STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455832	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens	2535 W Pleasant Run Lancaster, TX 75146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #7, Resident #98, and Resident #104) of twenty-one residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #7, Resident #98, and Resident #104's rooms were in a position that was accessible to the resident on 01/13/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #98Review of Resident #98's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with muscle weakness and abnormalities of gait and mobility.Review of Resident #98's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 11/12/2025, reflected the resident had a moderate (resident may need additional support and monitoring) impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 10. The Quarterly MDS Assessment indicated that the resident required moderate assistance for toileting hygiene, dressing, bed mobility, and transfer.Review of Resident #98's Comprehensive Care Plan, dated 08/18/2025, reflected the resident was at risk for falls one of the interventions was to be sure the resident's call light was within reach.During an observation and interview on 01/13/2026 at 9:45 AM revealed Resident #98 was in her bed, awake. It was observed that the resident's call light was on the floor. When asked about her call light, the resident did not reply and just shrugged her shoulders.Resident #104Review of Resident #104's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and lack of coordination.Review of Resident #104's Quarterly MDS Assessment, dated 11/26/2025, reflected the resident had a severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS score of 07. The Quarterly MDS Assessment indicated that the resident required maximal assistance for hygiene, shower, dressing, and transfer. Review of Resident #104's Comprehensive Care Plan, dated 08/18/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach.Observation and interview on 01/13/2026 at 9:49 AM revealed Resident #104 was in her bed, awake. It was observed that the resident's call light was on the floor, between her bed and her side table. When asked where her call light was, the resident said she did not have it.During an observation and interview on 01/13/2026 at 9:51 AM, ADON A stated call lights should be with the residents at all times so they could easily call the staff for assistance. He said call lights were important because the residents used them if they needed to be changed, needed a pain pill, or if they needed a refill of their pitchers. He went inside Resident #98's room, picked up the call light from the floor, and placed it where the resident could reach it. He then went to Resident #104's room, picked up the call light, and placed it where the resident could reach it. He said call lights were for all residents whether dependent or independent. He said an independent resident might be having a heart attack or shortness of breath and could not call anybody because the call light was not with the resident. He said she was one of the responsible in checking if the call lights were with the residents. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He said he would start an in-service about making sure call lights were within reach of the residents.Resident #7Record review of Resident #7's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and pain in right ankle.Record review of Resident #7's Quarterly MDS assessment dated [DATE], reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated that the resident required assistance for toileting, shower, dressing, transfer, and personal hygiene.Record review of Resident #7's Comprehensive Care Plan, dated 12/14/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was withing reach. During an observation and interview on 01/13/2026 at 11:33 AM revealed Resident #7 was in her bed, awake. It was observed that the resident's call light was on the floor under the bed. The resident said she had been looking for her call light because she needed to call the staff.During an interview and observation on 01/13/2026 at 11:35 AM, revealed ADON A went inside Resident #7's room and saw the call light on the floor. He picked it up and placed it where the resident could reach it. He said he already started an in-service about the call lights, and he did not understand why there was still a call light on the floor. He said the staff should make sure that the call lights were with the residents before leaving the room. He said the expectation was for all the staff to make sure the call lights were within reach of the residents before they left the residents' rooms.In an interview on 01/13/2026 at 11:33 AM, LVN B stated she was made aware about the call lights that were on the floor on her hall. She said she did not notice that the call lights were on the floor. She said the call lights should be with the residents at all times in case the residents needed the staff. She said the residents might get upset or even fall trying to do things by themselves.In an interview on 01/13/2026 at 11:43 AM, CNA D stated she did not notice that Resident #7, #98, and #104's call lights were not with them. She said the residents used the call lights to call the staff if they needed something or if they needed assistance. She said without the call lights, the residents might fall if they tried to do things by themselves. She said the call lights were for all the residents, whether they used them or not.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated that the staff should make sure that the call lights were with the residents before they leave the room. She said the staff should clip the call lights to make sure they would not fall when the residents moved. She said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. She said without the call light the residents might feel helpless, and the staff would not be able to help the residents when needed. She said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. She said she would collaborate with the DON about the issue regarding call lights.In an interview on 01/15/2026 at 9:04 AM, the DON stated that call lights were safety measures wherein the residents could call the staff if they needed something or needed assistance. She said residents might try to go to the bathroom by themselves because she had no way to call the staff that might result in a fall and injuries. She said all the staff were responsible for the call lights, including her. She said the expectation was for the staff to scan the residents' rooms when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. She said an in-service was already initiated but she would closely monitor the staffs' compliance about placing the call lights within reach of the residents. She added that, aside from the nurses and CNAs, she would include the therapists, housekeeping, maintenance, and management in the in-service.Record review of the facility's policy Call Lights: Accessibility and Timely Response P & P Committee revised 12/01/2025 reflected Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . Policy Explanation and Compliance Guidelines . 5. Staff will ensure the call light is within reach of resident and secured, as needed . 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room . 7. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure the resident's right to personal privacy and confidentiality of his or her personal and medical records for eleven (Residents #2, #5, #33, #40, #44, #49, #53, #91, #100, #116, and #117) of twenty-eight residents reviewed for resident rights. 1. The facility failed to ensure LVN B secured Resident #5's medical information before leaving her cart on 01/13/2026.2. The facility failed to ensure MA C secured Residents #2, #33, #40, #44, #49, #53, #91, #100, #116, and #117's medical information before leaving her cart on 01/14/2026.These failures could place the residents at risk of not having their personal and medical information confidential and exposed to unauthorized individuals.Findings included: 1. Record review of Resident #5's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with end-stage renal disease (a condition where the kidneys can no longer function adequately).An observation on 01/13/2025 at 11:33 AM revealed LVN B took a box of medication from Resident #5's side table and put it on top of the cart. After putting it on top of the cart, LVN B pushed her cart to attend to another resident. She went inside the room the resident's room leaving the box of medication on top of her cart that contained the resident's name and the medication that she was taking.During an observation and interview on 01/13/2026 at 12:04 PM, LVN B stated she should have placed Resident #5's box of medication inside the drawer of her cart because medical information was attached to it. She said the information should be secured and not exposed for everybody to see.2. Resident #2Record review of Resident #2's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with pulmonary embolism (blood clot in one of the blood vessels of the lungs).Resident #33Record review of Resident #33's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure).Resident #40Record review of Resident #40's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Resident #44Record review of Resident #44's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with heart failure.Resident #49Record review of Resident #49's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Resident #53Record review of Resident #53's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Resident #91Record review of Resident #91's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Resident #100Record review of Resident #100's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Resident #116Record review of Resident #116's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Resident #117Record review of Resident #117's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension.An observation on 01/14/2026 at 7:52 AM revealed MA C left her cart in the hallway and went to another hall to get a blood pressure cuff. A piece of paper was on top of the cart with Resident #2, #33, #40, #44, #49, #53, #91, #100, #116, and #117's blood pressures and pulses written beside their names. The cart was facing the hallway. Several residents and non-nursing staff were passing-by the cart.During an observation and interview on 01/14/2026 at 7:57 AM, MA C stated she always writes the residents' BP and pulses on a paper and would put it in the system later. She said she should have flipped the paper before she left her cart because the BP and pulses of the residents were medical information and should be secured. In an interview on 01/15/2026 at 8:16 AM, (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADON A stated the medical information of any resident should not be left unattended because it was confidential and could be a HIPAA violation. He said, before leaving the cart, the staff should have secured the box of medication and the piece of paper with medical information on them. He said the medical information should not be visible to unauthorized individuals. He said they already started an in-service about confidentiality of medical records.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated that staff must make sure that the residents' medical information was secured and only authorized individuals had access to it. She said it would be a HIPAA violation if the information was left unattended and unauthorized individuals were able to read it. She said the expectation was for the staff to make sure to secure everything that was confidential. She said she coordinated with the DON about the issue regarding confidentiality of records.In an interview on 01/15/2026 at 9:04 AM, the DON stated that if what was written on the box and on the piece of paper were medical information of the residents, then it should not be left unattended because the information was confidential. She said what the resident was taking and their blood pressures and pulses were medical information and leaving them unattended was a HIPAA violation. She said the expectation was for the staff to be mindful and protect the residents' information. She said she already started an in-service and would closely monitor the staffs' compliance about confidentiality of records.Record review of the facility's policy, Resident Rights The Compliance Store, undated, reflected 7. Privacy and confidentiality . The resident has a right to personal privacy and confidentiality of his or her personal and medical records . a. Personal privacy includes accommodations, medical treatment . b. The resident has a right to secure and confidential 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 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 three (Residents #2, #100, and #111) of twelve residents reviewed for care plans. 1. The facility failed to ensure Resident #2's care plan, dated 01/09/2026, included a care plan for pulmonary embolism. 2. The facility failed to ensure Resident #100's care plan, dated 01/09/2026, included a care plan for hypertension. 3. The facility failed to ensure Resident #111's Comprehensive Care Plan reflected the use of a BiPAP machine (noninvasive ventilation that helps you breathe) on 01/13/2026.These failures could place the residents at risk of not receiving the necessary care and services.Findings included: 1. Record review of Resident #2's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with pulmonary embolism (blood clot in one of the blood vessels of the lungs). Record review of Resident #2's Comprehensive MDS Assessment, dated 12/30/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had pulmonary embolism. Record review of Resident #2's Physician Order, dated 12/27/2025, reflected Xarelto Oral Tablet 15 MG (Rivaroxaban) Give 1 tablet by mouth one time a day for hx of pulmonary embolism. Record review of Resident #2's Comprehensive Care Plan, dated 01/09/2026, reflected the resident did not have a care plan for pulmonary embolism. Record review of Resident #2's Physician Order, dated 12/29/2025, reflected Anticoagulant SE Monitoring: Observe closely for significant side effects of Anticoagulant medication including . sudden changes in mental status or vital signs. 2. Record review of Resident #100's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #100's Comprehensive MDS Assessment, dated 11/30/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #100's Physician Order, dated 12/04/2025, reflected Hyzaar Oral Tablet 50-12.5 MG (Losartan Potassium & Hydrochlorothiazide) Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Hold for SBP less than 100, Hold for Diastolic blood pressure less than 60. Record review of Resident #100's Comprehensive Care Plan, dated 12/03/2025, reflected the resident did not have a care plan for hypertension. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/14/2026 at 12:56 PM, MDS Nurse F stated if the resident had hypertension or pulmonary embolism, then there should be care plan for it. He said care plans should be in place so the staff knew the interventions and goals for the resident and would be in sync in terms of the care to be provided. He said he was not responsible for doing Resident #2 and Resident #100's care plans but he could check their profiles. He logged onto his computer and saw that Resident #2 did not have a care plan for pulmonary embolism and Resident #100 did not have a care plan for hypertension. He said he would put a care plan for both. He opened the profile of both residents and placed a care plan for pulmonary embolism and hypertension. He said if the residents did not have a care plan, there would be confusion on their care or care would be not provided at all. In an interview on 01/15/2026 at 8:16 AM, ADON A stated care plans were important so the staff would be in sync with the care of the residents. He said without the care plan, needed interventions might not be provided. He said the expectation was all the issues of the residents were care planned. He said he would coordinate with the DON and the MDS Nurse to make sure the residents had appropriate care plans. In an interview on 01/15/2026 at 8:38 AM, the Administrator stated that all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. She said the expectation was for all the residents were care planned appropriately. She said she would coordinate with the DON to make sure all the residents were care planned. In an interview on 01/15/2026 at 9:04 AM, the DON stated that every resident needed a comprehensive care plan to make sure the residents received the applicable and appropriate care needed. She said the care plan should be in place so that the staff providing care would be on the same page. She said the care plan was important because it reflected the resident's problem lists, goals, and interventions. She said the expectation was for all residents to have care plans with regards to their medical issues. She said she would coordinate with the MDS Nurse to audit the care plans of the residents. 3. Record review of Resident #111's face sheet, dated 01/13/2026, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. He had diagnoses which included COPD (chronic lung disease that makes it difficult to breathe) and asthma (airway narrows and can make breathing difficult). Record review of Resident #111's Quarterly MDS (tool used to measure health status) Assessment, dated 11/13/2025, reflected intact cognition with a BIMS (tool used to measure cognitive status) score of 13. Section I (Active Diagnoses) indicated Resident #111 was treated for COPD. An observation on 01/13/2026 at 9:28 AM revealed Resident #111 was not in his room. Staff reported he was at dialysis. A BiPAP machine with face mask was on Resident #111's nightstand. During an interview on 01/14/2026 at 7:23 AM, Resident #111 was in bed awake. He stated he brought the BiPAP machine from home and had used it every night for almost 15 years. He stated he put the mask on each night before going to sleep and removed it the next morning to put his oxygen on. Record review of Resident #111's Comprehensive Care Plan, dated 12/26/2025, did not reflect the use of a BiPAP machine. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #111's Physician's Orders, on 01/13/2026, did not reflect an order for the BiPAP. During an interview on 01/15/26 at 8:23 AM, the DON stated Resident #111's BiPAP should have been included in his care plan. She stated the MDS Coordinator was responsible for ensuring the BiPAP was included the resident's care plan. She stated it was important to ensure the best possible outcome for the resident. She stated the BiPAP had been added to the resident's care plan. During an interview on 01/15/2026 at 12:20 PM, MDS Nurse G stated any nurse could add a care plan. She stated the staff's morning meetings was the time to capture what going on with residents and discuss care plan updates. She stated it was important to ensure the care plan reflected Resident #111's needs so he received the appropriate care during his stay. She stated the care plan was a way to communicate the resident's needs with other staff members. She stated the resident's care plan had been updated to reflect the BiPAP. Record review of the facility's policy, Comprehensive Care Plans Policy revised October 01, 2025 reflected Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . Policy Explanation and Compliance Guidelines . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team after each assessment for seven (Residents #33, #44, #91, #98, #100, #104 and #116) of twelve residents reviewed for care plans revision. The facility failed to complete a quarterly care plan for Residents #33, #44, #91, #98, #100, #104, and #116.This failure could place the residents at risk of care and needs not being met. Findings included:Resident #33Record review of Resident #33's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review on 01/14/2026 of Resident #33's Comprehensive MDS Assessment reflected the last MDS was done on 12/29/2025.Record review on 01/14/2026 of Resident #33's Comprehensive Care Plan reflected the last quarterly care plan completed for the resident was 09/17/2025.Resident #44Record review of Resident #44's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE].Record review on 01/14/2026 of Resident #44's Comprehensive MDS Assessment reflected the last MDS was done on 11/18/2025.Record review on 01/14/2026 of Resident #44's Comprehensive Care Plan reflected the last quarterly care plan completed for the resident was 08/19/2025.Resident #91Record review of Resident #91's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. Record review on 01/14/2026 of Resident #91's Comprehensive MDS Assessment reflected the last MDS was done on 12/29/2025.Record review on 01/14/2026 of Resident #91's Comprehensive Care Plan reflected the last quarterly care plan completed for the resident was 08/25/2025.Resident #98Record review of Resident #98's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. Record review on 01/14/2026 of Resident #98's Comprehensive MDS Assessment reflected the last MDS was done on 11/12/2025.Record review on 01/14/2026 of Resident #98's Comprehensive Care Plan reflected the last quarterly care plan completed for the resident was 08/18/2025.Resident #100Record review of Resident #100's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #100's Comprehensive MDS Assessment, dated 11/30/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. Record review of Resident #100's Comprehensive Care Plan, dated 12/03/2025, reflected the care plan only had two foci in the problem list, the code and ADLs. Resident #104Review of Resident #104's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review on 01/14/2026 of Resident #104's Comprehensive Care Plan reflected the last quarterly care plan completed for the resident was 08/18/2025.Record review on 01/14/2026 of Resident #104's Comprehensive MDS Assessment reflected the last MDS was done on 11/26/2025.Resident #116Record review of Resident #116's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review on 01/14/2026 of Resident #116's Comprehensive MDS Assessment reflected the last MDS was done on 11/17/2025.Record review on 01/14/2026 of Resident #116's Comprehensive Care Plan reflected the last quarterly care plan completed for the resident was 08/21/2025.In an interview on 01/15/2026 at 8:16 AM, ADON A stated care plans were done during admission and were being updated quarterly. He said the care plans were also updated if there was a change in condition, new wound, or the resident had a fall. He said care plans should be updated so the staff would know if there were new interventions that needed to be done and to monitor the resident's response to the new interventions. He said if the care plans were not updated, it could mess up the monitoring side of the interventions.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated that care plans were supposed to be updated quarterly to make sure that the care being given was still appropriate. She said the expectation was for all the residents to be care planned and that the care plans were updated quarterly and when (continued on next page)

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	455832	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens	2535 W Pleasant Run Lancaster, TX 75146

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed. She said she would coordinate with the DON and the NDS Nurses to make sure the care plans were current.In an interview on 01/15/2026 at 9:04 AM, the DON stated that every resident needed a thorough care plan to ensure the residents received the care they needed. She said the care plan should be done quarterly to monitor if there were new interventions or to assess if the goals were being met. She said the care plan could also be updated if there was a change in condition. She said if the care plan was not updated, as if they were not doing their due diligence in terms of assessing the residents. She said she would coordinate with MDS Nurses to audit the care plans of the residents.During an observation and interview on 01/15/2026 at 10:10 AM, MDS Nurse G stated she was responsible in making the care plans of the residents in long term care. She said she was responsible in making the care plans for Residents #33, #44, #91, #98, #100, #104, and #116. She opened the residents' profiles and saw the care plans were all overdue. She said she would work on updating their care plans and would also audit the care plans of the other residents in long term care. Record review of the facility's policy, Comprehensive Care Plans P & P Committee revised October 01, 2025, reflected Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . Policy Explanation and Compliance Guidelines . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for three (Residents #5, #17, and #111) of eighteen residents reviewed for medication storage. 1. The facility failed to ensure that Resident #5's carbonate powder used by the resident before dialysis was not inside the room on 01/13/2026.2. The facility failed to ensure that LVN B did not leave Resident #5's carbonate on top of her cart unattended on 01/13/2026.3. The facility failed to ensure that there were no medications inside Resident #17's room on 01/13/2026.4. The facility failed ensure Tums (treats indigestion) tablets were not left in a medicine cup on Resident #111's dresser on 01/13/2026.These failures could place residents at risk of misuse of medications that could lead to overdosing and other adverse reactions.Findings included: 1. Record review of Resident #5's Face Sheet, dated 01/14/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with end stage renal disease. Record review of Resident #5's Comprehensive MDS Assessment, dated 12/17/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident was on dialysis.Record review of Resident #5's Comprehensive Care Plan, dated 11/04/2025, reflected that the resident needed dialysis and one of the interventions was to encourage the resident to go to schedule dialysis appointments. During an observation and interview on 01/13/2026 at 11:30 AM revealed Resident #5 was in her bed, awake. It was observed that there was a box of carbonate on the resident's side table. When asked about the medication, the resident said she did not know who put the medication on her side table.During an observation and interview on 01/13/2026 at 11:33 AM, LVN B stated there should be no medications inside the residents' room because the residents could misuse them or take more than what was recommended. She went inside the room and saw the box of carbonate on Resident #5's side table. She said she did not notice the box when she checked on the resident. She took the box and said the staff were not giving it because the dialysis center was the one administering the medication. She put the box on top of the cart. She said she did not have an order for the carbonate because the dialysis center was the one giving it.2. An observation on 01/13/2026 at 12:04 PM revealed after LVN B placed Resident #5's box of medication on top of her cart, she pushed her cart and stopped on one of a resident's room. She went inside the room leaving the box of medication on top of her cart unattended. Several residents were observed passing by the cart.During an observation and interview on 01/13/2026 at 12:10 PM, LVN B stated she should have secured the box of medication inside her cart before leaving her cart unattended because a resident might take it and consume it. She opened her cart and placed the box of medication in the last drawer of the cart.3. Record review of Resident #17's Face Sheet, dated 01/14/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia and osteoarthritis.Record review of Resident #17's Comprehensive MDS Assessment, dated 11/04/2025, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had dementia and osteoarthritis.Record review of Resident #17's Comprehensive Care Plan, dated 11/06/2025, reflected that the resident was on pain management and one of the interventions was to assess resident and family/caregivers' knowledge of side effects and safetyprecautions related to use of pain medication.Record review of Resident #17's Physician Order, dated 06/03/2025, reflected Pain Monitoring - Assess for pain every shift Pain score is greater or equal to 1 or has been assessed with non-verbal/non-cognitive signs of Pain; the Pain must be addressed through pharmacological and/or nonpharmacological Pain (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions documented on the Treatment Administration Record.During an observation and interview on 01/13/2026 at 9:47 AM revealed Resident #17 was in her bed, awake. It was observed that there were an antiseptic liquid and topical analgesic inside a transparent container on the resident's bedside. The resident said those were her medications. The medications were in plain view and could be seen as soon as someone entered the room. During an observation and interview on 01/13/2026 at 12:14 PM, LVN B said she was not aware there were medications inside Resident #17's room. She went inside the resident's room and saw the medications. She talked to the resident that she would get the medications and would put them inside the cart. She said those medications should not be there because the resident might consume them or put them in her eyes causing irritation.In an interview on 01/15/2026 at 8:16 AM, ADON A stated medications should not be inside the residents' rooms and should be stored inside the carts. He said Resident #5's box of carbonate was not supposed to be in the facility because it was used in the dialysis clinic. He said the issue was not if the dialysis center mistakenly placed the box on Resident #5's room but that nobody noticed it. He said when the box of carbonate was taken from the Resident #5's side table, it should have placed directly inside the cart or inside the medication room. He said the box should not have been left unattended on top of the cart because residents might be able to get some, consume it, and be allergic to it. He said they already called Resident #17's family member regarding the medications inside the resident's room and the family member said they would come to the facility to pick it up. He said the expectations where no medications would be stored inside the residents' rooms and no medication would be left on top of the cart unattended. He said he already started an in-service about medication storage. He said the facility would also educate the family members that it was alright to bring medications, but they needed to let the staff know so the staff could assess if the medications were needed so they could request an order from the physician.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated the expectation was for the staff to be mindful to scan the residents' rooms for any medication and not to leave any medication on top of the carts for resident's safety. She said the residents might consume or use the medications inappropriately that could result in adverse reactions. She said she would coordinate with the DON regarding the issue about medication storage.In an interview on 01/15/2026 at 9:04 AM, the DON stated medications should not be medications inside the residents' rooms because they could overdose or could have adverse reactions from the medications that they were not supposed to have. She said the same reason applied to not leaving any medication on top of the cart unattended. She said the expectation was that no medications would be inside the rooms of the residents and no medications should be left on top of the carts. She said an in-service was already started and she would closely monitor the staff's adherence to the policy.4. During an observation on 01/13/26 at 9:41 AM, revealed Resident #111 was not in his room. On top of the resident's dresser were some of Resident #111's personal items. There was also a small medicine cup with over-the-counter TUMS in it. During an interview on 01/13/2026 at 2:33 PM, LVN H stated the TUMS should not have been in Resident #111's room and she did not notice it when she rounded that morning. She stated he was at a scheduled procedure. She stated she had removed and discarded the medication. She stated it was important for staff to wait for the resident to take medication before leaving the room. She stated the resident had not been able to eat or drink anything the night before because of the procedure and she did not give him any medication. She stated they did not want the resident to self-medicate. She stated another resident might go in the room and take the medication. During an interview on 01/13/26 at 3:14 PM, RN N stated Resident #111 had been out of the facility for several days. She stated the dialysis center sent him to the hospital on [DATE] and he returned to the facility on [DATE]. She stated she completed his assessment when re-admitted and he went to dialysis the same day. She stated he had an outpatient procedure today (01/13/2026) and had not returned to the facility. She stated she did not see the medication in his room. She stated it was important to ensure residents took their medication before leaving the room. During an interview on 01/13/2026 at 3:25 PM, MA O stated Resident #111 had been (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gone for a few days. She stated she did not give him the Tums. She stated the medication should not have been in his room. She stated she makes sure all medication is taken before she leaves a resident's room. She stated anyone could wander in and take the medication. MA O stated Resident #111 did have an order for TUMS. She opened the resident's chart to view the medication administration record and stated the last dose of TUMS was administered on 01/06/2026. During an interview on 1/14/2026 at 7:23 AM, Resident #111 was in bed awake. He stated he did not notice the TUMS in the medicine cup on top of his dresser. He stated he did not remember staff ever leaving medicine in his room. Resident #111 stated he had been out of the facility for several days. During an interview on 01/14/2026 at 1:14 PM, the DON stated the facility was providing in-service training to all staff including housekeeping, laundry, and the kitchen. She stated staff were told not to touch, but immediately report to the nurse, any medication in a resident's room. She stated medication should not be left in a resident's room, and staff must observe residents taking medication before leaving the room. She stated it was important for nurses to know what medication the resident was taking and when they were taking it. She stated medication should not be left out where another resident could have access to it. During a telephone interview on 1/15/26 at 1:15 AM, LVN I was at work and stated she worked 10:00 PM - 6:00 AM. She stated she came to work 01/12/2026 at 10:00 PM and worked overnight. She stated she did not take the medicine in the room. She stated she did not see the medicine on Resident #111's dresser. She stated it was important to know what medications the resident had taken. She stated she also did not want another resident to go in the room and take it. She stated it could be a medication another resident was allergic to. She stated Resident #111had been at the hospital for several days and returned to the facility 01/12/2026. She stated he was NPO (nothing by mouth) for a procedure the following day. She stated she did not notice the medication in the room. She stated he asked for a pain pill during the night, but she was unable to give it because he was NPO. During an interview on 01/15/2026 at 9:11 AM, ADON A stated medication should not have been in Resident #111's room. He stated part of rounding was for staff to notice those things. He stated there were elderly residents in their care and some had dementia. He stated some might think it's food and it was important to keep the environment free of anything that could potentially cause harm. He stated the staff received in-service training related to leaving medication in a room. He stated staff were told to immediately report to the nurse any medication observed in a resident's room. He stated nurses were to remove it and find out where it came from.Record review of the facility's policy, Medication Storage P & P Committee revised December 01, 2025, reflected Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms . Policy Explanation and Compliance Guidelines . 1. General Guidelines . a. All drugs and biologicals will be stored in locked compartments.Record review of the facility's policy Medication Administration, revised 12/01/2025, reflected Observe resident consumption of medication.

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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 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 three (Residents #24, #77, and #128) of fifteen residents reviewed for infection control. 1. The facility failed to ensure CNA D and the ABOM wore gowns when Resident #24, who had a catheter, was transferred to his wheelchair on 01/14/2026. 2. The facility failed to ensure CNA E performed hand hygiene and changed her gloves during Resident #77's incontinent care on 01/14/2026.3. The facility failed to ensure LVN M wore a gown when administering an antibiotic via PICC line (tubing inserted into a vein for long-term intravenous therapy) while caring for Resident #128, who was on enhanced barrier precautions, on 01/13/2026. 4. The facility failed to ensure MA C did not put her personal beverage on top of the medication cart while passing medications on 01/14/2026. 5. The facility failed to ensure Resident #102's oral liquid levetiracetam (medication used to treat seizures) did not have an open oral syringe secured to the bottle, with a rubber band, on 01/15/2026.6. The facility failed to ensure Resident #113's oral liquid potassium (vitamin supplement) did not have an open oral syringe secured to the bottle, with a rubber band, on 01/15/2026.These failures could place residents at risk of cross-contamination and development of infections. Findings include:1. Record review of Resident #24's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #24's Comprehensive MDS Assessment, dated 01/02/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had indwelling catheter.Record review of Resident #24's Comprehensive Care Plan, dated 10/13/2025, reflected that the resident had a suprapubic catheter and one of the interventions was to change the catheter as needed.Record review of Resident #24's Physician Order, dated 12/17/2025, reflected Enhanced Barrier Precautions every shift Follow Facility Policy - USE for patients with any of the following . Wounds or indwelling medical devices, regardless ofMDRO colonization status Infection or colonization with an MDRO.Observation on 01/14/2026 at 9:19 AM revealed CNA C and the ABOM were about to transfer Resident #24 to his wheelchair via mechanical lift (mechanical device used to lift and move people who have limited mobility). Both staff washed their hands, put on pairs of gloves, hooked the mechanical lift sling, and transferred the resident to his wheelchair. They did not wear gowns when they transferred the resident. It was observed that there was sign outside of the room on the door that the resident was on EBP and a gown was required during transfer.In an interview on 01/14/2026 at 9:31 AM, the ADOM stated she worked in the business office and she was also a CNA. She said she was not aware that they were supposed to wore a gown when transferring Resident #24. She saw the sign and said maybe there was a sign because the resident had a catheter. She said if the resident had a catheter, then she should have worn a gown to prevent cross contamination.In an interview on 01/14/2026 at 9:36 AM, CNA D stated they would only wear a gown during direct care of Resident #24 who had a catheter. She saw the sign posted outside the resident's door that indicated a gown was required during transfer of a resident with a catheter. She said, she guessed she should have worn a gown when they transferred the resident. She said PPE was required to prevent spread of germs.2. Record review of Resident #77's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with failure to thrive (significant decline in overall health). Record review of Resident #77's Comprehensive MDS Assessment, dated 12/23/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #77's Comprehensive Care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan, dated 11/23/2025, reflected that the resident had incontinence and one of the interventions was to provide pericare after each incontinent episode. An observation on 01/14/2025 at 12:58 PM revealed CNA E was about to do Resident #77's incontinent care. She put on a gown and a pair of gloves. She did not wash her hands before putting on her gown and gloves. She took a brief, opened it, and placed it beside the resident. She then took a sachet of skin barrier from the resident's overbed table and put it top of the opened brief. She cleaned the front of the resident and then assisted the resident to roll to his side. She then cleaned the resident's bottom. After cleaning the resident's bottom, she took the sachet she placed on top of the opened brief and applied it to the resident's bottom. She pulled the soiled brief and threw it in the trash can. She then pulled the new brief that she placed on the resident's side and placed it under the resident. She rolled back the resident and fixed the brief. She did not change her gloves after cleaning the resident's bottom, before applying the skin barrier cream, and before touching the new brief. She took off her gloves and gown, and washed her hands.In an interview on 01/14/2026 at 1:18 PM, CNA E stated she was supposed to change her gloves after cleaning the Resident #77's bottom and before touching the new briefs to prevent using dirty gloves. She said she applied the skin barrier using dirty gloves. She said using soiled gloves could cause transfer of germs to the new brief. She said it did not occur to her that she was not supposed to place the sachet from the resident's overbed table on top of the brief because she was not sure if the table was clean. In an interview on 01/14/2026 at 1:29 PM, ADON A stated the staff should be mindful that they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, after, and during any care. She said the staff should change their gloves after cleaning the resident's bottom. She said another way to prevent the spread of infection was to wear PPE when residents were on EBP. He said residents with catheters were on EBP to protect the resident and also the staff if the resident had any microorganism that could cling to them. He said he would start an in-service about infection control.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated that they always remind the staff to be vigilant with hand hygiene. She said after touching something soiled, the staff should change their gloves and sanitize the hands in between changing of gloves. She said she was not a clinician, but she knew that if there was an EBP sign outside the resident's room, then the staff should wear a gown in addition to the gloves. She said the concerns discussed would all contribute to the development and spread of infection. She said she would coordinate with the DON regarding the issue.In an interview on 01/15/2026 at 9:04 AM, the DON stated that hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care. She said gloves should be changed after cleaning the resident's bottom and before touching the new brief. She said the same principle applied before applying the skin barrier cream. She said the sachet of skin barrier cream should not be placed on top of the new brief because the staff was not sure if where it came from was clean. She said every resident with EBP had a sign outside or their room to remind the staff that they needed to wear a gown and gloves every time they had contact with the resident. She said the staff should also read the sign to make sure when they needed to wear a gown. She said EBP was implemented to protect the residents from cross contamination and probable infection. She said ADON A already started an in-service about infection control and would closely monitor the staff's adherence to the policy of infection control. 3. Record review of Resident #128's Face Sheet, dated 01/13/2025, reflected a [AGE] year-old female who admitted to the facility on [DATE]. The resident was diagnosed with osteomyelitis of lumbar vertebra (infection of vertebra in the lower back). Record review of Resident #128's Quarterly MDS Assessment, dated 01/16/2026, reflected moderately impaired cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated Resident #128 was treated for osteomyelitis of lumbar vertebra. Record review of Resident #128's Comprehensive Care Plan, initiated 01/11/2026, reflected The resident is on IV Medications. One intervention was to monitor, document, and report any signs of infection at the IV site. Record review of Resident #128's Physician's Orders, dated 01/13/2026, reflected Enhanced Barrier Precautions. Wear Gown and Glove. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PICC Line in use. Every shift.Record review of Resident #128's Physician's Orders, dated 01/11/2026, reflected to administer Vancomycin (antibiotic) intravenous (within a vein) Solution 750 MG/150ML. Use 750 mg intravenously every 12 hours.During an observation and interview on 01/13/2026 at 9:46 AM, revealed Resident #128 had an enhanced barrier precautions sign next to her door. A cabinet below the sign was stocked with personal protective equipment for staff to wear while caring for her. Resident #128 was lying in her bed. She stated she came to the facility two days prior and was receiving IV antibiotics for an infection in her spine. During an observation and interview on 01/13/2026 at 10:05 AM, LVN M entered Resident #128's room and prepared to administer the IV medication. LVN M washed her hands in the resident's restroom and put on gloves. LVN M did not put on a gown prior to administering the IV antibiotic. After exiting the room, LVN M was asked if Resident #128 was on enhanced barrier precautions, and she replied, yes. LVN M stated she did not have to wear a gown to administer IV medication. She stated she would have worn a gown and gloves if she changed the dressing that covered the IV site. She stated gloves and gown should also be worn for residents on dialysis, with a Foley catheter, or wound. LVN M stated enhanced barrier precautions added an extra barrier of protection and was important to help prevent cross-contamination and infection. During an interview on 01/15/2026 at 8:23 AM, the DON stated the enhanced barrier precautions sign on the door explained when staff were to wear personal protective equipment. She stated LVN M should have worn a gown when administering medication via the resident's PICC line. She stated all three shifts of nurses had received in-service training. She stated there was a reason the sign was on the resident's door. She stated her expectation was for staff to read the sign and apply it. She stated wearing the appropriate protection prevented infection and outbreaks. She stated it was best practice. During an interview on 01/15/2026 at 9:11 AM, ADON A stated there were two stops signs on the top of the enhanced barrier protection signs. He stated staff were expected to stop and read the list of things to gown up for. He stated it included residents on dialysis, with a catheter, wound, IV, g-tube (medical device inserted through the abdominal wall into the stomach to provide nutrition, fluids, and medication), and anything that required a dressing. He stated their residents were elderly and some were immunocompromised. ADON A stated enhanced barrier precautions helped to prevent infection and transmission to other residents. 4. An observation on 01/14/2026 at 7:14 AM revealed MA C was passing medications in the hall with a cup of coffee on top of the cart she was using. The Administrator saw the cup of coffee, took it, and told MA C that it should not be there.In an interview on 01/14/2026 at 7:57 AM, MA C stated she could not have her personal tumbler on the cart when passing medications because it could cause cross contamination, create clutter on the medication cart, and might accidentally be mixed with the medications she was preparing.In an interview on 01/15/2026 at 8:16 AM, ADON A stated staff should not put their cup of coffee on the medication carts they were using because aside from being a clutter that might contribute to medication error, staff might bring some microorganism from their home to the medication cart. He said the DON already started an in-service about no personal beverages in the carts. He said the personal beverages should be in the break room.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated she took the cup of coffee from MA C's cart for safety reasons. She said a resident might get a hold of a hot coffee and drink it. She said the coffee could spill on the medications that were being prepared. She said she would coordinate with the DON regarding the issue.In an interview on 01/15/2026 at 9:04 AM, the DON stated that the cup of coffee or any personal drinks should be in the breakrooms. She said aside from the risk of cross contamination, some residents might take it and drink it. She said its content might also spill on the medications the staff were preparing. She said the expectation was for the staff not to put their personal beverages on their carts. was that no residents were administering their medications without proper assessment. The DON said she already started an in-service about no personal beverages on the carts.5. Record review of Resident #102's Face Sheet, dated 01/15/2026, reflected a [AGE] year-old female who admitted on [DATE]. She had diagnoses which included cerebral infarction (stroke: blood flow to the brain is (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blocked) and seizure (abnormal activity in the brain that temporarily affects consciousness, muscle control, and behavior) disorder. Record review of Resident #102's Quarterly MDS Assessment, dated 11/14/2025, indicated a BIMS was not conducted because the resident was rarely/never understood. The staff assessment for mental status indicated severely impaired cognition for daily decision making. Section N (Medications) reflected Resident #1 received anticonvulsant (used to treat and prevent seizures) medication. Record review of Resident #102's Comprehensive Care Plan, dated 01/11/2026, reflected The resident is on anticonvulsant therapy. One intervention was to give medication as ordered, and monitor and report abnormal labs to the medical doctor. Record review of Resident #102's Physician's Order, dated 10/31/2025, reflected LEVETIRACETAM SOL 100MG/ML Give 5 ml orally two times a day for seizure.6. Record review of Resident #113's Face Sheet, dated 01/15/2026, reflected a [AGE] year-old female who admitted on [DATE]. One diagnosis was hypokalemia (low potassium). Record review of Resident #113's Quarterly MDS Assessment, dated 10/28/2025, indicated a BIMS was not conducted because the resident was rarely/never understood. The staff assessment for mental status indicated severely impaired cognition for daily decision making. Record review of Resident #113's Comprehensive Care Plan, dated 01/09/2026, reflected Resident is at risk for vitamin/mineral deficiency. One intervention was to administer medications as ordered.Record review of Resident #113's Physician's Order, dated 10/31/2025, reflected Potassium Chloride Liquid 20 MEQ/15ML (10%) Give 7.5 ml by mouth one time a day for Hypokalemia Dilute with 3 oz of water before administration.During an observation and interview on 01/15/2026 at 10:44 AM, RN K unlocked the medication aide's cart for hall 200. In one drawer were bottles of oral liquid medication. A bottle of Resident #102's oral liquid levetiracetam had an open oral syringe secured to the bottle with a rubber band. A bottle of Resident #113's oral liquid potassium had an open oral syringe secured to the bottle with a rubber band. RN K stated the syringes should not have been secured to the bottles of medication. She stated there was not a cap on the end of the syringe, and it was exposed to the air and germs. During an interview on 01/15/2026 at 11:04 AM, LVN L stated the oral syringe should not have been secured to the bottle of liquid medication. He stated medication bottles should not be stored like that on the cart. He stated staff must get a new syringe to draw up each medication dose and discard the syringe. He stated the oral syringe should not be open to air, touching other items in the cart, and used to draw up medication for administration. During an interview on 01/15/2026 at 11:09 AM, ADON A stated the syringe should not have been secured to the bottle of medication. He stated the syringes were a one-time use and to discard. He stated the facility had plenty available. He stated the syringes should not touch anything or be left open to air and bacteria. During an interview on 01/15/2026 at 11:26 AM, MA C stated she gave medication on the 200 hall. She stated she did not secure the syringes to the bottles of medication with rubber bands. She stated she got a new syringe from the medication room to administer each liquid medication. She stated she put the bottles of liquid medication back in the cart the way she found them. She stated she should have removed the syringes from the bottles and thrown them away. She stated the syringe was used to draw up the precise measurement of liquid and the medication was put in a plastic drinking cup or small plastic medication cup to administer to the residents. MA C stated she did not remember seeing the bottles that way yesterday. She stated it is important to use a new syringe for each dose of medication and not leave it in the cart where it is open to air and touching other items in the cart. During an interview on 01/15/2026 at 2:17 PM, the DON stated the expectation was for staff to discard an oral syringe after each use. She stated the bottles of liquid medication should not have been stored in that manner in the medication cart. She stated the oral syringes were readily available. She stated it was important for staff to avoid cross-contamination when administering medication. She stated they provided in-serviced training to the nursing staff.Record review of the facility's policy Enhanced Barrier Protection P & P Committee revised December 01, 2025 reflected Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . that employs targeted gown and gloves use during high contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care activities. Policy Explanation and Compliance Guidelines . 2. Initiation of Enhanced Barrier Precautions . b. An order for enhanced barrier precautions will be obtained for residents with any of the following . urinary catheters . 4. High-contact resident care activities include . Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters . transferring.Record review of the facility's policy Hand Hygiene P & P Committee revised November 01, 2025 reflected Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Policy Explanation and Compliance Guidelines . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . Before applying and after removing personal protective equipment (PPE), including gloves . Before and after handling clean or soiled dressings, linens . Before performing resident care procedures . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . When, during resident care, moving from a contaminated body site to a clean body site.A policy for not putting personal beverages on the cart was requested on 01/15/2026 at 10:17 via email to the Administrator but was not provided prior to exit. Record review of the facility's Medication Administration, revised 12/01/2025, reflected Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care that was developed within 48 hours of resident's admission and failed to provide the resident and their representative with a summary of the baseline care plan for two (Resident #127 and Resident #128) of four residents reviewed for baseline care plans. The facility failed to complete in its entirety the baseline care plan for Resident #127 and Resident #128 within 48 hours of admission. This failure could place newly admitted residents at risk of not being informed of their initial goals and services, receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission.Findings included: Record review of Resident #127's Face Sheet dated 01/14/2026 at 1:59 PM revealed she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included cirrhosis of liver (disease of liver,) cholelithiasis with obstruction (hardened deposits in gallbladder,) and lymphedema (swelling of the tissues.) Record review of Resident #127's Comprehensive Care Plan dated 01/11/2026 revealed missing data from either the plans focus, goal, and/or interventions. Resident's care plan revealed:The focus of Resident requests code status of DNR with a goal stated to carry out in accordance with resident's wishes on an ongoing basis. No interventions were reflected.The focus of Resident has impaired cognitive function/impaired thought processes r/t with no goal(s) listed. Interventions included to administer medications as ordered, ask yes or no questions, or communicate with the resident/family/caregivers regarding resident's capabilities and needs.The focus of Pressure Ulcer Prevention with no goal(s) listed. Interventions included barrier cream, and to turn and reposition every two hours and as needed. Record review of Resident #128's Face Sheet, dated 01/14/2026 12:53 PM revealed she was a [AGE] year old female admitted [DATE]. Relevant diagnoses included type 2 diabetes, heart failure, atrial fibrillation (heart dysfunction,) and back area wedge compression fracture. Record review of Resident #128's Comprehensive Care Plan dated 01/11/2026 revealed missing data from either the plans focus, goal, and/or interventions. Resident's care plan revealed:The focus of The resident has limited physical mobility r/t with a goal to remain free of complications related to immobility . and no interventions were listed.The focus of The resident has impaired cognitive function/impaired thought processes r/t with no goal reflected. The interventions were to administer medications as ordered. Monitor/document for side effects and effectiveness.The focus of The resident as at risk for falls r/t with no goal listed. The intervention included to anticipate and meet the resident's needs.The focus of The resident has/is at risk for constipation r/t with a goal resident will not experience constipation and will have normal pattern of bowel elimination. There are no interventions listed.The focus of Pressure Ulcer Prevention was stated, but no goal nor intervention was stated. In interview with MDS Nurse G on 01/15/2026 at 12:11 PM revealed she was responsible for updating Comprehensive Care Plans but was not responsible for Baseline Care Plans. She stated baseline care plans were important as they planned each residents' care at the facility. In interview with the facility DON on 01/15/2026 at 1:58 PM she stated her expectations were for the MDS department to ensure each new admission had a completed Baseline Care Plan. She stated Resident #127 and Resident #128's Baseline Care Plans were started but not finished and she was not certain as to the reason. She stated it was important for a resident baseline care plan to be completed because a resident's basic care needs can go unmet if not completed. Record Review of Facility's Baseline Care Plan Policy, dated 12/01/25, revealed 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders iv. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Therapy services v. Social Services . 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented in the designated format.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for one (Resident #77) of four residents reviewed for incontinent care. The facility failed to ensure that CNA E performed the right technique during Resident #77's incontinent care on 01/15/2026.This failure could place the residents at risk for urinary tract infection.Findings included:Record review of Resident #77's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with failure to thrive. Record review of Resident #77's Comprehensive MDS Assessment, dated 12/23/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident was frequently incontinent for bladder and bowel. Record review of Resident #77's Comprehensive Care Plan, dated 11/23/2025, reflected that the resident had incontinence and one of the interventions was to provide pericare after each incontinent episode. An observation on 01/14/2026 at 12:58 PM revealed CNA E was about to do Resident #77's incontinent care. She put on a gown and a pair of gloves. She started cleaning the resident's perineal area (area between the legs), starting on the sides and then on the top part of the perineal area. She then cleaned the resident's penis starting from the base of the shaft towards the tip. She did the procedure twice.In an interview on 01/14/2026 at 1:22 PM, CNA E stated she was not aware that she cleaned Resident #77's penis upward. She said the proper procedure was to clean it downward. She said the resident could have urinary tract infection because the germs from the shaft might go inside the resident's urethra (canal that carries urine out of the body).In an interview on 01/14/2026 at 1:29 PM, ADON A stated the proper technique in cleaning the shaft of the penis was downward and not upward. He said microorganisms might enter the opening on its tip. He said cleaning the penis was the same with clean the perineal area (area between the legs), and it was to clean away from and not towards where germs could have an entry. He said he would start an in-service about the issue.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated that the expectation was for the staff to follow the proper technique of incontinent care to prevent any unwanted outcome like urinary tract infections. She said she would coordinate with the DON about the issue.In an interview on 01/15/2026 at 9:04 AM, the DON stated that cleaning the penis upward was not right because unwanted microorganisms (organism that is too small to be seen) from the shaft could eventually enter the opening on its tip and could probably cause UTI. She said the expectation was for the staff to follow the right procedure in cleaning the penis. She said ADON A already started an in-service about the issue, but she would monitor the staffs' compliance on the right procedure.Record review of the facility's policy Incontinence P & P Committee revised December 01, 2025, reflected Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services . Policy Explanation and Compliance Guidelines . 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #96 and Resident #111) of twelve residents reviewed for respiratory care.1. The facility failed to ensure Resident #96 's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly when not in use on 01/13/2026.2. The facility failed to ensure Resident #111 's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) and BiPAP mask was stored properly when not in use on 01/13/2026. The facility failed to ensure Resident #111 had a physician's order for a BiPAP machine on 01/13/2026. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings include: 1. Record review of Resident #96's Face Sheet, dated 01/14/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).Record review of Resident #96's Quarterly MDS Assessment, dated 12/30/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #96's Comprehensive Care Plan, dated 12/01/2025, reflected the resident had oxygen therapy and one of the interventions was provide oxygen therapy as ordered. The Comprehensive Care Plan did not indicate that the resident was the one taking off her nasal canula.Record review of Resident #96's Physician's Order, dated 11/17/2025, reflected Oxygen at 2 LPM every shift for COPD.An observation and interview on 01/13/2026 at 9:41 AM revealed Resident #96 was in her bed, awake. It was observed that there was a nasal canula coiled on the push handle of the resident's wheelchair. The nasal cannula was not bagged and there was no bag at the back of the wheelchair. When asked who took off the nasal cannula, the resident did not reply.During an observation and interview on 01/13/2026 at 9:48 AM, ADON A stated the nasal canula should be bagged when not in use to prevent any respiratory infection. He said sometimes, Resident #96 was the one who would take it off so the staff should closely monitor the resident. He took the nasal canula from the wheelchair and threw it in the trash can. He said he would get a new one and would put it in a bag.In an interview on 01/13/2026 at 11:33 AM, LVN B stated she was made aware about the nasal cannula that was not bagged. She said she did not notice that the nasal canula on Resident #96's wheelchair. She said the nasal canula should be bagged to prevent cross contamination and respiratory infection.In an interview on 01/15/2026 at 8:38 AM, the Administrator stated the expectation was for the staff to bag the nasal cannula when not in use to prevent respiratory issues. She said she would coordinate with the DON about the issue.In an interview on 01/15/2026 at 9:04 AM, the DON stated the staff were responsible in making sure the nasal cannula was bagged when not in use to prevent respiratory infection. She said an in-service was already initiated by ADON A but she would closely monitor the staffs' compliance in bagging the nasal canula when not in use. She said if the resident was the one taking it off, the more the staff should monitor the resident.2. Record review of Resident #111's face sheet, dated 01/13/2026, reflected a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. He was diagnosed with COPD. Record review of Resident #111's Quarterly MDS (tool used to measure health status) Assessment, dated 11/13/2025, reflected intact cognition with a BIMS (tool used to measure cognitive status) score of 13. Section I (Active Diagnoses) indicated Resident #111 was treated for COPD. Record review of Resident #111's Physician's Orders, on 01/13/2026, did not reflect an order for the BiPAP. An observation on 01/13/2026 at 9:28 AM revealed Resident #111 was not in his room. The oxygen tubing was connected to the concentrator and draped across the top of the concentrator. It was not stored in a bag. The BiPAP machine and breathing mask was on the nightstand. The (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breathing mask was not bagged. During an interview on 01/13/2026 at 9:35 AM, CNA J stated the oxygen tubing should have been bagged. She stated she would get new oxygen tubing and place it in a bag. She stated it was important to prevent infection. During an interview on 01/13/26 at 9:37 AM, LVN H stated the BiPAP machine was Resident #111's personal property and he put the mask on and took it off himself at night. She stated for infection control purposes, the BiPAP mask should have been stored in a bag. She stated whoever switched the resident to his portable oxygen tank should ensure the oxygen tubing, connected to the concentrator, was placed in a bag. She stated the nurse was ultimately responsible for ensuring the respiratory items were bagged when not in use. She stated it could have a negative effect on the resident, especially since he was on precautions. She stated Resident #111 was on enhanced barrier precautions related to dialysis. She stated it was important for infection control. During an interview on 1/14/26 at 7:54 AM, LVN H stated Resident #111 came to the facility with the BiPAP machine. She stated she did not touch the BiPAP and had not noticed there was no order. LVN H stated there should have been a physician's order for the resident to use the BiPAP at the facility. She stated any medication or treatment required a physician's order. During a telephone interview on 01/15/2026 at 1:15 AM, LVN I stated she worked the 10:00 PM - 6:00 AM shift. LVN I stated Resident #111 put the BiPAP mask on himself. She stated he was wearing it at the beginning of her shift. She stated she had not noticed him wearing it before. LVN I stated she did not notice he had no order for the BiPAP. She stated the BiPAP mask and oxygen tubing should be stored in a bag when not in use. She stated they can become contaminated if left open to air and the risk to the resident was infection. During an interview on 01/15/2026 at 8:23 AM, the DON stated Resident #111 must have had an order for the BiPAP machine. She stated it was also important to ensure the order included the appropriate settings. She stated resident care was governed by physician's orders and necessary to provide the best possible care for the resident. She stated respiratory items must be bagged when not in use and was important for infection control. She stated the physician and respiratory therapist were notified and an order placed in the resident's chart. She stated staff had received in-service training. During an interview on 01/15/2026 at 9:11 AM, ADON A stated respiratory items must be bagged for infection control. He stated the resident puts the nasal cannula in his nose, which is a point of entrance for bacteria. He stated Resident #111 must have had an order to use the BiPAP at the facility. He stated when a resident brought equipment from home, the physician must be called and an order obtained. He stated staff received in-service training. Record review of the facility's policy Oxygen Concentrator P & P Committee revised November 11, 2025, reflected Policy Explanation and Compliance Guidelines . 4. Use of the Concentrator . l. Keep delivery devices covered in plastic bag when not in use.Record review of the facility's policy Consulting Physician/Practitioner Orders, implemented 11/01/2025, reflected The attending physician shall authenticate orders for the care and treatment of assigned residents. Call the attending physician to verify the order. Document the verification order by entering the order and the time, date, and signature on the physician order sheet.