| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455599 | A. Building<br>B. Wing | 02/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Heritage Park Rehabilitation and Skilled Nursing C | 2806 Real St<br>Austin, TX 78722 |

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) |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services timely to maintain good grooming and personal hygiene for two of seven residents (Resident #128, Resident #135) reviewed for ADLs. The facility failed to ensure Resident #128 and Resident #135 fingernails were trimmed and maintained. This failure could place residents at risk of not receiving care services, diminished quality of life, and decreased self-esteem.Findings included: Record review of Resident #128's Face Sheet, dated 02/19/2026, reflected an [AGE] year-old male, admitted [DATE] with diagnoses that included dementia (is the loss of cognitive functioning, thinking, remembering, and reasoning), cognitive communication deficit (a condition that affects how individuals think and communicate), muscle wasting (is the loss or thinning of muscle tissue, leading to decreased muscle mass and strength), need for assistance with personal care (requires help with ADL's), edema (is swelling from trapped fluid building up in tissues in your body), chronic combined systolic heart failure (systolic and diastolic dysfunction, leading to impaired heart function and various symptoms), and major depression (is a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems).Record review of Resident #128's quarterly MDS dated [DATE], reflected a BIMS Score of 10, which indicated mildly cognitively impaired.Record review of Resident #128's Care Plan, dated 11/28/2025, reflected Resident #128 required assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #128 to maintain current level of function with assistance in his ADL care needs.Record review of Resident #128's nail care and facial hair removal file in point click care dated 02/20/2026 reflected nail care and facial hair removal were to be completed every Tuesday, Thursday, and Saturday 6:00 a.m. to 2:00 p.m. There was no ADL documentation for fingernail trimming for the past month in the ADL tasks checklist. Record review of nursing progress notes file in point click care dated 02/20/2026 reflected no documentation that Resident #128 received ADL care services for fingernail trimming in the past three months. Record review of Resident #135's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old female, admitted [DATE] with diagnoses that included respiratory failure with hypoxia (is defined as a condition where there is insufficient oxygen in the blood hypoxemia without elevated carbon dioxide levels hypercapnia), major depression (is a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), morbid obesity (is a chronic medical condition characterized by excessive body fat that significantly increases the risk of serious health problems), contracture to left and right hand (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility), muscle wasting (is the loss or thinning of muscle tissue, leading to decreased muscle mass and strength), need for assistance with personal care (requires help with ADL's), and cognitive communication deficit (a condition that affects how individuals think and communicate.Record review of Resident #135's quarterly MDS dated [DATE], reflected a BIMS Score of 11, which indicated mildly cognitively impaired.Record review of Resident #135's Care Plan, dated 02/04/2025, reflected<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #135 required dependent assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #135 to maintain current level of function with assistance in his ADL care needs.Record review of Resident #135's nail care and facial hair removal file in point click care dated 02/20/2026 reflected nail care and facial hair removal are to be completed every Tuesday, Thursday, and Saturday 6:00 a.m. to 2:00 p.m. There was no ADL documentation for fingernail trimming for the past month in the ADL tasks checklist. Record review of nursing progress notes file in point click care dated 02/20/2026 reflected no documentation of Resident #135 receiving ADL care services for fingernail trimming in the past month. During an interview on 02/18/2026 at 1:30 p.m. with Resident #128, he stated he did not like his fingernails long. Resident #128 stated it bothered him that the facility staff told him multiple times in the past that facility staff would come by to trim his fingernails but never came by to provide him nail care. Resident #128 stated he had not had his fingernails trimmed by the facility staff or even offered to have his fingernails trimmed in a couple of months. Resident #128 stated he scratched himself doing things with his long fingernails.During an observation on 02/18/2026 at 1:31 p.m. of Resident #128 revealed the resident had long and not trimmed fingernails with jagged edges. During an interview on 02/19/2026 at 12:14 p.m. with Resident #135, she stated staff did not assist her with clipping fingernails. She stated that she asked nursing staff to clip her fingernails on multiple occasions and they did not do that. She stated that her fingernails were too long and not comfortable for her to use her hands during ADL activities.During an observation on 02/19/2026 at 12:15 p.m. of Resident #135 revealed her left hand had long fingernails on her index finger, thumb, and pinky finger. During an interview on 02/19/2026 at 1:10 p.m. with Resident #128, he stated the facility staff still had not come around to offer him fingernail trimming or any care services for his fingernails. During an observation on 02/19/2026 at 1:11 p.m. of Resident #128, revealed Resident #128's fingernails were still not trimmed or showed any signs of nail care being completed. Resident #128's fingernails had jagged edges and approximately one inch long from his fingernail bed on all his fingers to both his left and right hand. During an interview on 02/19/2026 at 1:28 p.m. with CNA A, he stated he worked at the facility for 3 months. The CNA A stated he received training on ADL care and trimming residents' fingernails timely. CNA A stated training on ADL care and trimming residents' fingernails timely went over residents' fingernails were to be trimmed or to tell a nurse if a resident refused. CNA A stated residents' fingernails should be trimmed and cleaned routinely once a week. CNA A stated if resident's fingernails were not trimmed, it was considered to be neglectful, but residents refused sometimes. CNA A stated after telling a nurse, the nurse followed up with residents about fingernail trimmings. CNA A stated ADL care and trimming residents' fingernails are monitored by the RNs or LVNs. CNA A stated he had not trimmed any residents' fingernails since working at the facility. CNA A stated he had not received complaints from residents that staff were not trimming their fingernails. CNA A stated it's the responsibility of all nursing staff to ensure ADL care and trimming residents' fingernails was taking place such as the CNAs. CNA A stated if ADL care and trimming a resident's fingernails was not taking place, it could affect and diminish the resident's quality of life and potentially their dignity. CNA A stated it's ultimately the overall responsibility of the ADM and DON to ensure ADL care and residents' fingernails were trimmed timely for all residents. During an interview on 02/20/2026 at 1:34 p.m. with CNA H, she stated residents' fingernails were done every shower, 3 times a week. The CNA H stated that she verbally notified charge nurse a few days prior that Resident #135 refused to clip her fingernails. CNA H could not remember exact date of the notification and name of the nurse. CNA H stated the nurse documented refusals. CNA H stated that she had an in-service on ADLs and trimming fingernails in which nursing staff needed to offer fingernail care to residents so residents could feel good and prevent infections. During an interview on 02/20/2026 at 1:35 p.m. with the RN, she stated she offered Resident #135 to clip her fingernails earlier this week and Resident #135 refused. RN stated that she did not document it, and she knew that she should have as if she did not document it, it did not happen. The RN stated that she had the in-service on<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | ADL a few months ago and she was aware of the need for trimming residents' fingernails every week during showers and as needed. She stated that CNAs communicated to charge nurses if residents refused to have their fingernails trimmed and charge nurses were responsible for documenting it in the patients' clinical records. She stated that not trimming fingernails could lead to an accumulation of dirt and bacteria and potentially could cause the spread of infection.During an interview on 02/20/2026 at 1:41 p.m. with LVN B, she stated she worked at the facility for 7 years. LVN B stated she received ADL care and trimming resident's fingernails timely training. LVN B stated ADL care and trimming resident's fingernails timely training goes over during shower days that residents' fingernails need to be observed and offered a fingernail trimming, if the resident had diabetes only nurses could trim those residents' fingernails, and sometimes residents refused in which staff would document it and care plan it. LVN B stated the last time that she received the ADL care training was an in-service yesterday that she did it verbally. LVN B stated it's the responsibility of the CNAs and nursing staff to make sure residents' fingernails were trimmed and cleaned. LVN B stated ADL care and trimming resident's fingernails timely were monitored by the nurses. LVN B stated she has not received complaints from residents that staff were not trimming their fingernails. The LVN B stated it's the responsibility of the LVN and nursing staff to ensure ADL care and trimming resident's fingernails was taking place for residents. The LVN B stated if ADL care and not trimming a resident's fingernails was not taking place, it could affect and diminish the resident's quality of life by the resident's potentially cracking a fingernail and hurting themselves. The LVN B stated it's ultimately the overall responsibility of the DON to ensure ADL care and resident's fingernails are trimmed timely for the residents at the facility. During an interview on 02/20/2026 at 3:38 p.m. with the DON, she stated she worked at the facility for 28 years. The DON stated she received training on ADL care and trimming for residents' fingernails. The DON stated that training on ADL care and trimming residents' fingernails timely for the nursing staff went over that during showers the nursing staff needed to examine residents' fingernails and for nursing staff to ask residents if they wanted a fingernail cleaning or trimming. The DON stated ADL care and trimming of residents' fingernails were monitored by all nursing staff, she did morning rounds and shook residents' hands to examine their fingernails. The DON stated she had not received complaints from residents that staff were not trimming their fingernails. The DON stated if ADL care and trimming residents' fingernails was not taking place, it could affect and diminish the residents' quality of life as it could bother the residents and or residents may feel embarrassed. The DON stated it's the responsibility of the DON to ensure ADL care and trimming residents' fingernails was taking place including is the responsibility of facility nurses. The DON stated it's the responsibility of the nursing staff to document if residents were getting their fingernails trimmed or not for all residents. The DON stated it's ultimately the overall responsibility of the DON and the ADM to make sure residents are getting ADL care services for their fingernails. During an interview on 02/20/2026 at 3:58 p.m. with the ADM, he stated he worked at the facility for 9 years and 3 months. The ADM stated he received training on ADL care and trimming residents' fingernails, and his nursing staff received training in ADL care and fingernail trimming. The ADM stated that ADL care with trimming fingernails was the job of nursing staff, nondiabetic residents would get fingernail trimmings from CNAs , and nurses completed fingernail trimmings for residents who were diabetic or if needed by a podiatrist. The ADM stated ADL care and trimming residents' fingernails were monitored by the direct CNA care staff, nurse managers, treatment nurses, and the entire nursing staff team during rounds. The ADM stated nursing staff was to be documenting ADL and fingernail trimmings for residents. The ADM stated he had not received complaints from residents that staff were not trimming fingernails. The ADM stated it's the responsibility of nursing staff and ambassadors to ensure ADL care and trimming residents' fingernails was taking place. The ADM stated if ADL care and trimming residents' fingernails was not taking place, it could affect and diminish the residents' quality of life by potentially causing bacteria issues, skin tears, infection control issues, and it can make a resident feel a certain way in which<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | should not take place as it was a problem. The ADM stated it's ultimately the overall responsibility of the DON and ADM to ensure ADL care and residents' fingernails were trimmed for all residents. The ADM stated it's his expectation for ADL care and fingernails being trimmed is taking place for residents and it's his expectation that it's being appropriately provided as needed and requested by residents. Record review of facility in-service education for ADL documentation dated 08/07/2025 reflected to have been provided and completed by nursing staff, LVN B, the RN, and not completed by CNA A or CNA H. Record review of ADLs policy dated 05/26/2023 reflected the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living, bathing, dressing, grooming, and oral care. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Documentation shall be completed at the time of service, but no later than the shift in which care service occurred. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the open date for insulin and secured med cart for 2 (med cart #2 and med cart #1) of 6 med carts reviewed for medication storage. The facility failed to ensure that Resident #195 and Resident #75's insulin pens were labeled with an open date on med cart #2.The facility failed to ensure that med cart #1 was locked when RN was not present.This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of their medications, a decline in health status, and adverse effects if they had access to an unlocked MC. Findings included:During an observation on 02/18/2026 at 4:52PM an unlocked medication cart #1 was observed unattended outside of a resident's bedroom on the 2400 hall. During an observation on 02/18/2026 at 4:56PM the same MC was further down the same hallway, unlocked with the red mark showing which indicated the lock was open and not secure. The observation also revealed that the hall was free from residents wandering. Record review of Resident #195's face sheet, dated 2/20/2026, revealed a 65-years-old male admitted on [DATE]. Resident #195's diagnosis included type 2 diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar resulting from insulin resistance) with hyperglycemia (high blood sugar). Record review of Resident #195's orders, revealed that Resident #195 had an active order, started on 02/18/2026, Lantus Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 15 unit subcutaneously at bedtime related to TYPE 2DIABETES MELLITUS WITHOUT COMPLICATIONS.Record review of Resident #75's face sheet, dated 2/20/2026, revealed a 51-years-old female admitted on [DATE] and readmitted on [DATE]. Resident's #75's diagnosis included type 2 diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar resulting from insulin resistance). Record review of Resident #75's care plan, dated 12/12/2023, revealed Resident #75 had altered endocrine status related to Diabetes Mellitus with interventions to monitor for signs of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). Record review of Resident #75's orders, revealed that Resident #75 had an active order, started on 08/12/2025, for Lantus Subcutaneous (administering medication into the fatty tissue layer just below the skin and above the muscle) Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 60 unit subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS. During the observation of the 2200/2500-hall nursing med cart on 02/20/2026 at 10:18 a.m., revealed an insulin pen with 100 units/ml of insulin glargine for Resident #195 and an insulin pen with 100 units/ml of insulin glargine for Resident #75 without open date information available.In an interview on 2/20/2026 at 10:05 a.m. with LVN G, she said she received the medication storage and proper insulin labeling in-service 2-3 months ago. She said that according to the facility's policy insulin pens must be dated when opened and discarded after 28 days. LVN G said that she forgot to check for the open date labeling for the insulin for Resident #195 and Resident #75. She stated that the potential risk for residents receiving insulin injections with unlabeled insulin pens could be not getting the intended therapeutic benefits from the medications.An interview on 02/20/2026 at 3:04PM with MA J, who stated he had been employed at the facility for 5 years. MA J stated he had received training on MCs which included locking the MC when he was not at the MC. MA J stated the MC should be locked whenever he was away, included if he was inside a resident's room. MA J stated the MC could be unlocked if he was at the cart actively working inside of the MC. MA J stated if a MC was left unlocked it could be bad because residents could open the cart and take the medications potentially leading to harm. An interview on 02/20/2026 at 3:10PM with RN K, who stated she had been employed at the facility for 2 years. RN K stated she had received training on MC (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | which included that staff were expected to keep the MCs locked and secure. RN K stated every time she left the cart; she was supposed to lock the MC. RN K stated the MC could be kept unlocked if she was working inside the cart actively. RN K stated residents could take the medications out of the cart if the MC had been left unlocked, potentially leading to harm for residents. In an interview on 2/20/2026 at 3:39 p.m. with the DON, she said she was trained in the facility's medication storage annually. She stated that nursing staff was in-serviced on medication storage including labeling insulin pens before opening annually, and throughout the year. She stated that once insulin was placed on the nursing med carts and before opening, they should be labeled with the open date and discarded after 28 days. The DON said the charge nurses and medication aides were responsible for monitoring accurate labeling of medications before administering them to residents and daily checking their med carts for expired meds. She said that DON, ADONs and pharmacist were auditing med carts for proper labeling on a weekly/monthly basis. She stated that potentially if expired medications were administered to residents, it could reduce the therapeutic effect of medication to treat their medical conditions. The DON stated her expectation for the MC was they should be locked at all times unless staff are actively working inside the MC. The DON stated the RNs were responsible for ensuring the MC was kept locked. The DON stated residents, and staff could have access to the medications inside the MC if they were left unlocked. In an interview on 2/20/2026 at 3:59 p.m. with ADM, he said he did not have any training on medication storage, but all nursing staff were trained on medication storage and were supposed to label insulin pens before opening and using it. He said that DON, ADONs, charge nurses and medication aides were responsible for monitoring their medication carts for proper labeling of medications. He said that potentially if not properly labeled and administering expired medications to residents, it could not provide an intended therapeutic effect to treat their medical conditions. The ADM stated the facility regarding MC was that MC was to be secured at all times, especially when away from the MC. The ADM stated licensed staff and staff assigned to the MC would be responsible for keeping the MC locked. The ADM stated there would be potential for a drug diversion if the MC were left unlocked. Record review of facility's Insulin Pen policy, dated 07/03/2023, revealed 8. Once opened, clearly labeled insulin pens may be stored at room temperature. 9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendations.Record review of facility's in-services for last 12 months (February 2025 - February 2026) did not reveal any record of completed nursing staff training on labeling insulin pens before opening. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 10 residents (Resident #20) reviewed for rights.The facility failed to ensure CNA B closed Resident #20's door while providing incontinent care. The deficient practice could place residents at risk of feeling embarrassed and diminish the residents' quality of life. Findings included:Review of Resident #20's Face Sheet dated 02/20/2026 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #20's diagnoses included depression (persistent sadness), insomnia (difficulty sleeping), muscle wasting, hypertension (high blood pressure), abnormalities of gait and mobility, hyperlipidemia (high cholesterol), schizophrenia (severe, chronic brain disorder causing disconnect from reality through hallucinations), and obstructive pulmonary disease (chronic progressive lung disease).Record review of Resident #20's Quarterly MDS assessment dated [DATE] revealed Resident #20 had a BIMS score of 15 indicating intact cognitive response. The MDS also revealed that Resident #20 was substantial/maximal assistance with toileting. Record review of Resident #20's care plan dated 08/27/2025, [Resident #20] had an ADL self-care performance deficit related to schizophrenia (severe, chronic brain disorder causing disconnect from reality through hallucinations). Interventions were The resident requires supervision to limited assist by 1 staff for toileting.Observation of Resident #20 on 02/18/2026 at 2:07 p.m., revealed staff took Resident #20 to his room because he had feces on the back of his pants and shirt. Staff entered the resident's room, took the resident by his bed, pulled the privacy curtains, and proceeded to change the resident without closing the resident's bedroom door. During an interview with Resident #20 on 02/20/2026 at 1:44 p.m., he said staff had changed him with the door open before. He said most of the time staff just closed the curtain. He said he wanted staff to close the door all the time when they helped him change. He said when staff did not close the door it upset him. He also said he had to ask the staff to close the door when they helped him change. During an interview with CNA B on 02/20/2026 at 2:25 p.m., he said he had been trained on resident rights. He said he had resident rights training last month. He said the policy for providing care to residents was that staff had to draw the curtain and close the bedroom door. He stated staff were responsible for providing privacy to the residents during care. He said if privacy was not provided during care the residents may feel ashamed or neglected. He said the charge nurse or the DON monitored to ensure staff were providing privacy during care. He said the charge nurse or the DON would monitor by checking on how staff were taking care of the residents. He said he did not plan to be stopped by the nurse to change Resident #20 because Resident #20 had feces on him while in the hallway. During an interview with the DON on 02/20/2026 at 3:39 p.m., she said she had been trained in resident rights. She said she last had the training was last week. She said the policy for privacy was that staff were to get all the materials needed, close the door, close the curtain, and provide the resident with the care needed. She said the CNAs or any staff providing care to the residents were responsible for providing privacy for the residents. She said it could be a dignity issue if staff did not provide privacy during care. She said, if the staff did not provide privacy to the residents during care the residents could feel embarrassed. She said the nurse monitored to ensure staff are providing privacy. She said the nurse monitored by observation. She said CNA B did not close the door because he could not remember if he had closed the door after taking Resident #20 into the room. She said CNA B did make sure he closed the privacy curtain.During an interview with the ADM on 02/20/2026 at 4:02 p.m., he said he had been trained on resident rights. He said he had resident rights training last month. He said the policy was to preserve the residents' dignity. He said that staff should have the door closed, and the privacy curtain pulled closed when providing care to a<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident. He said all direct care staff were responsible for providing privacy to the residents. He said that if staff did not close the door and the privacy curtain when providing care, the residents might feel uncomfortable. He said the ADM, unit managers and nurses monitored to ensure staff were providing privacy during care. He said the ADM, unit managers and charge nurse monitored by observation rounds. He said he did not know why CNA B did not close the door while providing care to Resident #20.Record review of Promoting/Maintaining Resident Dignity Policy dated 01/13/2023, revealed It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: Maintain resident privacy.Record review of Resident Rights Policy not dated revealed, Each resident has a right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. The facility will protect and promote the rights of each resident including each of the following rights: Each resident has a right to privacy. |

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| | 455599 | A. Building<br>B. Wing | 02/20/2026 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish a system of accurate reconciliation and determine that drug records were in order, and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 6 medication carts (2200/2500-hall med cart) in the facility effecting 2 residents (Resident #156 and Resident #71) reviewed for pharmacy services.The facility failed to ensure LVN G accurately reconciled Resident #156 and Resident #71's narcotic medication log when she administered but did not sign for Resident #156's Hydrocodone APAP 5-325mg (controlled medication used for pain) 1 tablet and for Resident #71's Hydromorphone Hch 2mg (controlled medication used for pain) 1 tablet on 02/20/2026 between 6:00 a.m. and 10:00 a.m. These failures could place residents at risk for loss of prescribed medications, potential for not receiving their prescribed medications, and risk of drug diversion. Findings included:Record review of Resident #156's face sheet, dated 2/20/2026, revealed a 66-years-old male admitted on [DATE]. Resident's #156's diagnoses included chronic pain, hypertension (high blood pressure), and cervical disc disorder with myelopathy (compression of the spinal cord in the neck).Record review of Resident #156's admission MDS assessment, dated 1/16/2026, revealed BIMS score of 6 indicating the severely impaired cognition. Record review of Resident #156's care plan, dated 01/13/2026, revealed Resident #156 had ADL self-care performance deficit related to chronic pain syndrome and low back pain. Record review of Resident #156's orders, revealed that Resident #156 had an active order, started on 02/09/2026, for HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth three times a day for PAIN. Record review of Resident #71's face sheet, dated 2/20/2026, revealed a 72-years-old female originally admitted on [DATE] and readmitted on [DATE]. Resident's #71's diagnoses included fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain and intense fatigue), bipolar disorder (a chronic mental health condition characterized by intense mood swings), and muscle spasm of back.Record review of Resident #71's annual MDS assessment, dated 1/15/2026, revealed BIMS score of 15 indicating the intact cognition. Record review of Resident #71's care plan, dated 01/30/2026, revealed Resident #71 had acute/chronic pain related to fibromyalgia and chronic pain with interventions identified to respond timely to any complaint of pain and monitor/document for side effects of pain medications. Record review of Resident #71's orders, revealed that Resident #71 had an active order, started on 02/19/2026, for HYDROmorphone HCl Oral Tablet 2 MG (Hydromorphone HCl) Give 1 tablet by mouth every 8 hours as needed for PainDuring observation of the 2200/2500-hall med carton 02/20/2026 at 10:18 a.m., the controlled medication log revealed a discrepancy in the count for Resident #156's Hydrocodone APAP 5-325mg with 80 pills in the blister pack and 81 pills counted on the controlled medication log for Resident #156 with one pill of Hydrocodone APAP 5-325mg was taken out, but not signed. In addition to that, the controlled medication log revealed a discrepancy in the count for Resident #71's Hydromorphone Hch 2mg with 12 pills in the medication bottle and 13 pills counted on the controlled medication log for Resident #71, with one pill of Hydromorphone Hch 2mg was taken out but not signed. During an interview on 2/20/2026 at 10:05 a.m. with LVN G, she said that she administered Resident #156's Hydrocodone APAP 5-325mg 1 pill to him this morning but did not sign for it in the controlled medication log. She said that she was busy with one resident leaving the facility and needed her medications before she went out. LVN G said she got busy and forgot to sign for controlled medications administered to Resident #156 and Resident #71 this morning about an hour ago, on 02/20/2026 between 8:00 a.m. and 10:00 a.m. She said that not documenting administration of controlled medications could cause a discrepancy in the count or a medication error, since other nurse could not know the resident had already received the controlled medication. She stated that she received the controlled medication administration training annually<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | but could not recall the exact date.During an interview on 02/20/2026 at 3:39 p.m. with DON, she said that she had the medication administration in-service annually and provided this training to nursing staff in the facility annually and on as needed basis. The DON said that charge nurses were responsible for monitoring accurate controlled medication count and signing controlled medications as soon as they administered to each resident. She said that she and the ADONs were auditing the med carts on a weekly basis. She stated if the administration of controlled medications were not properly counted and signed for, it could lead to a drug diversion and medication error.During an interview on 01/20/2026 at 3:59 p.m. with the ADM, he said that he was not trained in medication administration and storage as he was not medically licensed. He said that DON, ADON, charge nurses, and medication aides were responsible for counting controlled medications at shift change and monitoring medications' discrepancies especially with controlled medication to prevent drug diversion. He said if a discrepancy was noted, the nurse or med aide was responsible for notifying the ADON, DON or himself. The ADM said that if the controlled medications were not monitored and properly counted it could potentially harm the residents.Record review of facility's Medication Administration policy, revised 10/01/2019, indicated that 17. Sign medication administration record after administration of medication.18. If medication is a controlled substance, sign narcotic book. Record review of facility's Medication Carts and Supplies for Administering Meds policy, revised 10/24/20, indicated that 11. Document administered medications as they are passed. Record review of facility's In-Services for last 12 months did not reveal any record of completed nursing staff training on medication administration and signing controlled medication after administration to residents. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record reviews, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen.The facility failed to ensure the cook performed hand hygiene while preparing puree foods. This deficient practice could place residents who were served from the kitchen at risk for foodborne illnesses.Findings Included:Observation of puree being prepared by the [NAME] on 02/19/2026 at 9:55 a.m., revealed she had gloves on. She put the meat and potatoes in the puree machine. She then put the meat and potatoes in a pan. She tasted the puree, threw the spoon away, covered the meat and potatoes, and put the puree meat on the steam table. She opened a heated cabinet and got the beans. She checked the temperature, wiped the thermometer with an alcohol wipe. She did not change gloves or wash her hands. She poured the beans in the clean puree machine. She added a little thickener to the beans. She got a spatula and put the beans back in the pan she took them out of. She tried the beans, threw the spoon away, covered the beans and put them on steam table. She still did not wash or sanitize her hands. She went to the pantry, touched the door to the walk-in refrigerator, moved the clear flaps hanging down, opened the steam cabinet, got the corn out, checked temperature, wiped the thermometer with alcohol wipe, took off the plastic, and threw it away. She still did not wash her hands or change her gloves. She poured the corn in the puree machine and added thickener. Once the corn was at the correct thickness she put it into a pan. She tasted the corn and then threw the spoon away. She covered the corn and put the corn on the steam table. She went to the freezer and got a pan of a mix (a cinnamon and butter broth type mix) she said she used for the bread. She still had not washed her hands or changed her gloves. She put slices of bread in the puree machine and poured the mix onto the bread. She added more bread to the puree machine. She then got a pan to put the bread in. She tasted the bread, threw the in pan tried bread threw spoon away. She did not wash or change her gloves during the whole puree process. During an interview with the DM on 02/20/2026 at 11:13 a.m., she said she had been trained on infection control in the kitchen. She said she had the training two weeks ago. She said the policy was anytime staff went into the kitchen, when staff touched something, they were to wash their hands. She said all staff in the kitchen were responsible for washing their hands. She said if staff did not wash their hands the resident could be at risk of germs, and becoming ill. She said she monitored to ensure staff were washing their hands. She said she monitored through observation and asking the staff if they washed their hands. She said the [NAME] did not wash her hands or change her gloves because she had on fake nails. She said the [NAME] did not want the surveyor to see her nails and get a citation.During an interview with the [NAME] on 02/20/2026 at 12:11 p.m., She said she had been trained on infection control in the kitchen. She said she had the infection control training last month. She said the policy for washing your hand was that anytime staff touch raw food, cook food, and go in or out of the kitchen staff should be washing their hands. She also added that any time staff switched tasks they should wash their hands. She said everyone should be washing their hands in the kitchen. She said if proper hand hygiene was not done a resident could get sick. She said the DM monitored to ensure staff were washing their hands. She said the DM would ask staff if they washed their hands and did observations. She said she did not want the surveyor to see her nails because she just got back from vacation. During an interview with the ADM on 02/20/2026 at 3:58 p.m., revealed he had training on infection control in the kitchen. He said he had the infection control training in December. He said the policy for washing hands in the kitchen was staff should be washing their hands when the staff entered the kitchen, when the staff touched their clothing, and when staff were switching tasks. He said all staff in the kitchen or going into the kitchen were responsible for washing their hands. He said if staff were not performing hand hygiene in the kitchen could potentially cause a resident to get an infection or food borne illness. He said the DM monitored to ensure staff were washing their hands. He (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | said the DM monitored by doing weekly audits and monthly audits in the kitchen. He said the audits had hand hygiene on them. He said he did not know why the [NAME] did not sanitize her hands when fixing the puree foods. Record review of the Hand Hygiene Policy dated 10/24/2022 revealed All staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. The use of gloves does not replace hand hygiene. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**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 of 3 residents (Resident #164) observed for infection prevention.The facility failed to ensure Enhanced Barrier Precautions (EBP) were followed when CNA D and CNA E performed peri care for Resident #164.This deficient practice could place residents at risk for the spread of infection.Findings included:Record review of Resident #164s face sheet on 2/19/2026 revealed he was a [AGE] year-old male with an initial admission of 3/27/2025, with a readmission date of 12/19/2025. Diagnoses included: Stage 5 chronic kidney disease, Type II Diabetes Mellitus, Legal blindness, Hypertension. The record also revealed the resident has a dialysis fistula to his left arm (surgical connection of an artery to a vein enabling high flow repetitive needle insertion for routine blood cleansing) Record Review of Resident #164's Physician's Orders revealed an order with start date 1/20/2026, Enhanced Barrier Precautions. Use of gown and gloves for high contact resident care activities for those with known to be colonized or infected with CDC targeted MDRO as well as those with increased risk of MDR (residents with wounds or indwelling medical devices).Record review of Residents #164's Care Plan dated 1/20/2026 revealed a problem which included Resident has need for Enhanced Barrier Precautions due to: Dialysis status. This was noted as initiated on 8/8/2025. Interventions included: Place on Enhanced Barrier Precautions, ensure a sign is placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high- contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and may participate in communal activities. Use a mask, goggles/eye shield as indicated.In observation on 2/19/2026 at 11:29 AM revealed staff members CNA D and CNA E performed peri care for Resident #164. The CNAs performed peri care following aseptic technique. The CNAs changed gloves and cleansed their hands at appropriate intervals. The CNAs failed to wear gowns when providing peri care to Resident #164. Signage noted outside of Resident #164's door reflected that resident in bed A was on EBP. PPE was stored in hanging storage on Resident #164s door. In an interview on 2/19/2026 at 11:40 AM with CNA D and CNA E they stated that they did not wear gowns because the resident was not on EBP that the resident in bed B was. They could not explain why the letter A was on the sign and not the letter B. The CNAs stated that if a resident was on EBP they would wear gowns and gloves when providing care to the residents to prevent infection or the spread of germs from their clothing to another resident. They stated they were frequently in-serviced on infection control.In an additional interview on 2/20/2026 at 2:00 PM CNA D and CNA E stated they discussed with the DON and Resident #164 was on EBP and the resident's roommate was no longer on EBP. They stated they should have worn gowns when providing care to Resident #164.In an interview on 2/20/2026 at 2:15 PM with CNA F, she stated she was in-serviced on infection control including EBP. She stated that if a resident was on EBP she would wear a gown and gloves when performing care such as peri care, or bathing. She stated if the proper PPE was not worn then infections and germs could spread from one resident to the other. In an interview on 2/20/2026 at 2:35 PM with CNA C, he stated that he was regularly in-serviced on infection control. He stated that the in-service for infection control included training for EBP. In an interview on 2/19/2026 at 10:30 AM with RN I, the wound care nurse, she stated that she was frequently in-serviced on infection control which included EBP. She stated that if a resident was on EBP then any close contact care that was provided to a resident required staff to wear a gown and gloves while providing the care to prevent the spread of germs. She stated most residents on EBP had something going on that made them more susceptible to infection. In interview on 2/20/2026 at 3:47 PM with the DON, who worked in the facility for 28<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | years and 16 years as the DON, stated she frequently in-serviced her staff on infection control and the training included EBP, and isolation status. She stated that she expected staff to wear gowns and gloves to perform care when they have an order for EBP. She stated that if staff did not follow the set protocols for PPE there was a chance that cross-contamination could occur. She stated the staff know who as on EBP and other precautions by the sign on the door and they put which bed for example A, B, C. The DON stated that they did not have a specific policy for enhanced barrier precautions and followed their Infection control policy that included Isolation types.In an interview on 2/20/2026 at 4:00 PM with the ADM, he stated he has worked in the facility for 9 years. He stated that the staff and himself were frequently in-serviced on infection control which includes EBP. He stated that he expected staff to follow the guidelines that they have been in-serviced on when there is an order for EBP. He stated the staff knew a resident was on EBP by could spread infection. Every door with the resident has PPE and a sign designating which bed [NAME] EBP orders and it was on the Kardex, care plan. He stated the clinical administration and infection control person perform surveillance.In record review of facility policy, Infection Prevention and Control Policy, dated 5/13/2023, reviewed 5/21/2025, thee policy revealed This facility has established and maintains infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines, 2. All staff are responsible for following all policies and procedures related to the program. 4. Standard Precautions: - c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. |