

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an assessment accurately reflected a resident's status for 4 (Resident #1, #2, #28, and #40) of 24 residents reviewed for accuracy of MDS assessments. -The facility failed to accurately assess Resident #1, #2, and #40 for the use of restraints on their MDS assessments. -The facility failed to accurately assess Resident #28 for the use of CPAP therapy on his MDS assessment. This failure to accurately assess a resident could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings include: Resident #1 Record review of Resident #1's face sheet printed 02/10/26 revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include heart failure (a chronic condition in which the heart does not pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), pain, and diabetes (a chronic condition that affects the way the body processes blood sugar (glucose)). Record review of Resident #1's last MDS was a quarterly assessment completed 01/10/26 listing her with a BIMS score of 11 indicating she was moderately cognitively impaired, she had a functionality of being independent with lying to sitting at the side to the bed and Section P0100 - Physical Restraints Resident #1 was listed for using bed rails. Record review of Resident #1's care plan with admission date of 07/03/23 revealed the following: Focus:-Resident uses side rails for positioning. - Date initiated 07/21/2024. Intervention:-12/03/2024 Side rails in use for positioning. Record review of the clinical record for Resident #1 revealed an Order Summary Report with active orders as of 02/10/26 with the following order:- Side rails in use for positioning - Start Date: 12/04/2024. During an observation and interview on 02/10/2026 at 09:27 AM Resident #1 did not have any bedrails up but Resident #1 did report staff put them down during the day and up at night so she can use them to get in and out of bed and to move around in bed. Resident #2 Record review of Resident #2's face sheet printed 02/10/26 revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include discitis, unspecified of the lumbosacral region (a uncommon, painful condition characterized by inflammation and infection of the intervertebral disc between the lumbar vertebrae and the sacrum, often causing severe lower back pain), Osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), and altered mental status. Record review of Resident #2's last MDS was an annual assessment completed 12/06/25 listing her with a BIMS score of 15 indicating she was cognitively intact, she had a functionality of requiring partial/moderate assistance with lying to sitting at the side to the bed and Section P0100 - Physical Restraints Resident #2 was listed for using bedrails. Record review of Resident #2's care plan with admission date of 11/29/23 revealed the following: Focus:-Resident uses side rails for positioning. - Date initiated 07/21/2024. Record review of the clinical record for Resident #2 revealed an Order Summary Report with active orders as of 02/10/26 with the following order:-Bilateral side rails for self-positioning in bed and for transfers in and out of bed. - Start date of 1/28/2026. During an observation and interview on 02/10/2026 at 11:18 AM Resident #2 had her quarter bed rails in use. Resident #2 stated she used them to assist her getting in and out of bed and moving around in bed. Resident #28 Record review of Resident #28's face sheet (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: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	printed 02/12/26 revealed he was a [AGE] year-old male resident admitted to the facility originally on 01/16/23 and readmitted on [DATE] with diagnoses to include heart failure (a chronic condition in which the heart dose not pump blood as well as it should), dementia (a group of thinking and social symptoms that interfere with daily functioning), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), Parkinson's (a disorder of the central nervous system that affects movements to include tremors), and dysphagia (difficulty or discomfort in swallowing). Record review of Resident #28's last MDS was an annual assessment completed 12/24/25 listing him with a BIMS score of 12 indicating he was moderately cognitively impaired, he had a functionality of requiring partial/moderate assistance for most of his activities of daily living, and Section O - Special Treatments, Procedures, and Programs: Resident #28 was listed in Section G1. Non-invasive Mechanical Ventilator (BiPAP/CPAP) as not having it On admission or While a Resident. Record review of Resident #28's care plan with admission date of 12/17/24 revealed the following: Focus:-Resident uses CPAP at night. - Date initiated 12/17/24. Record review of the clinical record for Resident #28 revealed an Order Summary Report with active orders as of 02/12/26 with the following order:-C-PAP QHS at bedtime. - Start date 12/17/2024. During an observation on 02/10/2026 at 08:40 AM noted in Resident #28's room there was a CPAP machine on the bedside dresser with tubing and mask present. During an interview on 02/10/2026 at 11:17 AM Resident #28 stated he has used his CPAP for years and staff help him with all his needs and care of his CPAP. Resident #28's family member entered the room and reported Resident #28 had used CPAP therapy for 15 years. Resident #40 Record review of Resident #40's face sheet printed 02/10/26 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), and congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should). Record review of Resident #40's last MDS was a quarterly assessment completed 11/01/25 listing him with a BIMS score of 15 indicating he was cognitively intact, he had a functionality of requiring substantial/maximal assistance with lying to sitting on the side of the bed, and Section P0100 - Physical Restraints Resident #30 was listed for using bed rails. Record review of Resident #40's care plan with admission date of 03/12/14 revealed the following: Focus:-Resident uses a bed rail for mobility. - Date initiated 12/04/24. Record review of the clinical record for Resident #40 revealed an Order Summary Report with active orders as of 02/10/26 with the following order:- Bed rails for mobility. - Start Date: 12/04/24. During an interview on 02/10/2026 at 11:13 AM Resident #40 stated he liked his bed rails and stated, State better not get them taken away. Resident #40 stated they (his bed rails) are a benefit to him; they help him reposition, especially when staff are changing his brief, it helps him move from left to right. During an interview on 02/10/2026 at 2:40 PM the MDS Coordinator with the DON present stated she had been the MDS Coordinator for 4 months and she was currently in training. The MDS Coordinator reviewed Resident #1's last MDS assessment and verified Resident #1 was marked as having restraints for the use of her bed rails. The MDS Coordinator stated, That was my fault. When I first started, I thought when they had bed rails it was supposed to be marked in this section. I will get this corrected today. The MDS coordinator stated this was the case with Residents #2, #28 (with his CPAP therapy), and #40 also and she would get each MDS corrected as soon as possible. The MDS Coordinator stated an incorrect MDS assessment that does not accurately reflect the resident's status could affect the residents negatively and could affect the facility's reimbursement. The DON stated none of the residents had bed rails for the purpose of restricting their movements and therefore they should not be considered restraints. During an interview on 02/12/2026 at 8:56 AM the DON stated if the MDS assessment was not completed correctly then it would be an inaccurate reflection of the resident's condition and could affect reimbursement. The DON did not feel this would affect residents' care as long as the rest of the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' records such as orders and care plans addressed the residents' issues. During an interview on 02/12/2026 at 8:47 AM the MDS coordinator stated the facility used the RAI manual to complete all MDS assessments. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023 revealed the following: SECTION P: RESTRAINTS AND ALARMS Enter Codes in BoxesUsed in Bed-A. Bed rail-B. Trunk restraint-C. Limb restraint-D. Other SECTION O: SPECIAL TREATMENTS, PROCEDURES, ANDPROGRAMS Coding Instructions for Column b. While a ResidentCheck all treatments, procedures, and programs that the resident received or performed afteradmission/entry or reentry to the facility and within the last 14 days. If no treatments,procedures or programs were received by, performed on, or participated in by the residentwithin the last 14 days or since admission/entry or reentry, check Z, None of the above. O0110C1, Oxygen therapyCode continuous or intermittent oxygen administered via mask, cannula, etc., delivered to aresident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive AirwayPressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaricoxygen for wound therapy in this item. This item may be coded if the resident places or removestheir own oxygen mask, cannula.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 (Resident #46 and Resident #79) of 24 residents reviewed for medication administration.1. The facility failed to ensure LVN A stayed with Resident #46 until her medications were swallowed on the morning of [DATE].2. The facility failed to ensure LVN B stayed with Resident #79 until her medications were swallowed on the morning of [DATE].3. The facility failed to ensure the Southeast Hall medication cart did not contain expired eyedrops.4. The facility failed to ensure the Southwest Hall medication cart did not contain expired insulin.These failures could place residents at risk of harm due to not receiving necessary medications or receiving medications at the wrong time as well as taking medication that does not belong to them or is no longer effective due to being past expiration.Findings Included:1. Record review of Resident #46's admission record dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, rheumatoid arthritis (inflammatory disease causing painful swelling in affected areas of the body), hypothyroidism (thyroid gland does not make enough thyroid hormone resulting in fatigue, weight gain, increased blood cholesterol, sensitivity to cold, hair loss, constipation, joint pain, and puffy face), other specified depressive episodes (depressive conditions with significant symptoms and impairment that do not meet full criteria for major depressive disorder or other specific depressive disorders), hypertension (high blood pressure), gout (common and complex form of arthritis that can affect anyone. It's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints), pain in right shoulder, cognitive communication deficit, and hyperlipidemia (high cholesterol).Record review of Resident #46's annual MDS completed [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section GG Functional Abilities revealed Resident #46 was independent across most ADLs except eating where she required set up or clean up assistance and bathing where she required substantial maximal assistance. Section K Swallowing Nutritional Status revealed no issues with swallowing. Section N Medications revealed she received diuretic (medication that helps remove excess fluid and salt from the blood by increasing urination) and opioid medications (pain relief medication).Record review of Resident #46's care plan dated [DATE] revealed she was at risk for aspiration or impaired swallowing related to a diagnosis of GERD (risk of stomach acid going back and forth between the mouth and stomach). The care plan did not mention self-administration of medication.Record review of Resident #46's MAR dated February 2026 revealed she received the following medications on the morning of [DATE] from LVN A:Allopurinol Tablet 100 MG Give 1 tablet by mouth one time a day for GoutAtenolol Tablet 50 MG Give 1 tablet by mouth one time a day for HTN Hold if SBP is less than or equal to 120Cholecalciferol Tablet Give 2000 unit by mouth one time a day for OA (degenerative joint disease)Folic Acid Capsule 0.8 MG Give 1 capsule by mouth one time a day for SupplementLosartan Potassium Oral Tablet 100 MG Give 1 tablet by mouth in the morning for HTNMeloxicam Tablet 15 MG Give 1 tablet by mouth one time a day for painPoly-Iron 150 Oral Capsule Give 150 mg by mouth one time a day for anemiaSenna-S Oral Tablet 806-50 MG give 2 tablet by mouth two times a day for constipationTylenol with Codeine #3 Oral Tablet 300-30 MG Give 1 tablet by mouth 4 times a day for painDuring an observation and interview on [DATE] at 09:00 AM Resident #46 was seated in her room with a plastic medication cup containing several pills in front of her on her tray table. She stated the nurse left the medication with her to take. She stated she did not know what the medications were. She stated, The nurse tells me (what the medications were), but I forget.During an interview on [DATE] at 08:17 AM Resident #46 stated it was normal for the nurse to leave her medications with her for her to take on her own. She stated (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN A trusted her to take her medications.2. Record review of Resident #79's admission record dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), hypothyroidism (Thyroid gland does not make enough thyroid hormone resulting in fatigue, weight gain, increased blood cholesterol, sensitivity to cold, hair loss, constipation, joint pain, and puffy face), pain, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and hypertension (high blood pressure).Record review of Resident #79's quarterly MDS completed on [DATE] revealed a BIMS score of 14 which indicated intact cognition. Section GG Functional Abilities revealed Resident #79 dependent across most ADLs except eating where she required set up or clean up assistance and oral care where she required supervision or touching assistance. Resident #79 was independent in moving from sitting to lying. Section K Swallowing Nutritional Status revealed no issues with swallowing. Section N Medications revealed she received anticoagulant (blood thinning medication), diuretic (medication that helps remove excess fluid and salt from the blood by increasing urination) and opioid medications (pain relief medication).Record review of Resident #79's care plan dated [DATE] revealed she was at risk of aspiration or impaired swallowing due to chronic pain related to nausea and vomiting. The care plan did not mention self-administration of medication.Record review of Resident #79's MAR dated February 2026 revealed she received the following medications from LVN B on the morning of [DATE]:Amlodipine Besylate Oral Tablet 5 MG Give 1 tablet by mouth one time a day for HTNCalcium 600+D Oral Tablet 600-5 MG MCG (Calcium Carbonate-Vitamin D) Give 1 tablet by mouth one time a day for supplementEscitalopram Oxalate Oral Tablet 10 MG Give 1 tablet by mouth one time a day for depressionLevothyroxine Sodium Tablet 100 MCG Give 1 tablet by mouth one time a day for low thyroid hormone @630 (6:30 AM) per pt requestLosartan Potassium Oral Tablet 50 MG Give 1 Tablet by mouth one time a day for HTNPantoprazole Sodium Tablet Delayed Release 40 MG Give 1 tablet by mouth one time a day for GERDApixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day for atrial fibrillationSenna S Oral Tablet 8.6-50 MG Give 3 tablet by mouth two times a day for constipationVitamin C Oral Tablet 500 MG Give 1 tablet by mouth two times a day for supplementTylenol Oral Tablet 325 MG Give 2 tablet by mouth three times a day related to painDuring an interview and observation on [DATE] at 09:11 AM Resident #79 was lying in bed on her back with head of bed slightly raised and over the bed table in front of her. There was a small medication cup with more than six pills in it and a small plastic cup full of water on her over the bed table. She stated they were her morning medications, and the nurse regularly left them with her to take on her own. 3. During an observation and interview on [DATE] at 08:50 AM of the 1-Southeast medication cart with LVN A present. Noted Genteal Eyedrops marked as opened [DATE] and marked expiration of [DATE]. LVN A stated that they were advised that eye drops were to be disposed of every 90 days, LVN A stated it used to be 30 days, but they were going through too many bottles, so it was changed to every 90 days.4. During an observation and interview on [DATE] at 09:04 AM of the 1-Southwest medication cart with LVN G present. Noted was Insulin Glargine with open date of [DATE] and expiration date of [DATE]. LVN G stated that the insulin was expired, that the resident received a dose each evening, and that the insulin should have been pulled and replaced. LVN G stated that the facility policy was that all insulins should be initialed with the date they are opened, due to expire usually in 28 days, and that each medication cart has a guide provided for each medication and its expiration. LVN G stated giving expired insulin can result in the residents having raised blood sugar which would be a negative effect. During an interview on [DATE] at 01:21 PM LVN A stated that if a resident was given a medication that was expired, then that medication could possibly be not as effective as it should be, it would have decreased effectiveness, or it could be toxic which will affect the residents negatively. LVN A stated that each medication cart has information on medication storage and provided the directions for ophthalmic medication care that her cart currently had. During an interview on [DATE] at 02:17 PM ADON D (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the night shift should check all medication carts to ensure they are in good condition on Tuesdays and Thursdays which should have been checked the previous evening. ADON D stated all night staff will need to be retrained on how to inspect a medication cart. ADON D stated as far as any issues with the medication carts they usually do not have any problems because their staff are good about checking the carts. ADON D stated insulins should be marked when they are opened but do not need an expiration date because all the staff know when they expire in 28-30 days. ADON D stated that if a medication was given that was expired then it could have a bad effect. ADON D stated she was not familiar with the policy for the care of eye drop medications. During an interview on [DATE] at 09:01 AM the DON stated insulins should be marked with the date they are opened and the date they expire which should be 28 days and if a resident received an insulin that was expired then the insulin would have less efficacy, and the resident could have poor control of their condition. If a resident received an eye drop medication that was expired, then there could be an issue with infection control. The DON stated it was the responsibility of every nurse administering the medication to check and see if it was appropriate to administer. During an interview on [DATE] at 09:57 AM CNA M stated he had never noticed residents left with medication to take on their own. He stated nurses were responsible for administering medications. During an interview on [DATE] at 10:00 AM LVN F stated nurses or medication aides were responsible for administering medications. She stated nurses were to stay with the residents until the medications were taken. She stated it was never appropriate to leave medications with residents to take on their own. LVN F stated a possible negative outcome of leaving medications with residents was, You could have another resident wander in a take it or they could just not take it at all, or they could hold onto it and save it and take it at the wrong time. During an interview on [DATE] at 10:05 AM CNA N stated nurses were responsible for administering medications to residents. She stated she had never seen residents left with medications to take on their own. CNA N was working on Resident #79's hall at the time of the interview. During an interview on [DATE] at 10:12 AM CNA O stated nurses were responsible for administering medications to residents. She stated if medications were left with residents to take on their own, Another resident could pass by and get them (medications). She stated she had not seen residents left with medications to take on their own. CNA O was working on Resident #46's hall at the time of the interview and stated she worked all over the facility when she picked up shifts. During an interview on [DATE] at 10:14 AM LVN A stated nurses or medication aides were responsible for administering medications to residents. She stated she left medications with Resident #46 to take on her own in the morning because Resident #46 took several medications in the morning, and it made her nauseous to take all of them at the same time. LVN A stated, We are working on an order from [name of director of medicine] because Resident #46 was alert and oriented times a thousand. She stated Resident #46 was not able to identify each of her medications and what they were for, but she could identify her pain pill. LVN A stated she did not think there was a possible negative outcome for leaving medications with Resident #46. She stated, The only negative outcome is if someone came into (Resident #46's) room, saw those pills, and took them themselves. During an observation and interview on [DATE] at 10:21 AM ADON stated charge nurses were responsible for administering medications. She stated it was not okay for nurses to leave medications with residents to take on their own unless we have an order for it. She looked in the EHR for Resident #46 and Resident #79. ADON stated there was no such order for Resident #46 or Resident #79. She stated a possible negative outcome of leaving medications with residents to take on their own was maybe they just wouldn't take them (the medications). During an interview on [DATE] at 10:26 AM MDS RN stated nurses were responsible for administering medications to residents. She stated it was not appropriate to leave medications with residents to take on their own. MDS RN stated a possible negative outcome of doing so was the resident might not take their medication, or they might double up on the medication later. A call was placed to LVN B on [DATE] at 10:44 AM with no answer. During an interview on [DATE] at 11:06 AM DON stated charge nurses were responsible for administering (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications to residents. She stated nurses were not supposed to leave medications with residents to take on their own. DON stated a possible negative outcome of doing so was that the resident might not take their medication. She stated, They could throw it in the trash, flush it down the toilet, or give it to their roommate. During an interview on [DATE] at 11:11 AM ADM stated nurses were responsible for administering medications to residents. She stated nurses were not to leave medications with residents to take on their own. She stated the residents could fail to take the meds (medications). A call was placed to LVN B on [DATE] at 03:02 PM with no answer. Record review of an undated page from the facility's admission packet titled Common Items Not Allowed in Nursing Home Resident's Rooms revealed the following: The following is a list of items which are either specifically controlled by codes, standards, or regulations, or have been demonstrated by this facility as having an adverse effect on the health and safety of our residents. MEDICATIONS: (Includes all prescription and over-the-counter drugs) NOTE: if a resident is requesting to administer his/her own medications(s), the Physician must approve the request and the Care Plan Team must evaluate whether the resident is capable of this task, and there must be specific precautions taken to prevent other residents from possible harm by inadvertently eating or drinking it. Record review of facility policy titled Drug Administration Policy and dated [DATE] revealed no mention of nurses remaining with residents while medications were taken. Record review of the facility provided Medication Storage Guidance provided on each medication cart Clinical Geriatrics 2025, revealed the following: Ophthalmic Products - Date when opened and discard in accordance with manufacturer's recommendations. refer to manufacturer's recommendations. Record review of the facility provided Storage Recommendations for Injectable Diabetes Medications provided on each medication cart Clinical Geriatrics 2025, revealed the following: Insulin Vial - Lantus (Glargine) - Until Expiration Date - Opened - 28 days. Record review of the Ophthalmic Medication Beyond-Use Guide provided by Health Direct Pharmacy Services (From the Centers for Medicare & Medicaid Services (CMS)) dated [DATE] revealed the following: Manufacturer - [name of manufacturer] Drug Name - Genteal Tear Sol - Moderate Expiration Date - 90 days from opening Record review of the facility provided policy titled Drug Security Policy dated [DATE], revealed the following: Medications must be properly labeled and stored in locked medication room, cabinet, or cart.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 2 kitchens when they failed to: Ensure kitchen staff used proper hand washing and sanitation procedures when handling food. Ensure kitchen staff and other employees wore hair restraints and beard coverings while in the kitchen. This failure could cause decreased meal satisfaction and decreased meal consumption due to using unsanitary practices in the facility's kitchen and could affect all residents in the facility that receive meals from the facility kitchen. Findings included: In an observation and interview of the kitchen food prep activities on 2/10/26 at 8:50 am, [NAME] I was observed in the kitchen with his beard cover under his chin and not covering his moustache. He stated he had been aware it should have been covering the moustache and just forgot to pull the face covering up over his moustache. He stated food borne illness would be a consequence of not having the proper covering. In an observation of the kitchen prep area on 2/10/26 at 8:52 am, the MM was observed in the kitchen with no beard cover. A repairman from outside the facility was in the kitchen with no hairnet or beard cover laying on the floor in the middle of the kitchen repairing the kitchen equipment. In an observation and interview on 2/10/26 at 9:00 am [NAME] K was observed in the back of the kitchen putting up groceries from the truck delivery. [NAME] K did not have a beard cover on his face. [NAME] K stated he had just forgotten to put it on. He stated he had been trained to wear a beard cover while in the kitchen and food borne illness would be a consequence. In an observation on 2/10/26 at 10:40 am, [NAME] I was observed in the kitchen with his moustache uncovered. In an observation and interview on 2/10/26 at 11:02 am, [NAME] L was observed touching various kitchen surfaces and the puree blender with her gloved hands. [NAME] L then walked across the kitchen to a pan of rolls on a rack and picked up a handful of rolls in her gloved hands. [NAME] L then walked back to the blender and put the rolls into the blender. [NAME] L tore rolls up with her gloved hands and began to puree. [NAME] L stated she had not been aware she had touched other surfaces before touching the rolls. She stated she should have changed her gloves. In an observation on 2/10/26 at 11:22 am [NAME] I was observed touching various kitchen surfaces with his gloved hands. [NAME] I then picked up a pan of rolls from a rolling rack and placed the pan on the prep counter. [NAME] I picked up rolls with his gloved hands and broke them into sections and placed the rolls into several serving pans. [NAME] I filled up a serving pan then touched the pan to move it. [NAME] I then picked up more rolls and placed the rolls into other serving pans. In an observation on 2/10/26 at 12:07 pm [NAME] J was observed touching various kitchen surfaces with gloved hands. [NAME] J opened the oven, pulled out a pan of rolls, picked a roll up with his gloved hand and checked for doneness by touching the roll. [NAME] J then put the roll back on the tray and returned the pan of rolls to the oven. In an observation and interview on 2/10/26 at 12:07 pm [NAME] I was observed serving the lunch meal. [NAME] I touched various kitchen surfaces with his gloved hands, picked up a plate, used serving utensils to plate food then picked up a roll with his gloved hand and placed the roll on the plate. [NAME] I stated he had been aware he touched the roll with his hands and should not have done that. He stated he had been trained in the kitchen duties and had been aware he needed to use tongs to plate rolls. He stated he had been using the tongs but had just forgotten to use the tongs for that roll. He stated food borne illness would be a possible consequence to the residents. In an interview on 2/11/26 at 9:40 am, the DM stated beard covers and hair restraints should always be worn even by the maintenance and other visitors. She stated moustaches should always be covered. The DM stated tongs should always be used when serving bread and when preparing food. She stated food should not be touched with hands that had touched other surfaces. She stated she was new and had not had any in-services with the kitchen staff but would schedule them. The DM stated the consequences of not washing hands and changing gloves would be cross contamination. In an interview on 2/12/26 at 9:30 am, the MM was asked about not (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	having a beard cover on his face when in the kitchen on 2/10/26 at 10:40 am. He denied he did not have a beard cover on his face on 2/10/26 and stated if he had been repairing the ice machine that day, he did have a beard cover on. He stated he always wore a beard cover when in the kitchen. In an interview on 2/12/26 at 9:40 am, the RD stated she had been told about the issues in the kitchen during the survey. She stated she expected all staff and visitors to have effective hair and beard covers while in the kitchen. She stated she expected hand washing and glove changes when changing tasks and for staff to use tongs when handling food. She stated she had not had any recent in-services with the staff but had been told the DM had scheduled an upcoming training for handwashing, hair restraints and general cleanliness in the kitchen. She stated the DM had been recently hired and seemed to have some good ideas about how to run the kitchen. She stated the issues in the kitchen could cause food borne illness as well as meal dissatisfaction in the residents. In an interview on 2/12/26 at 10:00 am the DM stated he had a current Dietary Managers certificate but did not supervise the DM. He stated he had been on the clinical side dealing with admission paperwork and did not go in the kitchen very often. He stated he had not been in charge of training the DM in kitchen duties. He stated he had been aware of the issues in the kitchen and would make sure staff were retrained. He stated of the issues with touching food with contaminated hands that he expected all staff to always follow the handwashing guidelines and to use tongs with serving bread. He stated he expected all staff to wear beard covers and hair restraints at all times and for the beard covers to completely cover the facial hair. He stated all issues in the kitchen would cause issues of food borne illness for the residents. Record Review of the facility's policies titled Handwashing Policy with a date of 1/11/19, documented: ' It is the policy of this facility that hand washing be regarded as the single most important means of preventing the spread of infections. Record Review of the facility's policies titled Traffic in Food Service Areas with a date of 1/16/17, documented: ' Traffic of non-food employees will be kept to a minimum. Any employee entering the food service area must wear appropriate hair restraint. The traffic of non-service food personnel through the food preparation and utensil areas is prohibited. Record Review of the USDA Food Code, dated 2017, documented: Hair Restraints 2-402.11 Effectiveness. (A) FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; Record Review of the USDA Food Code, dated 2017, documented: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room. (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS. (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD, (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #55) of 25 residents reviewed for advanced directives. Resident #55's DNR form lacked a dated notarial acknowledgment and therefore was not fully executed. This failure could place residents at risk of receiving medical treatment inconsistent with their or their legal representative's expressed wishes. Findings included: Record review of Resident #55's face sheet dated [DATE] revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses including but not limited to unspecified atrial fibrillation (irregular heart rhythm), drug induce subacute dyskinesia (movement disorder related to side effects of medications), peripheral vascular disease (narrowed arteries/reduce blood flow to limbs) and hypertension (high blood pressure). Resident #55 was identified as a DNR in the Advance Directive section. Record review of Resident #55's quarterly MDS Assessment was completed on [DATE]. In section C0500 the BIMS Summary Score was blank. In section C1000- Cognitive Skills for Daily Decision Making reflected Resident #55 was severely impaired. Record review of Resident #55's care plan revised on [DATE] included the following: Focus/intervention: Advanced Directives: Do not administer CPR if heart stops and/or breathing stops (initiated [DATE]). Record review of Resident #55's active physician orders as of [DATE] revealed the following order: DNR (Do not resuscitate) dated [DATE]. Record review of the clinical record for Resident #55 revealed a DNR signed by the Resident's Representative and physician dated [DATE]. Under the Two Witnesses section: the document contained the notary's signature/seal and printed name; however, there was no date indicating when the notary completed the form. An attempted telephone call on [DATE] at 3:06 PM to Resident #55's family representative was unsuccessful. During an interview on [DATE] at 2:22 PM, the DON reviewed Resident #55's DNR and stated it was not correct due to the missing notary date. The DON stated the SW was responsible for ensuring DNRs were accurate and acknowledged the potential outcome would be the facility would be legally in trouble because the facility would not be following the resident's wishes. During an interview on [DATE] at 3:01 PM the SW stated she was responsible for verifying the DNRs were correct. Upon reviewing the DNR document, the SW acknowledged the document lacked a notary date and stated she mistook the notary commission expiration date as the date signed. The SW did not give a negative outcome for not having a completed/accurate DNR. During an interview on [DATE] at 9:38 AM, RN C stated she worked on the hall where Resident #55 resided. After reviewing Resident #55's DNR, she stated the document would be considered null and void because it did not have the date the notary signed. RN C stated that because the DNR was not completed correctly, she would have to initiate resuscitation, which would be against the resident or their representative's wishes. RN C further stated she believed it was the social worker's responsibility to ensure DNRs were completed correctly. Record review of a blank OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES revealed the following: The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional. Record review of facility policy Advance Directives dated [DATE] reflected the following: The facility recognizes the right of each individual to make choices and decisions regarding his/her treatment, including the right to withdraw or withhold life sustaining treatment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review; the facility failed to ensure medications were stored in accordance with currently accepted professional principles for 1 (the 1-Northwest Hall medication cart) of 10 medication storage areas reviewed for medication storage. -The 1-Northwest Hall medication cart has loose medication pills. The facility's failure could result in a resident receiving medications that would be ineffective for their treatment resulting in exacerbation of the resident's condition and disease processes. Findings included: During an observation on 02/11/2026 at 08:44 AM of the 1-Northwest medication cart with LVN E present. Noted two loose pills identified by the LVN E as Levothyroxine and Atorvastatin. During an interview on 02/11/2026 at 1:24 PM LVN E reported loose medication in a medication cart can result in a resident missing a dose of medication, they could run out of the medication early and the insurance might not refill it. This could affect the residents if they do not receive the dose of medication they need. During an interview on 02/11/2026 at 2:17 PM ADON D reported that the night shift should check all medication carts to ensure they are in good condition to include no loose pills on Tuesdays and Thursdays which should have been checked the previous evening. ADON D reported all night staff will need to be retrained on how to inspect a medication cart. ADON D reported as far as any issues with the medication carts they usually do not have any problems because their staff are good about checking the carts. During an interview on 02/12/2026 at 9:01 AM the DON reported the night shift should review all medication carts for loose or expired medications, but they often get busy and cannot get to that duty. The DON reported loose pills in a medication cart should not be an issue if there are 1-2 loose pills. If there were 5-6 then the residents could incur increased expenses. The DON reported there was a chance that the pill could get stuck in the foil when the nurse expressed the medication from the blister pack but that was an unlikely occurrence. The DON reported it was the responsibility of every nurse administering the medication to check and see if it was appropriate to administer. Record review of the facility provided policy titled Drug Security Policy dated 01/30/2017, revealed the following: Medications must be properly labeled and stored in locked medication room, cabinet, or cart.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #11) of 4 residents observed for infection control. -LVN E did not perform hand hygiene properly while performing wound care for Resident #11. This deficient practice has the potential to affect residents by exposing them to care that could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene. Findings included: Record review of Resident #11's admission record dated 02/12/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to included Parkinson's (a disorder of the central nervous system that affects movements to include tremors), dementia (a group of thinking and social symptoms that interfere with daily functioning), Osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), and repeated falls. Record review of Resident #11's clinical record revealed his last MDS was a significant change of condition completed 11/28/2025 listing him with a BIMS score of 12 indicating he was moderately cognitively impaired, he had a functionality of being dependent on staff for most of his ADL's and he had one stage 2 pressure ulcer. Record review of Resident #11's Order Summary Report with Active Orders as of 02/12/2026 revealed the following order:- Wound care to coccyx wound. Clean with wound cleanser and pat dry. Apply Collagen to wound bed and cover with Allevyn gentle border dressing every day shifr for wound healing. Active 12/16/2025. Record review of Resident #11's care plan with admission date of 08/26/2025 revealed the following: Focus:- Resident has impaired skin integrity. Revised on 10/29/2025. Intervention:-Wound care to coccyx wound . Date initiated: 12/18/2025. During an observation on 02/11/2026 at 10:03 AM of wound care LVN E (with LVN F assisting) cleaned Resident #11's wound with two wet 4x4's, dried the wound with a dry 4x4, removed her gloves, did not perform hand hygiene, then placed new gloves, applied collagen to the wound bed, and covered the wound with a dry dressing. LVN E then removed her gloves and performed hand hygiene. During an interview on 02/11/2026 at 10:17 AM LVN E stated, I should have probably used hand sanitizer or washed my hands when I went from the dirty to the clean portion of the wound care. LVN E reported by not performing hand hygiene at the correct time the resident was placed at risk for infection. LVN E reported the staff are currently trained by the DON on hand hygiene. During an interview on 02/11/2026 at 10:20 AM LVN F reported that hand hygiene should have been performed between the dirty and clean portion of the wound care and if proper hand hygiene was not completed then the resident can develop an infection. During an interview on 02/12/2026 at 8:58 AM the DON reported she expects staff to perform hand hygiene to include removing gloves, washing hands, and placing new gloves at multiple times of care to include the dirty to clean portion of wound care, catheter care, and incontinent care. The DON reported if hand hygiene was not completed correctly the resident could be placed at risk for infection and staff could spread infection from one room to another. During an interview on 02/12/2026 at 9:20 AM the DON reported they do an annual training on hand hygiene, and the last training was 4/2025. Record review of the facility provided training titled, 2025 Annual Competency Topics - Competency Checks: Hand Hygiene undated revealed the following:LVN E passed her competency. Record review of the facility provided policy titled, Infection Control Program dated 09/18/2023, revealed the following: Policy: The facility will establish and maintain and Infection Control Program.Objectives of the Infection Control Program are: 2. Maintain a safe, sanitary, and comfortable environment. B. Components of the Infection Control Program include: m. Hand washing. Record review of the facility provided policy titled, Handwashing Policy dated 01/11/2019, revealed the following: Policy - It is the policy of this facility that hand washing be regarded as the single most important means of preventing the spread of infections. Record review of the facility provided policy titled Perineal Care effective 05/11/2022, revealed the following: Important Points - Always perform hand hygiene before and after glove use.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, within 7 days after completing a resident's assessment, encode the following information for each resident in the facility: A subset of items upon a resident's transfer, reentry, discharge, and death for 3 (Resident #49, Resident #53, and Resident #60) of 21 residents reviewed for assessments.1. The facility failed to encode a death in facility assessment for Resident #49 within 7 days of his death in the facility on [DATE].2. The facility failed to encode a discharge assessment for Resident #53 within 7 days of his discharge on [DATE].3. The facility failed to encode a death in facility assessment for Resident #60 within 7 days of her death in the facility on [DATE].These failures could place residents at risk of inaccurate medical records.Findings Included:1. Record review of Resident #49's admission record dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included heart disease (a range of conditions that affect the heart) and kidney disease. He was receiving hospice services. He died in the facility on [DATE].Record review of Resident #49's EHR under the MDS tab revealed he did not have a death in facility MDS assessment completed. The last MDS listed in the EHR was a significant change assessment with an ARD of [DATE]. Record review of this significant change assessment revealed a BIMS of 6 which indicated severely impaired cognition.Record review of Resident #49's progress notes revealed his hospice nurse pronounced him dead on [DATE] at 08:56 PM and his body was released to the funeral home the same day at 10:40 PM.Record review of Resident #49's discharge summary revealed he was deceased and discharged to the funeral home on [DATE]. The section labelled Brief History revealed the following: admitted for long term care [DATE]. Decline in condition due to CHF. Hospice admit [DATE], deceased [DATE].2. Record review of Resident #53's admission record dated [DATE] revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), fracture of left clavicle (broken collar bone), prostate cancer and bone cancer. Resident #53 was discharged on [DATE] to an acute care hospital.Record review of Resident #53's admission MDS completed on [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section GG Functional Abilities revealed he needed assistance across all ADLs. Section N Medications revealed he was receiving opioid (pain) medication.Record review of Resident #53's EHR under the MDS tab revealed he did not have a discharge MDS assessment completed. The last MDS listed in the EHR was an Entry MDS dated [DATE].Record review of Resident #53's care plan initiated on [DATE] revealed no mention of discharge plans.Record review of Resident #53's miscellaneous tab in the EHR revealed no discharge summary.Record review of Resident #53's progress notes revealed Resident #53 was taken by family members to the veteran's hospital and admitted for therapy on [DATE] at 09:00 AM.3. Record review of Resident #60's admission record dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). She was receiving hospice services. She died in the facility on [DATE].Record review of Resident #60's EHR under the MDS tab revealed she did not have a death in facility MDS assessment completed. The last MDS listed in the EHR was a significant change assessment with an ARD of [DATE].Record review of Resident #60's progress notes revealed she died on [DATE] at 08:32 PM and her body was released to the mortuary at 09:10 PM.Record review of Resident #60's discharge summary revealed she was deceased and discharged to the mortuary on [DATE]. The section titled Brief History revealed the following: Resident had confusion pleasantly confused and started to decline during the weekend (sic) [DATE]. Hospice was notified also [family member]During an interview on [DATE] at 10:21 AM ADON stated she and MDS RN were responsible for completing discharge MDS assessments. She stated she did not think there (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Ware Memorial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 S Van Buren St. Amarillo, TX 79101	
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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	was a negative outcome for a resident if a discharge MDS was not completed timely. She stated, We will eventually get them done. Just sometimes we get behind. During an interview on [DATE] at 10:26 AM MDS RN stated she was responsible for completing discharge MDS assessments. She stated ADON was helping and training her. She stated she used the RAI as her policy when completing MDS assessments. She stated according to the RAI a discharge MDS was to be completed within 14 days of discharge. She stated a possible negative outcome of not completing discharge MDS assessments timely was, If they (the discharge resident) come back in, we would have the same information, and it might not be accurate. During an interview on [DATE] at 11:06 AM DON stated MDS RN and ADON were responsible for completing discharge MDS assessments. She stated she did not think a resident would be negatively impacted if a discharge MDS was not completed timely. DON stated, My perspective of MDS is that if there is a negative outcome it would be a facility issue, fines, reimbursement, something like that. During an interview on [DATE] at 11:11 AM ADM stated MDS RN was responsible for completing discharge MDS assessments. She stated discharge planning was more important and had more potential to negatively impact a resident than did completing a discharge MDS timely. Record review of facility policy titled, Resident Assessment and dated [DATE] revealed the following: . The facility will complete the MDS assessment in accordance with the RAI manual as may be amended from time to time. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated [DATE] revealed the following: . the following situations warrant a Discharge assessment. Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record) . Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when . they leave a nursing home . Discharge reporting includes. OBRA Discharge assessments, . and Death in Facility tracking record.		