave her the Lispro 14 units and Lantus 10 units at 2:40 p.m. and just rechecked BS with reading of 563 mg/dl, was looking at labs to see if we could do labs and saw these on [DATE], not sure if these were sent to you. LVN B attached a copy of the lab report dated [DATE] to text message.Telephone call was placed [DATE] at 11:24 a.m., to Resident #1's attending physician. There was no answer, left message to call state surveyor.During a telephone interview on [DATE] at 12:08 p.m. with the attending physician for Resident #1 revealed he was also the facility's Medical Director. He said the nurses had not called him on [DATE] to report Resident #1's blood glucose continued to rise after sliding scale coverage had been administered or that the resident became unresponsive. The Physician was informed by state surveyor that the evening nurse had reported he had placed a group telephone call and had sent a group text message to him and his NP on [DATE] when Resident #1 became unresponsive and the nurse had not received a call back and/or text message from him and/or NP. The physician said, That is not true. That is monstrously false. I have several NPs and designate an NP assigned to the facility. We are always available by telephone and/or group text so there is no need for me to have an alternate physician when I go out of town. He said he expected the nurses to immediately report Critical Lab values to him and/or the NP. He said the critical lab values for the WBC is an indication the resident is going into sepsis and the increased blood glucose levels is the body's stress response that showed the resident was acutely ill and going into full sepsis. He said the facility needed to work on better communication between physicians and NP to prevent this from happening. He said the Lab should call the physicians directly for Critical Lab values. He said the nurses should have notified me and/or NP that the resident continued to complain of abdominal pain [DATE] - [DATE] if prescribed medications are ineffective so that a medical decision could be made regarding treatment options.Telephone call placed to FNP Q on [DATE] at 4:43 p.m., there was no answer, left message to call state surveyor back. Return call pending. NP did not return telephone call prior to exit.The state surveyor requested a copy of the facility's policy and procedure on physician services from the DON on [DATE] and was not provided prior to exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 13 Residents (Resident #1) reviewed for medication administration.:The facility failed to ensure facility's emergency insulin kit contained Lantus to use in an emergency when Resident #1's blood glucose reading was at 517 on [DATE]. The physician gave a STAT order for Lantus and was not available in the facility's emergency insulin kit. The nurse borrowed a Lantus insulin vial that belonged to another resident.This failure could place residents at risk of not receiving prescribed medications that could result in delayed medical treatment and decline in medical condition.Findings included:Closed record review of the Face Sheet dated [DATE] for Resident #1 revealed, original admission date [DATE].Review of admission MDS for Resident #1 dated [DATE] revealed: Date of admission [DATE] from acute hospital. BIMS Summary Score: 15 Cognitively Intact. Active Diagnoses: Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Post Procedural Pain, Aftercare following surgical amputation, left below knee amputation High-Risk Drug Classes: Opioid. Discharge Plan already occurring for the resident to return to the community.Review of Care Plan for Resident #1 dated [DATE] revealed:-The resident has Diabetes Mellitus. Approaches: Diabetes Medication as ordered by doctor. Monitor/document for side effects and effectiveness. Educate resident/family as to the correct protocol for glucose monitoring. Monitor/document/report PRN any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Monitor for signs and symptoms of infection to any open areas: redness, pain, heat, swelling, or pus formation.Review of Hospital ED Triage Note dated [DATE] at 4:28 p.m. for Resident #1 revealed Chief Complaint: Unresponsive. Diagnoses: Altered Mental Status. Vitals: Pulse Rate 91, blood pressure 87/60. At 4:13 p.m. EMS Blood Glucose Check 561, SPO2 less than 90%, pt arrived being bagged by EMS, chest compressions were performed; 4:50 p.m. family member revoked hospital DNR/DNI over the phone. Emergent intubation at this time. While preparing for intubation pt pulse is no longer palpable, CPR started; 4:43 p.m. Patient intubated due to respiratory failure. At 5:00 p.m.; 4:59 p.m. EKG Post ROSC has hyperkalemia, severe acidosis, and hypoxia; 5:45 p.m. patient noted to have agonal respirations, and a faint pulse is placed back on ventilator. At 5:28 p.m. patient is becoming bradycardic, no pulse felt at this time, witnessed arrest. Family members wished to discontinue CPR and resuscitation efforts at this time. Time of death 5:45 p.m.Review of Medical Visit dated [DATE] at 10:29 a.m. written by attending physician revealed Reason for Visit follow up: c/o Abd pain and diarrhea. History: new Abd pain and diarrhea with low appetite ordered amylase and lipase and Pepto started. No other medical concerns reported DOS [DATE]. Summary of Findings: Abdominal pain diarrhea. Plan: Start Bentyl & Zofran PRN.Review of Physician Order Summary dated[DATE] Resident #1 revealed: Order Date: [DATE] Insulin Glargine Subcutaneous Solution 100 unit/ml Inject 10 units subcutaneously at bedtime for DM. Order Date: [DATE] Insulin Lispro Injection Solution 100 unit/ml Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 5 units; 251 - 300 = 7 units; 301 - 350 = 10 units; 351 - 399 = 12 units. If >400 administer 14 units and notify MD, subcutaneously before meals and at bedtime for DM. The physician order summary did not document the STAT order received on [DATE] by LVN B to administer 10 units of Lantus subcutaneously.Review of the Medication Administration Record dated February 2025 for Resident #1 revealed:[DATE] Insulin Glargine Subcutaneous Solution 100 units/ml inject 10 units subcutaneously at bedtime for DM. The Medication Administration Record did not document on [DATE] by LVN B to administer 10 units of Lantus subcutaneously STAT according to physician's order.Review of the Nurse Note dated [DATE] for Resident #1 at 4:03 p.m. written by LVN B revealed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon further assessment pt became unresponsive, clammy, HR elevated to 194, family at bedside, notified attending physician by phone, with no answer, sent group message to attending physician and FNP, no response, EMS activated via 911, decision to be sent to hospital based on symptoms above. Family concurred with decision to be sent to hospital.Review of eINTERACT SBAR Summary dated [DATE] for Resident #1 at 4:00 p.m. written by LVN B revealed Situation: Abdominal pain/Altered mental status. Pulse: 194, Respirations 12, Blood Glucose 563, Relevant Medical History: Diabetes. Review and Notify: Primary Care Clinician Notified: Yes [DATE] at 4:00 p.m.Review of Nurse Note dated [DATE] for Resident #1 at 3:35 p.m. written by DON revealed LATE ENTRY: Informed by weekend supervisor labs pending review from Friday have not been reported to physician, DON informed RN to inform MD for further evaluation and review. CN reported lab values to physician and is awaiting orders. Resident's Glucose continues to trend up and is now 567, informed to encourage oral fluids, as per weekend supervisor resident has received 14 units of lispro and 10 units of Lantus, as per MD order. Resident to be encouraged to increase oral fluid intake.Review of Nurse Note dated [DATE] for Resident #1 at 2:55 p.m. written by LVN B revealed Upon doing rounds, pt was crying and stating pain to abdomen area, PRN Hydrocodone administered, pt stated pain decreased but 30 minutes later increased to 8/10. Family arrived, pt showed to be agitated and irritable. BS checked with reading of 473 mg/dl Family stated wanted to have pt leave AMA, notified DON and spoke to pt family and informed that if leaves AMA not able to come back. Family agreed to have pt. stay in facility. Notified attending physician by phone and ordered BS checks ac and Hs, with moderate sliding scale and to give Lispro 10 units STAT. Administered 10 units to back of left arm. Pt tolerated well. Rechecked BS 45 minutes later and BS increased to 515 mg/dl Pt clammy and stated feels sleepy. Notified attending physician and ordered D/C moderate sliding scale and start patient on high sliding scale and to give 14 units of Lispro STAT, and to give the Lantus 10 units as well. Administered both to back of right arm. Pt tolerated well. Educated family on purpose of each insulin. Will continue to monitor.During a Telephone interview on [DATE] at 11:18 a.m. with LVN B revealed Resident #1 complained of abdominal pain on [DATE] and had administered PRN Hydrocodone. He said blood glucose check had been done by resident's family on [DATE] at 2:55 p.m. and the physician was notified and ordered blood glucose checks ac meals and HS and had started the resident on Moderate Sliding Scale coverage. He said he had administered 10 units of the Lispro stat and could not remember the time the insulin was administered. He said he had rechecked the resident's blood glucose again 45 minutes later after the insulin was administered and it when up to 517 and the resident complained of being sleepy. He said he had notified the physician a second time, and the physician gave orders to discontinue the Moderate Sliding Scale coverage and to start the resident on High Sliding Scale coverage and to administer 14 units of Lispro and to also administer10 units of Lantus. He said he had not documented the actual times the blood glucose checks were done or when the insulin was administered in the resident's electronic record. He said they had been trained to document the date and times when blood glucose checks were done and administered insulin according to physician's orders. He said they did not have Lantus in the Insulin Ekit and RN A weekend supervisor had borrowed a vial from another resident. He said that at approximately 4:03 p.m., the resident became clammy, unresponsive Heart Rate was 194, family was in the room with the resident. He said he had called the physician and NP, and they had not answered his call. He said he sent the physician/NP a group text message and had not responded so he called the DON to report the situation and he instructed him to call 911 and send the resident to the Emergency Room. The state surveyor requested a screen shot of the text message.During an interview on [DATE] at 11:18 a.m. with RN A Weekend Supervisor revealed LVN C worked on [DATE] during the morning shift. She said, LVNtold me the family member had checked the resident's blood glucose, and I told him to notify the physician and DON to see what they wanted to do. The family member told LVN B they wanted to take the resident to the hospital. She said, I notified the DON and LVN B that I had notified the physician. That is when the doctor ordered blood glucose checks ac and HS and new orders for insulin. She said (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON talked to the family and he informed the physician that the family wanted to take the resident to the hospital. The DON told her the physician wanted to start the resident on insulin and to keep her at the facility. She said LVN B had rechecked the blood glucose after the first dose of insulin was administered and notified the physician that the blood glucose was higher and physician gave a new order for insulin. She said the physician had ordered Lantus and they did not have Lantus in the insulin Ekit so she had borrowed a new vial of Lantus from another resident to administer the Lantus as ordered by the physician. She said after the Lantus was administered she threw the insulin vial in the biohazard container. She said they had been trained not to borrow medications from other residents.Review of the facility's policy and procedure on Administering Medications revised 2019 revealed: Policy Heading Medications are administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation: Medications are administered in accordance with prescriber's orders, including any required time frames. Vials labeled as single dose or single use are not used on multiple residents. Such vials are used only for one resident in a single procedure. The individual administering the medication initials the residents MAR on the appropriate line after giving each medication. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: the date and time the medication was administered; the dosage, the route of administration; injection site (if applicable); any results achieved and when those results were observed; and signature of the person administering the drug.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices, for 2 of 13 residents (Residents #1 and #2) reviewed for clinical records with transfer assistance.-The facility failed to ensure LVN C documented in Resident #1's clinical record on 2/18/26 that the attending physician gave new orders for labs, Abd US and KUB when resident had a change in condition.-The facility failed to ensure RN A Weekend supervisor documented in Resident # 1's clinical record on 2/18/26 when Abd US and KUB results were sent to the attending physician. -The facility failed to ensure LVN C and LVN D documented in Resident #1's clinical record on 2/19/26 of the follow-up on lab orders that were ordered 2/18/26.- The facility failed to ensure LVN H documented in Resident #1's clinical record on 2/20/26 of the follow-up on lab orders that were ordered 2/18/26.- The facility failed to ensure LVN C documented in Resident #1's clinical record on 2/20/26 that labs were drawn and pending results.- The facility failed to ensure LVN B documented in Resident #1's clinical record on 2/22/26 he had received a telephone call from the lab to report critical lab results from the for Resident #1 on 2/20/26 had not been this in the resident's clinical record.-The facility failed to ensure LVN B documented in a telephone order physician had given a STAT order to administer Lantus 10 units Stat on 2/22/26 when Resident #1's blood glucose was at 517.-The facility failed to ensure LVN B documented in Resident #1's Medication Administration Record on 2/22/26 STAT doses of Lantus were administered according to physician's orders.-The facility failed to ensure DON and Dietary Manager V documented concerns voiced by Resident #1's family member regarding concerns related of not following the resident's prescribed diet in the resident's electronic record.These failures place residents at risk of having incomplete and accurate clinical records.Findings included:Resident #1Closed record review of the Face Sheet dated 02/25/26 for Resident #1 revealed an original admission date 1/14/26.Review of the admission MDS for Resident #1 dated 1/18/26 revealed: Date of admission [DATE] from acute hospital. BIMS Summary Score: 15 Cognitively Intact. Active Diagnoses: Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Post Procedural Pain, Aftercare following surgical amputation, left below knee amputation, PRN pain medication, Recent surgery requiring active SNF Care, High-Risk Drug Classes: Opioid. Speech/Occupational/Physical Therapy. Discharge Plan already occurring for the resident to return to the community.Review of Medical Visit dated 1/22/26 written by attending physician for Resident #1 revealed Reason for Visit: admission Record Review. History of Present Illness: The patient has a history of DM, HTN, PVD, CAD and recent left foot osteomyelitis and gangrene, status post left below-knee amputation. She agreed to transfer to inpatient rehabilitation/skilled nursing facility for continued recovery, wound care, and functional rehabilitation.Review of a Medical Visit dated 2/18/26 written by attending physician for Resident #1 revealed Reason for Visit: New c/o pain and diarrhea. Patient reporting new Abd pain and diarrhea with low appetite today, ordered us Abd, basic labs and amylase and lipase. Ordered Lomotil. No other medical concerns.Review of Physician Order Summary dated 2/25/26 for Resident #1 revealed: Order Date: 02/22/26 Insulin Glargine Subcutaneous Solution 100 unit/ml Inject 10 units subcutaneously at bedtime for DM. The Physician Order Summary did not list the Stat Order for Lantus 10 units ordered by the physician on 2/22/26.Review of the Medication Administration Record dated February 2026 for Resident #1 revealed LVN B had not documented he had administered Lantus 10 units stat as ordered by the physician on 2/22/26. Review of a Nurse Note dated 2/22/26 for Resident #1 at 2:55 p.m. written by LVN B revealed Upon doing rounds, pt was crying and stating pain to abdomen area, PRN Hydrocodone administered, pt stated pain decreased but 30 minutes later increased to 8/10. Family arrived, pt showed to be agitated and irritable. BS checked with reading of 473 mg/dl Family stated (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avir at Patriot		STREET ADDRESS, CITY, STATE, ZIP CODE 11490 Gateway North Blvd El Paso, TX 79934	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wanted to have pt leave AMA, notified DON and spoke to pt family and informed that if leaves AMA not able to come back. Family agreed to have pt. stay in facility. Notified attending physician by phone and ordered BS checks ac and Hs, with moderate sliding scale and to give Lispro 10 units STAT. Administered 10 units to back of left arm. Pt tolerated well. Rechecked BS 45 minutes later and BS increased to 515 mg/dl Pt clammy and stated feels sleepy. Notified attending physician and ordered to D/C moderate sliding scale and start patient on high sliding scale and to give 14 units of Lispro STAT, and to give the Lantus 10 units as well. Administered both to back of right arm. Pt tolerated well. Educated family on purpose of each insulin. Will continue to monitor.Review of the Physician Order Summary dated 2/25/26 for Resident #1 revealed: Order Date: 02/18/26 CBC w/Diff, Comprehensive Panel, Lipase, Amylase Blood. Order Date: 02/22/26 Insulin Glargine Subcutaneous Solution 100 unit/ml Inject 10 units subcutaneously at bedtime for DM.During an interview and Record 2/24/26 at 10:30 a.m., with DON and ADON C of the 24-Hour Report Sheet dated 2/18/26 - 2/22/26 and Residents electronic Nurses Notes revealed:-LVN C had not documented on 2/18/26 in the Resident #1's clinical record the physician had given new orders for labs and were pending to be drawn.- RN A Weekend supervisor had not documented in 24-Hour Report Sheet and/or Resident # 1's clinical record on 2/18/26 when Abd US and KUB results were sent to the attending physician.- LVN C on the 6-2 shift and LVN D on the 2-10 shift had not documented in Resident #1's clinical record on 2/19/26 the nurses had followed-up on lab orders that were ordered 2/18/26 and were still pending to be drawn.- LVN H had not documented in Resident #1's clinical record on 2/20/26 follow-up on lab orders ordered 2/18/26 and were still pending to be drawn.- LVN C on the morning shift had not documented in Resident #1's clinical record labs were drawn 2/20/26 at 8:19 a.m. and results were pending.- LVN D on the evening shift had not documented in Resident #1's clinical record if LVN C had reported to her at the change of shift lab were drawn on 2/20/26 during the morning shift and results were pending.- LVN B had not documented in Resident #1's clinical record on 2/22/26 when he had notified the physician of critical lab results that were received on 2/20/26 had not been reported to physician.-Resident #2Review of the Face Sheet dated 3/06/26 for Resident #2 revealed original admission date was 3/31/25 and re-admission date was 08/12/2025. Resident #2's diagnoses included: Dementia, Diabetes Mellitus, Hypertension, End Stage Renal Disease, and Adult Failure to Thrive.Review of the Quarterly MDS dated [DATE] for Resident #2 documented Date of Entry 08/13/2025. Clear speech sometimes makes self-understood, sometimes understands others; BIMS Score 2 (severely cognitively impaired); dependent with personal hygiene. Active Diagnoses: End Stage Renal Disease, Diabetes Mellitus, Non-Alzheimer's Dementia, Malnutrition. No weight loss. Therapeutic Diet. High-Risk Drug Classes: HypoglycemicReview of the Care Plan revealed: Review of Care Plan initiated 4/01/25 for Resident #2 documented ADL self-care performance deficit Approaches: The resident requires assistance with personal hygiene.- Review of the Care Plan initiated 4/02/25 for Resident #2 revealed Impaired Cognitive Function: Approaches: Ask yes/no questions. Communicate with resident/family regarding Residents, capabilities and needs.-Review of the Care Plan initiated 4/01/25 for Resident #2 documented: Resident has nutritional problems or potential nutritional problem r/t adult failure to thrive and protein calorie malnutrition. Approaches: Provide, serve diet as ordered. Monitor intake and record every meal. RD To evaluate and make diet change recommendations as needed.-Review of the Care Plan initiated 4/01/25 for Resident #2 documented Resident Receiving a therapeutic diet. Reduce concentrated sweets and Regular texture. Approaches: Administer snacks/Supplements as ordered/Desired within the restrictions. RD To review. Nutritional and hydration status, quarterly and as needed.-Resident #2 had renal failure r/t end stage renal disease. Approaches: Assist with ADLS as needed.Review of the Care Plan Conference dated 3/10/26 for Resident #2 revealed Meeting Time: 03/10/26 at 1:00 p.m. Attendance at Meeting: RN, Dietary, Social Worker, Family, and MDS Nurse. Quarterly Care Plan meeting. Nutrition: Renal regular diet thin liquids. Weight 106.7 labs; Eating 75-100%, mighty shake once a day. Summary of Care Plan: Resident's care plan reviewed with family member. Family requesting cookie (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protein supplement that is provided at dialysis to be given at facility. Agreed to have resident receive both extra protein and health shake for meals. Facility to continue looking for orange blanket. Family member requesting monthly care plan meetings moving forward. All questions answered. Family attended via phone and agreed with plan of care. Dietitian participated in care plan meeting.Review of the Diet Slip for Resident #2 revealed RCS/Regular House Shake, Regular Texture. Fortified meal plan.Review of the Menu dated 2025 Diet: Regular Thursday Loaded Baked Potato, Toss Salad, Dressing of Choice, Saltine Crackers, Frosted Cake, Milk and Beverages.Review of the Physician Order dated 3/06/26 for Resident #2 revealed: Liberal Renal Diet Regular Texture, Health Shake once a day, HS snack, Needs potassium rich foods for breakfast. Dialysis Monday-Wednesday-Friday.Review of the Nurses Note dated 1/30/26 at 5:46 p.m. written by LVN M for Resident #2 revealed family member had called regarding how CNAs are preparing resident hair before she goes to appointments or dialysis, she verbalized I don't want them to be doing ponytails and putting flower clips, she's not a child and it looks like they are making fun of her, she's old and maybe she's not going to complain but at the other facility she would not agree to have ponytails and flower clips this nurse explained she will pass on report to CNAs and nurses.Review of Nurses Note dated 1/30/26 at 6:06 p.m. written by LVN M for Resident #2 revealed Dietary Manager was notified family had concerns regarding food that was served to the Resident #1 for the dinner meal. During an interview on 2/24/26 at 10:47 a.m. with LVN R revealed that she was not aware of any concerns related to how staff combed the Resident #2's hair or any concerns about the food. She said the resident was alert, oriented to person, place, situation, recognized familiar faces and recognized family members. She said the resident went to dialysis three times a week from 7:30 a.m. - 2:00 p.m. and they packed her a lunch for the resident to eat while at the dialysis center. She said, The never eats her lunch at the dialysis center. She said she checked the lunch box in the morning and always brings her lunch back untouched. She said the resident wants to eat when she returns to the facility from dialysis.During an interview on 2/24/26 at 10:50 a.m. with CNA U said the facility packed a lunch for those residents that went to dialysis in a blue lunch bag. She said Resident #2 never ate her lunch at the dialysis center and the nurses were aware that the resident did not eat while at dialysis because she got nauseated. She said LVN R Charge Nurse on the 400 Hall during the day shift had informed them approximately two weeks ago that the resident's family member did not want them to comb the resident's hair with ponytails, and not want us to put on ribbons, colored rubber bands and barrettes. She said the resident liked the way that they combed her hair because she got a lot of compliments from the staff at the dialysis center. She said the resident was very sad because her family member no longer allowed the staff to comb her hair like they used to.During an observation and interview on 2/24/26 at 10:52 a.m. with Resident #2 revealed, the resident was sitting in a wheelchair by the side of her bed, clean and well groomed. The resident's hair was combed and did not have any ponytails, colored rubber bands, ribbons, or hair barrettes. She said her family member worked and would occasionally come to visit her on the weekends. She said the family member did not like the way the girls combed her hair with ponytails, colored rubber bands, ribbons and little girl barrettes. She said she liked the way the girls combed her hair, but family member did not like it, so now they only brush her hair. The resident appeared to be sad and said she preferred to have her hair done the way they used to before the family member asked that the girls not to put anything on her hair and/or with ponytails. She said, I will do whatever my family member wants. The resident said the facility packed her lunch when she went to the dialysis center on Monday-Wednesday-Friday and did not eat at the dialysis center because she got nauseated while getting her dialysis treatment. She said she would not be able to eat lying down because she was afraid of choking. She said that upon return to the facility, the staff facility checked the blue bag to check if she ate and she reminded the staff that she did not like to eat while getting her dialysis treatment. She said she preferred not to eat upon return from dialysis and would wait for her dinner meal to be served.During a telephone interview on 2/20/26 at 10:56 a.m. with the family member for Resident #2 revealed a visit was made (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during dinner time on January 29, 2026, and noted the resident had been served a very small baked potato, small salad and ice cream. She said the resident was confused at times and could voice her needs. The family member said she had asked LVN M about the dinner that had been served to Resident #2 on that day. LVN M said they had already notified the Dietary manager that the menu was not followed on that day. The family member said she had reported her concerns about the food that was served to the Resident #2 for dinner on 1/29/26 to the Dietary manager and the DON on that day, and she said that she was not aware of what had been served to Resident #2 for dinner on that day. The family member said she had voiced concern to the evening nurse who was assigned to Resident #2 about how the staff combed the resident's hair like a little girl with bright color ties in her hair and Butterfly clips when she went to appointments and/or dialysis and she felt The staff was not treating the resident with dignity and respect. The family member said the facility sent the Resident #2 with a sack lunch when the resident went to dialysis on Monday-Wednesday and Friday, and the resident did not eat her sack lunch at the dialysis center. She said the sack lunch consisted of a sandwich and yogurt. She said the sack lunch was packed in a plastic bag and was placed in the blue bag that the resident took with her to the dialysis center. She said that when Resident #2 returned to the facility from the dialysis center, no one checked the reusable blue bag to see Resident #1 she ate her sack while she was at the dialysis center. She said she had also reported to the nursing staff that the facility staff had lost a blanket that the Resident #2 had had for almost a year. She said the facility staff just gave Resident #2 another blanket. The family member said she had talked to the weekend staff about the missing blanket and all they did was asked if the blanket was labeled with the resident's name. The family member said the staff had not reported this to Administration or the Social Worker. The family member said the MDS nurse were not inviting her to attend Care Plan meeting again when they had changed staff. The family member said the care plan conference scheduled for January 2026 had been cancelled because the Social Worker had an emergency and they did not reschedule the care plan meeting.During an interview on 2/24/26 at 10:59 a.m. with the DON revealed he was not informed by the staff that the Resident #2's family memberad voiced concern about the way that the staff combed the resident's hair. He said he was not familiar with the facility's staff on Grievances/Concerns. He said he started working on the weekends and had taken over the DON position a month ago. He said the resident's family had reported to him a concern about the food that was served to the resident during the dinner meal and did not recall the date. He said the family was concerned that the resident was not getting enough protein. He said the resident was already eating her dinner meal on that day. He said, I told family to let us know if the resident did not like the food that was served for dinner so the kitchen could give the resident an alternative. He said that the family member for Resident #2 had attended a care plan conference and they had discussed the concerns related to residents' diet, about the food that was served to the residents for the dinner meal. He said, I don't keep notes. I apologize. The DON said he had not documented the family members in the resident's electronic record.During an interview on 2/24/26 at 11:06 a.m. with Dietary Manager V revealed Resident #2's family member spoke to LVN M on the evening shift assigned to Resident #2 and said, I do not remember the date, about the food that was served for dinner. She said she needed to look at the menus to see what day it was that the concern was reported to the facility staff. She said, I was not at the facility when the family came to the facility and voiced the concerns. She said, I called the family two times and left a message, and she never returned the calls. I can go and get my cell phone to give you the dates. She said that on the date in question, they had served Resident #2 a loaded baked potato, with sour cream and cheese, green salad with ranch dressing and dessert. She said she needed to check what type of diet was ordered for the resident. She said she had not documented in the resident's clinical record when she had called the family member to follow up on her concerns related to the food that was served to the resident.During a second interview on 2/24/26 at 11:21 a.m. with Dietary Manager V revealed she had not completed a Grievance/Concern Form to give to the facility's Social Worker when the family member for Resident #2 had voiced a (continued on next page)

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