

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: 455685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Lake Forest Village by Purehealth		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 Montecito Dr Denton, TX 76210	
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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. Dietary staff failed to dispose of expired foods items in the pantry and refrigerator. Dietary staff failed to ensure the ice machine scooper was clean and sanitized. These deficient practices could place residents at risk for cross-contamination and foodborne illness. Findings included: Observation on 09/09/2025 from 9:10 AM to 9:45 AM in the facility's kitchen revealed: One wrapped bag of powdered sugar on the top shelf, labeled with a prep date of 09/02/25, with a use by date of 09/08/25. Three stainless steel containers of Mushrooms on the middle shelf in one of the refrigerators, labeled 09/04, with a use by date of 09/07. The Ice machine scooper bin was cracked and had a thick calcium buildup around the bottom. During an interview on 09/11/2025 at 1:00 PM, DD stated has been a DD, about 6 years. DD acknowledged the surveyor observations. The DD stated he is responsible to ensure for kitchen sanitation and proper storage of food products and the deficient practices were oversights. DD stated the powdered sugar item appeared to be out of place based on where it was located by surveyor and DD, further one of staff probably picked it up and inadvertently put it down and went about doing something and forgot about it being there. DD stated the risk of all the concerns observed in the kitchen could result in residents getting sick. DD stated the risk of the concerns not being addressed could result in food-borne illnesses. DD stated if food items were not dated when they opened then they will not be able to know how long they will last. Items stored in the refrigerator must be dated upon receipt, unless they contain a manufacturer use by, sell by, best by date, or a date delivered. DD stated the fridge, and freezer should be checked daily for spoiled foods. During an interview on 09/11/2025 at 2:49 PM, the ADMIN stated oversaw all departments, and ensured residents were taken care of. The ADMIN stated the policy or procedure for storing food was, everything needed to be dated, and if opened it needed to have an open date and an expiration date. ADMIN stated the risk to residents, if the policy was not followed was, they could get sick from food borne illnesses. The ADMIN stated he expected staff to ensure they followed the policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. Record review of the facility's Food-Supply Storage-Food and Nutrition Services Policy, dated 05/19/2025, indicated USE By/USE or Freeze By* (expiration date) - This is used on Time/temperature Control for Safety Foods (TCS). Safety phrasing will inform customers that these products should be consumed on or before the date listed on the package. The product should not be consumed after the date on the package due to the product's perishable nature and the product should be disposed of. This date label is for perishable products with potential safety implications or material degradation of critical performance, such as nutrition. BEST If Used By/BEST If Used or Freeze By* - Quality phrasing will indicate to consumers that after the specified date, the product may not taste or perform as expected but is safe to use or consume. For example, the quality of the product taste or texture may have diminished slightly, or it may not have the full vitamin content indicated on the package. Best if used by/Best if Used or Freeze By dates such as sell by or best if used by, are not expiration dates. Refer to USDA guidance on Shelf-Stable Food Safety (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(www.fsis.usda.gov). Time/temperature control for safety food (TCS)-A food that requires time/temperature control for safety (TCS) to limit pathogenic microorganism growth or toxin formation. Leftovers-Food items prepared for service that were not served subsequently stored for use within seven days per Food Code. Check state regulations for more detail. 6. Storeroom layout:Foods that have been opened or prepared are placed in an enclosed container, dated, labeled, and stored properly.7. The items being prepared for the next meal do not have to be dated and labeled but must be covered. Once meal service is over, cover, date, and label trays of individually portioned items such as desserts, salads, glasses of juice, milk, and supplements.8. Use By and Freeze By (expiration) dates are checked on a regular basis; foods/fluids that have expired or are otherwise unsafe for use are discarded.9. In addition, once opened, all food items must be clearly labeled and dated. Time/temperature control for safety (TCS) foods must be used or discarded within 7 days of opening or preparation(including the day of preparation). Specific product categories follow USDA/FDA guidance, such as dairy products and deli meats 3 days, juices 7 days, frozen opened items 6 months to 12 months,Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Packaged Food shall be labeled as specified in law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for fiscal year 2025 for the first quarter (October 1, 2024, to December 31, 2024) reviewed for one of one facility administration reviewed. The facility failed to submit PBJ (Payroll Based Journal) staffing information to CMS for October 1, 2024, to December 31, 2024. This failure could place all residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings Included: Record review of the Casper3 PBJ report (CASPER Certification and Survey Enhanced Reporting) revealed the facility had four areas triggered on the FY Quarter 1 (October 1 - December 31) report. The areas were One Star Staffing Rating, which refers to (A quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average.) Excessively low Weekend Staffing, No RN hours, and Failed to have Licensed Nursing Coverage 24 hours/day. The report details no RN hours for every day in October 2024. It also details Failed to have Licensed Nursing Coverage 24 hours/day for every day in October 2024. During an interview on 09/11/2025 at 1:32 PM with the DON. The DON stated she has been here for 4 years at this facility as the DON. The DON stated was working during the month of October and there would have been no days without a working RN. The DON stated she was unaware of any issues and would pull the working schedule for the specified time. During an interview on 09/11/2025 at 2:00 PM HR stated has been the HR have been here for about a year and half. Does the facility use a vendor to submit information on behalf of the nursing home is still ultimately responsible for meeting all the requirements. I collect the data and send it up to corporate, and they send the information. HR stated so for 10/1/24 - 10/31/24 we just could not get anything even employee files from the previous owners. During an interview on 09/11/2025 at 2:52 PM The ADMIN stated he has been the ADMIN for approximately 11 years. ADMIN stated they were aware the PBJ data had not been submitted for the quarter 1 to CMS. The ADMIN stated the facility had a change of ownership effective November 1, 2024. The previous company stated they would submit the PBJ data to CMS. ADMIN stated this has been an on-going issue with the previous owner. He stated that the corporate office enters the PBJ information. He stated that this was the only month with this error and was related to the change from one company to the new company and does not expect any issues in the future. The ADMIN stated their corporate offices were currently in the process of getting this rectified. Record review of PBJ data submission policy attempted / requested verbally on 09/09/2025 at 12:45 PM with the ADMIN. A follow up request via email was sent to the ADMIN & DON on 09/11/25 at 11:10 AM for PBJ Submission, Facility Assessment RN Hours / Staffing, and RN Coverage for the specified dates covering Quarter 1 (October 1 - December 31). The policy was not provided prior to the exit. Requested time sheets, and Punch Detail reports were requested from DON and ADMIN and were not provide prior to exit.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to secure confidential medical records for three (Resident #16, Resident #21, and Resident #61) of eighteen residents reviewed for resident rights. The facility failed to ensure LVN I secured Resident #16, Resident #21, and Resident #61's medical information before leaving her cart on 09/10/2025. This failure could place the residents at risk of not having their medical information exposed to unauthorized individuals. Resident #16 Record review of Resident #16's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with infection and inflammatory reaction due to other internal joint prosthesis (artificial device that replaces a missing body part). Record review of Resident #16's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 09/02/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 14. The Comprehensive MDS Assessment indicated the resident had an infection and inflammatory reaction due to other internal joint prosthesis. Record review of Resident #16's Comprehensive Care Plan, dated 09/09/2025, reflected the resident had infection to right shoulder and one of the interventions was to administer antibiotic as per MD orders. Record review of Resident #16's Physician Order, dated 08/29/2025, reflected Admit to skilled level of care (a level of care designed for individuals with complex medication that needed a high level of care) on 8/29/25. Record review of Resident #16's Physician Order, dated 08/30/2025, reflected Daptomycin (antibiotic used to treat bacterial infection) Intravenous Solution Reconstituted (Daptomycin). Use 300 mg intravenously one time a day for Post surgical right shoulder for 13 Days. Record review of Resident #16's Progress Notes, dated 09/01/2025, reflected Continue with IV (intravenous: administering fluids or medications directly into a vein) . transferred to . for skilled nursing care. Resident #21 Record review of Resident #21's Face Sheet, dated 09/09/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with acute kidney failure and retention of urine. Record review of Resident #21's Comprehensive MDS Assessment, dated 09/08/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had acute kidney failure (kidneys stop working) and retention of urine. Record review of Resident #21's Comprehensive Care Plan, dated 09/03/2025, reflected the resident had renal insufficiency (kidney unable to filter waste from the blood) and one the interventions was to monitor laboratory results. Record review of Resident #21's Physician Order, dated 09/02/2025, reflected Admit to skilled level of care on 9/2/25. Record review of Resident #21's Physician Order, dated 09/08/2025, reflected Culture, Urine Automated Urine - UA one time only related to RETENTION OF URINE . ACUTE KIDNEY FAILURE. Record review of Resident #21's Physician Order, dated 09/09/2025, reflected Zinc oxide to perineum (area between the thighs) and buttocks, turn and reposition when in bed as needed every shift for Redness . Order Type: . TAR. Record review of Resident #21's Progress Notes, dated 09/08/2025, reflected New order . UA . Record review of Resident #21's Progress Notes, dated 09/10/2025, reflected Skin note: Zinc applied to perineum and buttock redness. Resident #61 Record review of Resident #61's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with fracture (broken bone) to right foot. Record review of Resident #61's Comprehensive MDS Assessment, dated 09/09/2025, reflected the resident cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had a fracture related to fall. Record review of Resident #61's Comprehensive Care Plan, dated 4/12/2025, reflected had pain due to fracture to right foot and one of the interventions was to monitor was to administer analgesia (pain relief medication) as ordered. Record review of Resident #61's Physician Order, dated 09/04/2025, reflected Admit to skilled level of care on 9/4/25. Record review of Resident #61's Progress Notes, (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 09/05/2025, reflected Skilled Evaluation. An observation on 09/10/2025 at 6:52 AM revealed LVN I left her cart and went inside a resident's room. A piece of paper was on top of the cart that was parked in front of the nurses' station and was facing the hallway. On the piece of paper was some of Resident #16, #21, and #61's medical information. The piece of paper revealed that Resident #16 was on skilled nursing and needed urinalysis; Resident #21 was on skilled nursing, antibiotics, and to change the order of zinc in his TAR; and Resident #61 was on skilled nursing. During an observation and interview on 09/10/2025 at 7:02 AM, LVN I stated she always wrote what she needed to do for her shift on a piece of paper, so she had a brief summary of the things needed to monitor or accomplish. She said she would list who was on skilled nursing, any new orders, or which resident was on antibiotics. She said she would also write down their blood sugar. She said the numbers on the piece of paper were the residents' blood sugar. She said she was not sure if what she wrote was medical information. She said, she guessed she should have flipped the paper before she left her cart if it contained medical information. In an interview on 09/11/2025 at 7:43 AM, the DON stated if what was written on the piece of paper was medical information of the residents, then it should not be left unattended because some of the visitors were lay persons, and did not have an idea of what was written on the piece of paper, but some would be clinicians that would have a good idea of what was written. She said if confidential information were left unattended, unauthorized personnel could had access to them. She said she would do an in-service about confidentiality of records. In an interview on 09/11/2025 at 8:45 AM, the ADON stated the medical information of any resident should not be left unattended because they were confidential and could be a HIPAA violation. She said, before leaving the cart, the staff should have secured it somewhere so unauthorized individuals would not see them. She said visitors were not all lay persons, but others could be nurses, paramedics, or pharmacist that could clearly understand what was written on the paper. She said she would coordinate with the DON to do an in-service about privacy and confidentiality. Record review of the facility's policy entitled, Confidentiality of Information and Personal Privacy Strategy, Delivery, Performance revised 8/2024 reflected Policy Statement: Our facility will protect and safeguard resident confidentiality and personal privacy . 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for four (Resident #7, Resident #9, resident #35, and Resident #37) of fifteen residents reviewed for Care Plans. 1. The facility failed to ensure Resident #7's care plan for diabetes, dated 08/25/2025, had appropriate interventions. 2. The facility failed to ensure Resident #7 was care planned for hypertension. 3. The facility failed to ensure Resident #9's care plan for diabetes, dated 08/25/2025, had appropriate interventions. 4. The facility failed to ensure Resident #35 was care planned for hypertension. 5. The facility failed to ensure Resident #37 was care planned for hyperlipidemia. These failures could place the residents at risk of not receiving the necessary care and services needed. Findings included: 1. Record review of Resident #7's Face Sheet, dated 09/10/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with type 2 diabetes mellitus (high blood sugar) and long-term use of insulin. Record review of Resident #7's Quarterly MDS Assessment, dated 06/08/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #7's Comprehensive Care Plan, dated 08/25/2025, reflected that the interventions for the resident's diabetes were to check all body parts, licensed nurse to provide foot care, and ensure socks were dry. The care plan did not reflect that the resident was taking medications for diabetes, to have a dietary consult, to check the fasting blood sugar, and to monitor for signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). Record review of Resident #7's Physician Order, dated 08/27/2024, reflected Insulin Lispro Solution (man-made insulin to treat diabetes) 100 UNIT/ML. Inject subcutaneously (administer under the skin) before meals and at bedtime for DM2 (Type 2 diabetes: adult-onset diabetes). 2. Record review of Resident #7's Face Sheet, dated 09/10/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). The Face Sheet indicated to call MD's office and notify if systolic less than 110. Record review of Resident #7's Quarterly MDS Assessment, dated 06/08/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had hypertension for the last seven days. Record review of Resident #7's Comprehensive Care Plan on 09/10/2025 r reflected no care plan for hypertension. Record review of Resident #7's Physician Order, dated 12/04/2021, reflected Cozaar tablet (Losartan Potassium). Give 12.5 mg by mouth once a day for hypertension. 3. Record review of Resident #9's Face Sheet, dated 09/10/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed last 12/22/2023 with type 2 diabetes with diabetic neuropathy (nerve damage due to diabetes). Record review of Resident #9's Comprehensive MDS Assessment, dated 06/30/2025, reflected the resident had severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #9's Comprehensive Care Plan, dated 08/25/2025, reflected that the interventions for the resident's diabetes were to observe the resident and family's ability to manage the treatment and to encourage resident to practice good general health practices. The care plan did not reflect that the resident was taking medications for diabetes, to have a dietary consult, to check the fasting blood sugar, and to monitor for signs and symptoms of hyperglycemia and hypoglycemia. Record review of Resident #9's Physician Order, dated 09/09/2025, reflected Humalog (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro). Inject subcutaneously before meals for elevated A1C (test done to check the amount of sugar in the blood). Record review of Resident #9's Progress Notes, dated 08/16/2025, reflected Note Text: Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML . no insulin required; 141. Record review of Resident #9's Progress Notes, dated 08/21/2025, reflected Patient is stable . n/o received for insulin lispro 5U SQ before meals. 4. Record review of Resident #35's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #35's Quarterly MDS Assessment, dated 08/23/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #35's Comprehensive Care Plan on 09/10/2025 reflected no care plan for hypertension. Record review of Resident #35's Physician Order, dated 08/21/2021, reflected Lisinopril Oral Tablet 20 mg. Give 1 tablet by mouth once a day. 5. Record review of Resident #37's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female admitted on the facility on 09/03/2025. The resident was diagnosed with hyperlipidemia (high cholesterol in the blood). Record review of Resident #37's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had hyperlipidemia. Record review of Resident #37's Comprehensive Care Plan on 09/10/2025 reflected no care plan for hyperlipidemia. Record review of resident #37's Physician order, dated 09/03/2025, reflected Atorvastatin Calcium Oral Tablet 10 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day for HLD (high density lipoprotein: good cholesterol). In an interview on 09/11/2025 at 7:18 AM, the MDS Coordinator stated she was responsible in doing the care plans of the residents. She said, without the care plans, the staff might not be in sync in terms of care. She said, she felt that if there was already an order and the staff were already doing the treatment, there was no need to put them in the care plan. She said, what should be in the care plan were what else needed to be done and if the resident was doing differently. She said, care plans were to guide care not covered in the orders. She said, do not see what referring back to the care plan will help. She said, she feels like checking the boxes was just to feel in the boxes. She said, if all the conditions of the residents were care planned, it could produce more than a 20-page care plan. In an interview on 09/11/2025 at 7:43 AM, the DON stated the care plan was the living document of what care were being done for the resident. She said the care plan complimented the orders and supplemented the care provided. She said the care plan should be person-centered and should contain the problem, the goals, and the interventions. She said the care plan should be tangible and specific. She said care plans also make it possible that all the providers taking care of the residents would be on the same page. She said if the resident was diabetic, the care plan should reflect that the resident was being checked for blood sugar and was taking insulin. She said if the resident was hypertensive, there should be a care plan for hypertension. She said the MDS Coordinator was mainly responsible in doing the care plan but she did help. She said she would coordinate with the MDS Coordinator to check and audit the care plans of the residents. In an interview on 09/11/2025 at 8:45 AM, the ADON stated care plans were done so the staff would know the care needed by the residents. She said if a resident had was diabetic, the care plan should indicate that the resident was on insulin therapy or receiving oral medications for diabetes. She said the intervention should also reflect that blood sugars were being checked. She said if the resident had hypertension and whatever else condition they had should be care planned. She said she was not that familiar with care plan and would coordinate with the DON and the MDS Coordinator about the issue. In an interview on 09/11/2025 at 2:50 PM, the Administrator asked, Are the residents not being cared for? Record review of facility's policy, Care Plans, Comprehensive Person-Centered Strategy, Delivery, Performance revised 08/2024 reflected Policy Statement: A comprehensive, person-centered care plan . is developed and implemented for each resident . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive assessment . 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful . 9. Care plan interventions are chosen only after careful data gathering . 10. When . interventions address the underlying source(s) of the problem area(s).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that medications were stored properly in locked compartments for 4 (Resident #11, Resident #37, Resident #44, and Resident #60) of eighteen residents reviewed for medication storage, 1. The facility failed to ensure Resident #11's zinc oxide (medicated cream used to prevent skin irritation) was not left inside the resident's room on 09/09/2025. 2. The facility failed to ensure LVN A did not leave Resident #37's tramadol inside the resident's room for the resident to take unsupervised on 09/09/2025. 3. The facility failed to ensure Resident #44's zinc oxide was not left inside the resident's room on 09/09/2025. 4. The facility failed to ensure Resident #60's xeroform, petroleum dressing, and calcium alginate were not left inside the resident's room on 09/09/2025. These failures could place the residents at risk of accidental overdose or misuse of medications. Findings included: 1. Record review of Resident #11s Face Sheet, dated 09/10/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #11's Comprehensive MDS Assessment, dated 07/24/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder and was at risk of developing pressure ulcers/injuries. Record review of Resident #11's Comprehensive Care Plan, dated 08/13/2025, reflected the resident had incontinence and one of the goals was for the resident to be free from skin breakdown. Record review of Resident #11's Physician Order on 09/09/2025 reflected no order for barrier cream. Observation on 09/09/2025 at 9:18 AM revealed Resident #11 was not inside the room. It was observed that a tube of zinc oxide was on the resident's side table. In an interview on 09/09/2025 at 12:39 PM, CNA B stated she did not notice that the zinc oxide was at Resident #11's side table when she did her morning round. She said she did not do the resident's incontinent care because the resident was already up. She said the zinc oxide should be inside the drawer of the resident's side table when not in use because the resident might consume it. She said it should be not within the reach of any resident for their safety. 2. Record review of Resident #37's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female admitted on the facility on 09/03/2025. The resident was diagnosed with fracture to right femur and acute pain due to trauma. Record review of Resident #37's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had fracture and had acute pain. Record review of Resident #37's Comprehensive Care Plan, dated 09/04/2025, reflected the resident had acute pain related to fracture and one of the interventions was to monitor the effectiveness of the pain interventions. Record review of Resident #37's Physician Order, date 09/03/2025, reflected Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for pain. Observation and interview on 09/09/2025 at 9:21 AM revealed Resident #37 was in her bed, awake. It was observed that there was a small plastic cup, with one pill inside, on the resident's food tray. The resident took the cup and took the medication. She said the nurse left it there and told her to take the medication after she was done with breakfast. She said the medication was a tramadol. In an interview on 09/09/2025 at 1:52 PM, LVN A stated Resident #37 requested for a tramadol and she gave her one as her PRN. She said she should have made sure that the resident swallowed the tramadol before leaving the resident because the resident might not take them, throw them, or choke while taking them and no one would know. She said it was a controlled substance and a resident who was allergic to tramadol might get a hold of it. 3. Record review of Resident #44's Face Sheet, dated 09/10/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and needed assistance for personal care. Record review of (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #44's Quarterly MDS Assessment, dated 08/25/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated that the resident was incontinent for bowel and bladder. Record review of Resident #44's Comprehensive Care Plan, dated 08/27/2025, reflected the resident had incontinence and one of the goals was for the resident to be free from skin breakdown. Record review of Resident #44's Physician Order on 09/09/2025 reflected no order for barrier cream. Observation and interview on 09/09/2025 at 9:14 AM revealed Resident #44 was in her bed, awake. It was observed that there was a tube of zinc oxide on the resident's side table. She said the aides use the cream after they clean her bottom. She said the tube of zinc oxide had always been on the table. In an interview on 09/09/2025 at 12:48 PM, CNA C stated she did not notice the tube of zinc oxide on Resident #44 side table when she did her round. She said the resident was done with her incontinent care when she came. She said when she did the resident's incontinent care, she saw the tube of zinc oxide at the resident's side table, and she did not know who left it there. She said she placed the zinc oxide inside the resident's side table drawer when she was done providing incontinent care. She said the resident might eat the cream and it could be harmful to the residents. 4. Record review of Resident #60's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with history of falling. Record review of Resident #60's Quarterly MDS Assessment, dated 08/08/2025, reflected the resident had severe impairment in cognition with a BIMS score of 04. The Quarterly MDS Assessment indicated the resident had a skin tear. Record review of Resident #60's Care Plan, dated 09/08/2025, reflected the resident had a skin tear and one of the interventions was to treat the skin tear. Record review of Resident #60's Physician Order, dated 09/04/2024, reflected WOUND CARE: skin tear to RUE and forearm cleanse with vashe solution, pat dry, apply oil emulsion dressing to wound bed and open skin flaps, then calcium alginate, wrap with kerlix and secure with tape every day shift every other day for skin tears. Observation on 09/09/2025 at 9:10 AM revealed Resident #60 was not inside the room. It was observed that there were several materials for wound care, such as xeroform, alginate dressing, petroleum dressing, on top of the resident's dresser. One of the packaging had an instruction Caution: The Packaging of This Product Contains Natural Rubber Latex Which May Cause Allergic Reactions. Observation and interview on 09/09/2025 at 12:20 PM, LVN A stated Resident #60 had a skin tear to his right arm. She said she did not know who left the wound care materials on top of the resident's dresser. She said it should be inside the cart or inside the resident's drawer. She said residents might get hold of them and consume them. She said the dressings were medicated dressing that were applied topically to facilitate healing of the wound but might have a different effect when ingested. She said residents might be allergic to them. She gathered the wound care materials and said she would put them in the cart. She said the wound care materials were also accessible to other residents and they could accidentally consume them as well. In an interview on 09/11/2025 at 7:43 AM, the DON stated zinc oxide, and the medicated dressing should not be within reach of the residents because of the possibility of the residents consuming it. She stated they may only present little risks when ingested but there was still a risk. She said the residents might be allergic to them when consumed or used differently. She said the zinc oxide should be stored along with the wound care materials inside the carts. She said the expectations were for the staff to always scan the residents' rooms to make sure they were not leaving the tubes of zinc oxide and materials for wound care. She said she would do an in-service about storing medications accordingly. In an interview on 09/11/2025 at 8:45 AM, the ADON stated the zinc oxide should be inside the drawer or somewhere the residents could not access them. She said the materials for wound care should be inside the cart and not left inside the room after wound care. She said confused residents might mistake them as something that could be eaten and could result in upset stomach. She said the expectation was for the staff to make sure no zinc oxide was placed where the residents could access them and the materials for wound care, which some of them were medicated, were stored in the cart when not in use. She said she would coordinate with the DON to do an in-service (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about medication storage. In an interview on 09/11/2025 at 2:50 PM, the Administrator stated according to SDS, a large quantity of zinc oxide was needed to be ingested before there would be an effect. Record review of the facility's policy, Medication Labeling and Storage Strategy Delivery Performance revised 08/2024 reflected Policy Statement: The facility stores all medications and biologicals in locked compartments . Medication Storage . 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and 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 five (Residents #4, #6, #32, #35, and #43) of twelve residents reviewed for infection control. 1. The facility failed to ensure CNA B wore a gown when she transferred Resident #4, who had a catheter, from bed to wheelchair on 09/09/2025. 2. The facility failed to ensure CNA F and CNA G performed hand hygiene and changed their gloves after touching Resident #6's catheter tubing on 09/10/2025. 3. The facility failed to ensure CNA F performed hand hygiene and did not put gloves in her pocket when she assisted Resident #32 on 09/10/2025. 4. The facility failed to ensure LVN A wore a gown when she administered Resident #35's IV on 09/09/2025. 5. The facility failed to ensure PTA D and PT E wore a gown while assessing, repositioning, and trying to transfer Resident #43, who had a surgical wound, on 09/09/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #4's Face Sheet, dated 09/09/2025, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of bladder (the muscles and nerves that control the bladder do not work properly due to illness). Review of Resident #4's Comprehensive MDS Assessment, dated 06/20/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (device that drains urine from the urinary bladder). Review of Resident #4's Comprehensive Care Plan, dated 09/09/2025, reflected the resident required enhanced barrier precaution. Record review of Resident #4's Physician Order, dated 10/10/2024, reflected CATHETER: 18 fr (French: unit of measurement for catheter sizes)with 10 cc balloon to dependent drainage. Change catheter PRN if dislodged or plugged and unable to clear with irrigation. Observation and interview on 09/09/2025 revealed Resident #4 was in her bed, awake. She stated she had the catheter since last year. It was also observed that there was sign outside the resident's door that EBP was required during transfer. Observation and interview on 09/09/2025 at 12:03 PM revealed CNA B was walking towards Resident #4's room. She said she would get the resident to eat lunch at the dining area. She went inside the room without wearing a gown. Observation on 09/09/2025 at 12:07 PM revealed there was no PPE cart inside Resident #4's room. Observation and interview on 09/09/2025 at 12:18 PM revealed Resident #4 was on her wheelchair waiting for her lunch in the dining area. She stated she was transferred to her wheelchair from her bed before lunch. She said the staff that transferred her did not have a gown during transfer. In an interview on 09/09/2025 at 12:39 PM, CNA B stated she did transfer Resident #4 from her bed to wheelchair to go to the dining area to eat lunch. She said she did not wear a gown when she transferred the resident. She said she should have worn a gown when she transferred the resident because there was an EBP sign on the resident's door that specified to wear a gown during transfer. She said her action could cause cross contamination and infection. 2. Record review of Resident #6's Face Sheet, dated 09/10/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of bladder. Record review of Resident #6's Comprehensive MDS Assessment, dated 07/13/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had an indwelling catheter. Record review of Resident #6's Comprehensive Care Plan, dated 10/06/2025, reflected the resident had a catheter and one of the interventions was to monitor for signs and symptoms of UTI. Observation on 09/10/2025 at 10:26 AM revealed Resident #6 just came back from her shower and would be transferred to her bed via mechanical lift. It was observed that the resident had a catheter. CNA F and CNA G transferred the resident to her bed, and both started to detach the sling from the mechanical lift. CNA G hung the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's catheter on the railing below the bed. Both CNAs changed their gloves, but CNA G did not sanitize her hands before putting on a new pair of gloves. They assisted the resident to roll on her right side. CNA F rolled the draw sheet along with the sling towards the center of the bed. While the resident was still on her right side, CNA F took off her gloves, sanitized her hands, put on a pair of gloves, and put the brief under the resident. After putting the brief under the resident, they assisted the resident to turn on the other side so CNA G could pull the draw sheet and the sling for the mechanical lift. While in the process of pulling the draw sheet and the sling, both CNAs touched the tubing of the catheter to adjust so the draw sheet and the sling could be pulled. After touching the tubing of the catheter, CNA F proceeded to fix the brief some more. She did not change her gloves after touching the tubing of the catheter. After pulling the draw sheet and the sling, CNA G changed her gloves but did not sanitize her hands before putting on the new pair of gloves. In an interview on 09/10/2025 at 10:40 AM, CNA F stated she thought the tubing of the catheter was clean because Resident #6 just came out of the shower. She said she guessed she should have changed her gloves because the tubing might still be dirty and could result in cross contamination and infection. In an interview on 09/10/2025 at 10:46 AM, CNA G stated she did change her gloves several times but did not sanitize her hands. She said it was important to sanitize the hands before putting on a new pair of gloves to ensure the hands were clean before touching the new pair of gloves. She said sanitizing the hands in between changing of gloves should be done to prevent infection. 3. Record review of Resident #32's Face Sheet, dated 09/11/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #32's Comprehensive MDS Assessment, dated 07/11/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Quarterly MDS Assessment indicated the resident needed moderate assistance for toileting hygiene. Record review of Resident #32's Comprehensive Care Plan, dated 08/04/2025, reflected the resident had an ADL self-care performance deficit related to weakness and one of the interventions was to assist during transfer. Observation on 09/10/2025 at 8:40 AM revealed CNA F was ushering Resident #32 to her room. She said the resident wanted to go to the bathroom. Once inside the room, she pulled a pair of gloves from her pocket, put them on, and assisted the resident to transfer to the toilet bowl. She did not do hand hygiene before putting on a pair of gloves that she pulled from her pocket. After transferring the resident to the toilet bowl, she lowered the resident's pants and took the resident's brief that was already unfastened. She placed the brief in a plastic bag. She took off her gloves and said she would wait for the resident to be done inside the room. While waiting, she took some gloves from the box of gloves on the wall and put them inside her pocket. When the resident was done, she pulled a pair of gloves from her pockets, put them on, and put a new brief on the resident. In an interview on 09/10/2025 at 8:51 AM, CNA F stated she did put some gloves in her pocket, but she was not sure if her pocket was clean. She said she guessed her pocket was not clean because she would put her keys, and sometimes money in her pocket. She said she would not put gloves inside her pocket again and would just get them from the box to make sure she was using clean gloves. 4. Record review of Resident #35's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with infection following a procedure. Record review of Resident #35's Comprehensive MDS Assessment, dated 08/23/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident had a wound infection and was receiving antibiotics. Record review of Resident #35's Comprehensive Care Plan, dated 08/19/2025, reflected the resident required enhanced barrier protections related to infection to surgical wound. Record review of Resident #35's Physician Order, dated 08/20/2025, reflected Ceftriaxone Sodium Injection Solution Reconstituted 2 GM. Use 2 gram intravenously once daily. Record review of Resident #35's Physician Order, dated 08/19/2025, reflected IV-PICC Normal Saline Flush Solution 0.9 % 10 mL RUE every shift for patency (the tube was not blocked). Record review of Resident #35's Progress Note, dated 09/10/2025 reflected PICC line is patent. PICC (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing intact. Observation on 09/09/2025 at 11:45 AM revealed LVN A went inside the room to connect Resident #35's IV antibiotics. She did not wear a gown before going inside the room. A signage was posted on the resident's door that said to wear a gown for use of central line. Observation and interview on 09/09/2025 at 11:50 AM, revealed Resident #35 was in her bed receiving IV antibiotics. She said she had a surgical wound to the back of her neck that got infected and that was why she was getting an antibiotic. She said she did not notice if the nurse that connected the IV was wearing a gown or not and then she said she was not wearing the yellow gown. It was also observed that there was no PPE cart inside the resident's room. Observation and interview on 09/09/2025 at 11:55 AM, LVN A stated she would disconnect Resident #35's IV that she earlier connected. She went inside the room and went straight to the IV pole. She did not wear a gown before entering the room. When she was about to disconnect the IV, she saw that the IV antibiotics was not yet done. She said she would come back to check if the antibiotics was done. Observation and interview on 09/09/2025 at 12:13 PM, LVN A said she would disconnect Resident #35's IV antibiotics because it was done already. She went inside the room holding a saline syringe. Before she entered the room, LVN A was observed looking at the sign posted on the resident's door. After looking at the signage, she took a gown from the PPE cart and wore it before entering the room. She disconnected the IV and flushed it afterwards. In an interview on 09/09/2025 at 1:52 PM, LVN A stated she connected the IV antibiotics without a gown, went inside the room to disconnect the IV the first time and she also did not wear a gown. She said Resident #35 had an IV and that was why she was on EBP. She said the EBP was for residents with IV to prevent cross contamination and infection. 5. Record review of Resident #43's Face Sheet dated 09/10/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with presence of artificial knee joint. Record review of Resident #43's Comprehensive MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a joint replacement surgery. Record review of Resident #43's Comprehensive Care Plan, dated 09/09/2025, reflected the resident required enhance barrier precautions related to wound to right knee. Record review of Resident #43's Physician Order, dated 09/08/2025, reflected WOUND CARE: Surgical wound to Right knee- keep dressing clean dry and intact. Monitor for s/s of infection every shift for post-surgical. Record review of Resident #43's Physician Order, dated 09/08/2025, reflected PT . to evaluate . Observation and interview on 09/09/2025 at 9:16 AM revealed Resident #43 was in his bed, awake. It was observed that the resident had a bandage on his right knee. He said he just had surgery for a knee replacement. He said he was just admitted the day before. It was also observed that there was a sign outside the resident's door indicating that EBP was required during transfer. Observation on 09/09/2025 at 11:36 AM revealed PTA D and PT E went inside Resident #43's room. They both did not wear a gown. Observation and interview on 09/09/2025 at 11:39 AM revealed LVN A stood up because she said she could hear somebody in pain. She said it looked like it was coming from Resident#43's room. She opened the door and saw PTA D and PT E inside the room. PTA D was on the right side of the resident while PT E was on the left side. The resident was observed in a slant position and PT E was fixing the resident's bed linens. Both staff had gloves on and were holding the resident. LVN A said the physical therapist was assessing the resident. She said they were trying to get him up. She said she was not sure if they needed to wear a gown. In an interview on 09/09/2025 at 11:43 AM, PTA D stated they were assessing Resident #43 to see how far he could go. She said they were trying to sit him up and see if he could transfer to the wheelchair. In an interview on 09/09/2025 at 11:44 AM, PT E stated they were doing an initial assessment to evaluate Resident #43's condition and what were the resident's current capabilities. He said they were trying to transfer the resident and sit him up, but the resident was still in pain, so they were repositioning him back. He said he did not think he needed to wear a gown because the surgery site was wrapped, and they were wearing gloves. In an interview on 09/09/2025 at 12:36 PM, Resident #43 stated he was assessed by the physical therapists. He said (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they were trying to get him up or see how far he could go in terms of transferring. He said they tried to sit him up, one staff on his feet and the other on his back. In an interview on 09/11/2025 at 7:43 AM, the DON stated the gloves should not be placed inside the pockets because the pockets were not always clean. She said using gloves from the pocket was like using soiled gloves. She said the staff must do hand hygiene before putting on a pair of gloves because the gloves were porous, and drainage or contaminants could seep inside making the hands unclean. She said the staff should do hand hygiene before and after any care. She said the gloves should have been changed after touching the catheter tubing. She said when transferring a resident with a catheter, the staff should wear gloves and a gown because the resident was on EBP. She said it was tricky with therapy but if they were doing a high contact activity inside the room, like repositioning the resident with surgical wound, they should have worn a gown. She said she was not sure about administering antibiotics via IV because the staff was not touching the resident. She said the issues discussed could lead to cross contamination and probable infection. She said the expectation was for the staff to give the best care. She said another expectation was for the staff to communicate if they were not sure of what they were supposed to do. She said she would do an in-service pertaining to infection control focusing on all the issues discussed. She said she would closely monitor the staff with their compliance to the policy of infection control. In an interview on 09/11/2025 at 8:45 AM, the ADON stated staff must perform hand hygiene before doing any care so not to transfer any germs that they may have on their hands. She said staff must sanitize their hands before putting on a new pair of gloves because the gloves have small holes in them and fecal or wound drainage could seep inside the gloves rendering the hands dirty. She said the pocket was not a place to put the gloves because it was where the car keys, money, snacks, and dirty hands were. She said the pocket was not always clean. She said the gloves should have been changed when the tubing of the catheter was touched even if the resident just came out from the shower because it was a passage for urine. She said EBP should be worn during transfer of a resident with a catheter, repositioning, and bed mobility of a resident with a surgical wound and, IV use. She said the purpose of an EBP was to not carry any microorganism from one resident to another. She said EBP was used to prevent the spread of MDRO around the facility. She said the expectation was for the staff to be mindful and compliant with the policy of infection control. She said she would coordinate with the DON to do an in-service about infection control, and she would closely monitor the staff compliance since she was the IP. In an interview on 09/11/2025 at 2:50 PM, the Administrator stated will let the DON handle the issue of infection control. Record review of the facility's policy Handwashing/Hand Hygiene Strategy, Delivery, Performance revised 08/2024 reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub . b. Before and after direct contact with residents . e. Before and after handling an invasive device (e.g., urinary catheters .). Record review of the facility's policy Enhanced Barrier Precaution undated reflected Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities . expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . Wounds include . unhealed surgical wounds . Indwelling medical device examples central line, urinary catheter . [NAME] Gloves and Gown . transfer a resident . Yes .Turn and Reposition or assist with bed mobility . Yes . Device care or use: central line . Yes.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown and infection for one (Resident #44) of four residents reviewed for quality of care. The facility failed to ensure that LVN A did not use only one gauze to clean Resident #44's pressure ulcer to her sacrum (bone of the bottom) back and forth, and one gauze to pat dry the pressure ulcer as well as the surrounding skin on 09/09/2025. This failure could place the residents with pressure ulcers at risk for worsening of the existing pressure ulcers and infection. Findings included: Record review of Resident #44's Face Sheet, dated 09/10/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a fracture to sacrum. Record review of Resident #44's Quarterly MDS Assessment, dated 08/25/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needed little support) with a BIMS score of 13. The Quarterly MDS Assessment indicated that the resident had an unstageable pressure ulcer. Record review of Resident #44's Comprehensive Care Plan, dated 08/27/2025, reflected the resident had pressure ulcer to sacrum due to immobility one of the interventions was to administer treatment as ordered and monitor for effectiveness. Record review of Resident #44's Physician Order, dated 09/04/2025, reflected WOUND CARE: Clean sacral pressure ulcer with wound cleanser or NS and pat dry. Collagen powder alginate and border gauze qd and prn if soiled, saturated, or dislodged. Every day shift every 2 day(s) for sacral ulcer AND as needed for sacral ulcer prn saturated, soiled or dislodged. Observation on 09/09/2025 at 1:33 PM revealed LVN A was about to do Resident #44's wound care. She said the resident had a pressure ulcer to her sacrum and the treatment would be to clean with normal saline, collagen powder, and cover with a dressing. She sanitized her hands, put on a pair of gloves, sanitized the table, and waited for it to dry up. When the table was dry, she placed a blue pad on the table and put the gauze, powder alginate, gelling fiber silver dressing, and normal saline bullets on top of the pad. She then taped a plastic bag at the side of the table. She took off her gloves and sanitized her hands. She put on a gown and a pair of gloves, and closed the door using her foot. She told the resident to roll on her side, unfastened the brief and took off the old dressing. She took off her gloves, sanitized her hands, and put on a new pair of gloves. She squeezed the normal saline bullet on a couple of gauze and started to clean the resident's pressure ulcer to the resident's sacrum. She started by cleaning the pressure ulcer downward, but then with the same gauze, wiped the pressure ulcer upward. She used the same gauze to clean the pressure ulcer upward and downward four times. It was observed that the wet gauze touched the surrounding skin of the pressure ulcer. She then took some gauze and patted dry the wound and the surrounding skin of the wound. She took off her gloves, sanitized her hands, and put on a pair of gloves. She then put some collagen powder on the wound and covered it a dressing. In an interview on 09/09/2025 at 1:52 PM, LVN A stated the right procedure in cleaning the wound was to clean the wound from inside to outside and not to use the gauze that was already used again. She said she should have discarded the first gauze that she used to clean one wound and take another one to clean it. She said as if the microorganism accumulated from the first cleaning was introduced back to the wound. She said she should have cleaned and then discarded the gauze and then repeated. She said she would be mindful the next time she would do wound care not to use soiled gauze to clean the pressure ulcer and to clean from inside out to make sure the pressure ulcer would not be infected. In an interview on 09/11/2025 at 7:43 AM, the DON stated the gauze should be changed after every stroke and should not touch the pressure ulcer again. She said the soiled gauze should not go back and forth on the pressure ulcer because the goal was to clean the wound. She said if the same gauze was used, the microorganism might be introduced back to the pressure ulcer and could result in infection. She said the expectation was for the staff doing wound care to do the right procedure. She (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Lake Forest Village by Purehealth		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 Montecito Dr Denton, TX 76210	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she would do an in-service about proper technique in wound care. In an interview on 09/11/2025 at 8:45 AM, the ADON stated using the gauze used to clean the pressure ulcer again could lead to infection. She said the proper procedure in cleaning the wound be from inside out and then discard the gauze, get another gauze, clean the wound again, and then discard the gauze, and so on and so forth. She said if the same gauze just went back and forth, it would be as if the microorganisms was just trapped in the wound instead of washing it out. She said touching the surrounding skin with the gauze could introduce other bacteria from the surrounding skin to the wound. She said the expectation was to keep the bacteria out and not introduce germs from the surrounding skin. She said she would coordinate with the DON to do an in-service about wound care. In an interview on 09/11/2025 at 2:50 PM, the Administrator stated improper wound care could lead to infection. He said the expectation was to do wound care the right way according to wound care technique. He said they would do an in-service and check-offs. Record review of the facility's policy Wound Care 2001 MED-PASS, Inc. revised October 2010 reflected Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . 11. Cleanse wound and peri wound . Policy specific to not using the same gauze in cleaning the wound requested on 09/11/2025 at 12:39 PM via email but was not provided prior to exit.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the residents were provided medications and/or biologicals and pharmaceutical services to meet their needs for one (Resident #37) of eight residents reviewed for pharmaceutical services. 1. The facility failed to ensure that Resident #37 was not self-administering her Tramadol without assessment on 09/09/2025. 2. The facility failed to ensure that there was no expired medication inside the medication cart since Resident #37's admission to the facility on [DATE]. These failures could place residents at risk of not receiving medications as ordered by the physician, for potential overdose, and adverse effects. Findings included: Record review of Resident #37's Face Sheet, dated 09/10/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with fracture to right femur, acute pain due to trauma, and hyperlipidemia (high cholesterol in the blood). Record review of Resident #37's Quarterly MDS Assessment, dated 09/09/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had fracture and had acute pain. Record review of Resident #37's Comprehensive Care Plan, dated 09/04/2025, reflected the resident had acute pain related to fracture and one of the interventions was to monitor the effectiveness of the pain interventions. The care plan did not indicate that resident could self-administer her medications. The resident was not care planned did not for hyperlipidemia. Record review of Resident #37's Physician Order, date 09/03/2025, reflected Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident #37's Physician Order on 09/09/2025 reflected no order that the resident could self-administer her medications. Record review of Resident #37's Physician order, dated 09/03/2025, reflected Atorvastatin Calcium Oral Tablet 10 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day for HLD. Record review of Resident #37's Clinical Assessment on 09/09/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage her own medications. 1. Observation and interview on 09/09/2025 at 9:21 AM revealed Resident #37 was in her bed, awake. It was observed that there was a small plastic cup, with one pill inside, on the resident's food tray. The resident took the cup and took the medication. She said the nurse left it there and told her to take the medication after she was done with breakfast. She said the medication was a tramadol that she requested because she would go to therapy after breakfast, and most of the time, her body gets sore after therapy. She said she had a routine Tylenol, but it was not enough. She said as much as possible, she would not take tramadol, but her body was still sore from the last therapy session. In an interview on 09/09/2025 at 1:52 PM, LVN A stated Resident #37 requested for a tramadol and she gave her one as her PRN. She said she thought the resident took it. She said she should have made sure that the resident swallowed the tramadol before leaving the resident. She said the pills should not be left with the resident because the resident might not take them, throw them, or choke while taking them and no one would know. 2. Observation on 09/10/2025 at 11:05 AM revealed during inspection of the medication cart, one bottle of Atorvastatin for Resident #37 was dated 10/07/2024. Observation and interview on 09/10/2025 at 11:06 AM, MA J saw the bottle of medication and stated she did not know that the bottle was dated 10/07/2024. She said she administered Resident #37's atorvastatin earlier and took the medication from the resident's blister pack (a type of packaging in which a product is sealed in plastic, often with a cardboard backing). She said she noticed the bottle of medication but did not check for the expiration date of the bottles. She said if expired medications were used, it would be considered as a medication error. She said expired medications could be less effective or could have adverse reactions. She said she saw the bottle of medications but should have checked the dates of expiration. She said she did not know who placed (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lake Forest Village by Purehealth		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 Montecito Dr Denton, TX 76210	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medications inside the cart. She took the bottle of medication and said she would discard it. In an interview on 09/10/2025 at 3:03 PM, MA K stated she remembered that there was a bottle of medication for Resident #37. She said the nurse put the bottle of medication in her cart but did not touch it because it was not in the system for her to give. MA K said she did not check the medications when they were placed in the cart. She said the resident had blister pack for atorvastatin and that is what she used when she administered the medication. She said there should be no expired medication inside the cart because it would not be good for the residents if they were given it accidentally. In an interview on 09/10/2025 at 3:09 PM, RN H stated she was the one who admitted Resident #37 on 09/03/2025 and she remembered that medications in bottles were handed to her by a family member. She said she placed the bottles of medications inside the medication cart. She said she was handed two bottles of medication in a plastic bag. She said she did not check the medications before placing them inside the medication cart. She said she was not aware that one of the medication bottles was dated 10/07/2024. She said she did notice that the bottle was old, and the words could not be read anymore, and that should have prompted her to check the expiration date. She said expired medications could be harmful to the residents depending on what kind of medication. In an interview on 09/11/2025 at 7:43 AM, the DON stated a staff should never leave the medications at the bedside for the resident to take later unsupervised. She said the staff must ensure the resident took the medications before leaving the room. She said the resident might not take the pills or hide the pills to avoid taking them. She said the residents could also overdose if they took the pills given with the hoarded pills. She said expired medications should not be inside the medication carts because if taken by the residents, it could result in reduced effectiveness of the medication to unfavorable side effects. She said some expired medications lose their potency, but some would be toxic. She said the bottle of medication should have been handed to her because the facility had an in-house pharmacy where they order the medications. She said the expectations were for the staff not to leave any medication inside the room for the residents to take unsupervised and for no expired medications in the medication cart. She said she would do an in-service pertaining to all the issues mentioned. In an interview on 09/11/2025 at 8:45 AM, the ADON stated medication should not be left with the residents because the resident might not take it, throw it, or hide it. She said the resident might take the medication that she hid with the one that was just given to her and could overdose from it. She said another concern would be someone else might take it, like a confused resident or a visitor. She said the staff should stay with the resident until the resident was done taking the medications. She said residents could take their own medications if they have an assessment that they were competent enough to take the medications by themselves and without supervision. She said expired medications should not be inside the cart for the basic reason that it was expired. She said the bottle of medication should have been inspected upon receiving it and before placing it inside the cart. She said she was not sure what would be the adverse effects of expired medication, and she would consult the provider regarding what could be the effect of the expired medication. She said she would coordinate with the DON to do an in-service about not leaving any medications with the residents and about expired medications. In an interview on 09/11/2025 at 2:50 PM, the Administrator stated the medication should not be left inside the room because a wrong resident could take the wrong dose. He said the staff should make sure that the medication was swallowed before going out of the room. He said the staff must make sure there were no expired medications in the cart. Record review of the facility's policy, Administering Medications Strategy Delivery Performance revised 08/2024 reflected Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so . 12. The expiration/beyond use date on the medication label is checked . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.		