STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455866	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Westlake Hills	1034 Liberty Park Dr Austin, TX 78746

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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 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 observation, interview, and record review, the facility failed to have a person-centered care plan developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs for three of (52, 67, and 73) eight residents reviewed for care plans. The facility failed to ensure Resident # 67's initial care plan was completed upon admission to reflect Resident #67's need for treatments, such as TPN-Total Parental Nutrition (a method of delivering essential nutrients-carbohydrates, proteins, fats, electrolytes, vitamins, and minerals-directly into the bloodstream via a central vein catheter, bypassing the digestive system. It is used for patients unable to eat or absorb nutrients), PICC- Peripherally inserted central catheter (a long, thin, flexible tube inserted into an upper arm vein and threaded into a large vein near the heart, typically lasting for weeks or months. Used for long-term IV therapy, it reduces needle sticks by enabling safe, repeated delivery of medications, chemotherapy, nutrition, or blood sampling.), EBP-Enhanced Barrier Precautions (an infection control strategy for nursing homes, requiring gowns and gloves during high-contact care to reduce multidrug-resistant organism (MDRO) transmission), JP Drain-Jackson Pratt drain (a bulb-suction device used after surgery to remove internal fluids, reduce swelling, and prevent infection), code status and ABT-Antibiotics (powerful, prescription-only medications used exclusively to treat bacterial infections. Antibiotics are targeted based on the bacteria type and site of infection). The facility failed to ensure Resident #73's initial care plan was completed upon admission to reflect Resident #73's G-Tube, - Gastrostomy tube (a surgically placed device providing direct, long-term access to the stomach for feeding, fluids, and medication when oral intake is insufficient), EBP, and code status. The facility failed to ensure Resident #52's care plan was completed to reflect Resident #52's code status. These failures could place residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in a decline in physical and psychosocial well-being. Findings included:Record review of Resident #67's face sheet, dated 04/07/2026, reflected an [AGE] year-old male, admitted [DATE], with diagnoses that included Diverticulitis of intestine (the inflammation or infection of small pouches (diverticula) that form in the colon wall, commonly causing severe lower-left abdominal pain, fever, nausea, and changes in bowel habits), other specified sepsis (sepsis is a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage, organ failure, and potential death), recurrent major depressive disorder (a chronic condition characterized by two or more distinct episodes of severe sadness, hopelessness, and loss of interest, separated by at least two months of recovery). Record review of Resident #67's care plan, dated 04/02/2026, reflected Resident #67's risk for falls, potential impairment to skin integrity, pain, and risk for hot liquid injury. Further record review reflected no care plan completed addressing other health concerns, such as the use of antibiotics, TPN infusion, JP drains, code status, and PICC line access. Review of Resident #67's interim care plan initiated 04/02/2026 reflected no to EBP and gastrointestinal issue for Resident #67. Record review of Resident #67's admission skin assessment, dated 04/03/2026, reflected Resident #67 had a PICC line at right arm and 2 JP drains, 1 to the left (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	upper quadrant and the other to the right lower quadrant of the abdomen. Record review of Resident #67's admission MDS assessment dated [DATE] reflected no BIMS score due to MDS not yet being completed. MDS addressed Resident #67's diagnoses as listed above. Record review of Resident #67's physician orders reflected the following:JP Drain #1- empty suction bulb every shift, record output every shift for JP drain #1 dated 04/02/2026.JP Drain #2- empty suction bulb every shift, record output every shift for JP drain dated 04/02/2026.Flush each valved PICC catheter lumen with 10 ml NS prior to medication infusion. Following each medication infusion, flush with 10ml NS. every shift for PICC Line Maintenance dated 04/02/2026.Clinimix/Dextrose (5/15) Intravenous Solution 5 % (Amino Acid Infusion in D15W) Use 60 ml/hr intravenously one time a day for Nutrition dated 04/03/2026.Ciprofloxacin HCl Tablet 500 MG Give 1 tablet by mouth every 12 hours for Infection for 7 DaysADD-DNR dated 04/06/2026. Record review of Resident #73's face sheet, dated 04/08/2026, reflected a [AGE] year-old female, admitted [DATE], with diagnoses including adult failure to strive, gastrostomy status (the presence of a surgically created opening (stoma) in the stomach wall, used for a feeding tube (G-tube) to deliver nutrition, hydration, or medication directly to the stomach. It is used for long-term nutritional support when swallowing is unsafe or oral intake is insufficient.), unspecified severe protein-calorie malnutrition (a critical deficiency of nutrients-specifically energy and protein). Record review of Resident # 73's interim care plan, dated 04/02/2026, reflected feeding tube was not checked, Gastrointestinal not checked, EBP /infection not checked. Record review of Resident #73's comprehensive care plan, dated 04/03/2026. addressed Resident #73's risk for falls, communication problems, ADLs self-care performance deficit, and ADD. There was no other care plan completed for Resident #73 to include other health concerns such as the use of G-tube and EBP management. Record review of Resident # 73's admission MDS assessment, dated 04/06/2026, reflected no BIMS score due to MDS not yet being completed. MDS addressed Resident #67's diagnoses as listed above. Record review of Resident # 73's physician orders reflected the following:Enteral Feed Order four times a day for Nutritional Maintenance Bolus feeding: Jevity 1.5 1 can QID flush 70 mls of water before and after bolus dated 04/03/2026.NPO diet Refer to diet type for texture, NPO consistency, Has Peg tube dated 04/05/2026.Enhanced Barrier Precautions (EBP) for (PEG) dated 04/08/2026.ADD: Full Code dated 04/08/2026 Record review of Resident #52's face sheet, dated 04/08/2026, reflected an [AGE] year-old male, admitted [DATE], diagnoses included hypotension (abnormally low blood pressure), other unspecified disorder of the muscle, history of falling, atrial fibrillation (a common, often chronic arrhythmia characterized by rapid, disorganized electrical activity in the heart's upper chambers (atria), causing a fast, irregular heartbeat), Ischemia cardiomyopathy (a weakened heart muscle (often the left ventricle) caused by reduced blood flow from coronary artery disease or a heart attack, leading to heart failure) Review of Resident # 52's comprehensive care plan, dated 03/27/2026, reflected Resident #52 was at risk for fall, potential/actual impairment to skin integrity, Pressure Ulcer on the sacrum but did not address, ADL Self Care Performance Deficit. Record review reflected the care plan did not address Resident #1's code status and EBP status. Review of Resident # 52's admission MDS assessment, dated 04/01/2026, reflected BIMS score 14 which indicated no cognitive impairment. Review of Resident # 52's physician orders reflected the following:Enhanced Barrier Precautions (EBP) for (wound) dated 04/08/2026.ADD: Full Code dated 04/08/2026 During an interview on 04/09/2026 at 08:20 a.m., the DON stated baseline care plans should be completed with 24-48 hours of admission. The DON stated everything that the resident was being treated for should be carefully planned. The DON stated Resident #67's interim or baseline care plan should have addressed his ABT, TPN, PICC, and any other care area for which the facility was providing care. During an interview on 04/09/2026 at 08:53 a.m., the MDS Nurse stated she was responsible for completing care plans based on the data collection done by the admitting nurse during the admission assessment. She stated that data flowed to the comprehensive care plan and the MDS. The MDS Nurse stated if the data collection was not completed accurately upon admission, the interim care plan was not completed accurately. The MDS (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse stated that the data collection for the interim care plan should be completed within 2 days. The MDS Nurse stated she builds up on whatever information that was collected by the admitting nurse to complete the comprehensive care plan. The MDS Nurse stated Resident #67's interim care plan should have addressed TPN, ABT, EPB, PICC and it would have flowed to Resident #67's comprehensive care plan. The MDS Nurse stated Resident #73's interim care plan should have addressed G-tube because it was important to know how Resident #73 was being fed but the admitting nurse did not check feeding tube, so the information did not transfer to the comprehensive care plan. The MDS Nurse stated care areas from admission would trigger if the admitting nurse checked the appropriate box that applied. The MDS nurse stated it was important for the admitted nurse to check all that applied for staff to know what care to provide for a particular resident. The MDS nurse stated Advance Directives should be added to the care plan upon admission because when a resident's heart stops, the staff on duty should know what care to provide. The MDS Nurse stated that EBP should be added to the care plan for residents and staff safety, to prevent cross contamination and to alert the staff on what PPE to use when providing care. During an interview on 04/09/2026 at 11:31 a.m., the admission Coordinator stated she was trained on Advanced Directives. She stated the policy for entering advanced directives was three to five days after admission. The admission Coordinator stated if there was not a DNR copy, she would input the resident as a full code. The admission Coordinator stated code status should be put in the residents' records right away. The admission Coordinator stated the staff would not know if the resident was DNR and that was not acceptable. The admission Coordinator stated she monitored to ensure the advance directives were entered into the resident's medical chart by doing an audit. The admission Coordinator stated she did not know why the code status for Residents #67 and Resident #52 were not in the residents' chart or on the care plan. Review of facility's policy titled, Interim Care Plan, revised 03/2026 reflected: An Interim baseline care plan should be developed for each resident within forty-eight (48) hours of admission to the skilled healthcare community.Policy detail1. Within forty-eight (48) hours of admission to the skilled healthcare community, an interim baseline care plan should be developed which includes the minimum healthcare information necessary to care for the residents' immediate health and safety needs.2. The interim care plan should be developed by the admission nurse with the assistance of interdisciplinary team members.3. The Interim care plan should use but not be limited to, the resident's initial goals of care, physician's orders, dietary orders and instructions, therapy orders, resident cognitive, physical, and psycho-social needs, and any PASRR recommendations if applicable.4. The Interim care plan should be person-centered and include services and treatments administered by the community.5. The interim care plan should be used until the completion of the comprehensive assessment, and the comprehensive care plan is developed. Review of facility's policy titled Comprehensive care plan dated 11/2017 reflected: A comprehensive, person-centered Care Plan will be developed for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs that have been identified through a comprehensive assessment.Policy detailA person-centered, comprehensive care plan will be developed and implemented in accordance with the following:1. The Comprehensive Care Plan will describe treatments and services to assist the resident to attain or maintain the highest level of physical, mental, and psychosocial wellbeing.2. The comprehensive care plan is based on a comprehensive assessment which includes, but is not limited to, the MDS, Care Area Assessments, clinical assessments and data collection forms, Therapy Evaluations, psychosocial and cognitive evaluations, physician assessments/consults.

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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, record review, the facility failed to ensure storage of medications used in the facility in accordance with currently accepted professional principles and included the appropriate expiration dates to preserve their integrity for the stored medications, and to store medications properly to prevent deterioration for two medications carts out of four and two nursing carts out of 4 reviewed for medications storage. The facility failed to ensure that the MC-D (hall 200) did not have 1 medication bottle that was undated in the drawer. The facility failed to ensure that the MC-D (hall 200) did not have 7 medication bottles that were labeled incorrectly. The facility failed to ensure that the MC-D (hall 200) did not have 1 white round TAB inside of unlabeled medication cup.The facility failed to ensure that the MC-D (hall 200) did not have 1 unknown orange round TAB. The facility failed to ensure that the MC-E (hall 200) did not have 1 unknown orange round TAB. The facility failed to ensure that the MC-E (hall 200) did not remove 1 bottle of liquid medication. The facility failed to ensure that the MC-E (hall 200) did not have 6 medication bottles that were labeled incorrectly. The facility failed to removed Resident #30's Narcotic medication from the medication cart four days after Resident #30 was discharged from the facility on 04/03/2026. The facility failed to labeled Resident #68's insulin pen with opened date after it was opened and being used. The facility failed to removed Resident #8's scopolamine patch from the medication's cart for seventy-seven days after the medication was discontinued on 01/21/2026. The facility failed to ensure that the NC-E (hall 200) did not remove 2 blister packs with white round tabs after the resident's discharge. The facility failed to ensure that the NC-E (hall 200) did not have 6 medications that were labeled incorrectly.ˆ The facility failed to ensure that medication tablet is not removed from the floor in Resident 68's room. This failure could place residents at risk for missed medications and/or receiving unidentified medications. Findings included: Record review of Resident #30's face sheet, dated 04/08/2026, reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included Pressure ulcer of right hip, Paraplegia (the partial or complete paralysis of the lower half of the body, including both legs, usually caused by spinal cord damage in the thoracic, lumbar, or sacral regions), Post Traumatic seizures (abnormal electrical brain events occurring after a traumatic brain injury (TBI), often resulting in seizures), Post traumatic Brain injury- TBI (results from an external force causing brain dysfunction, ranging from mild concussions to severe, long-term impairment), Recurrent Major Depressive Disorder, recurrent (a chronic condition characterized by two or more distinct episodes of severe sadness, hopelessness, and loss of interest, separated by at least two months of recovery). Face sheet also reflected Resident #30 was discharged on 04/03/2026. Record review of Resident #30's care plan dated 03/06/2026, addressed Resident #30's potential/actual impairment.to skin integrity, an ADL Self Care Performance Deficit r/t right hip flap. Care plan did not address the need for pain medication. Record review of Resident #30's admission MDS assessment, dated 04/06/2026, reflected a BIMS score of 09 which indicated moderate cognitive impairment. Section J-Pain Assessment indicated Resident #30 did not have pain. Record review of Resident #30's physician order, dated 03/06/2026, reflected:Hydrocodone-Acetaminophen Tablet 7.5-325 MG Give 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident #30's MAR, dated ??, reflected:Hydrocodone-Acetaminophen Tablet 7.5- 325 MG Give 1 tablet by mouth every 6 hours as needed for pain -Start Date- 03/06/2026 and D/C date of 04/06/2026. Record review of Resident #30's Narcotic Medication log, dated ??, reflected:Hydrocodone-Acetaminophen Tablet 7.5- 325 MG take 1 tablet by mouth every 6 hours as needed for severe pain with 10 pills being delivered on 03/06/2026. It was noted none was given to Resident #30.Hydrocodone-Acetaminophen Tablet 7.5-325 MG take 1 tablet by mouth every 6 hours as needed for severe pain with 25 pills being delivered (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 03/10/2026. It was noted none was given to Resident #30. Record review of Resident # 8's face sheet date 04/08/2026 reflected a [AGE] year-old female, admitted [DATE] and readmitted [DATE], with diagnoses that included Multiple Sclerosis (a chronic autoimmune disease where the immune system attacks the myelin sheath covering nerves in the brain and spinal cord, causing communication issues between the brain and body), Recurrent Major Depressive Disorder, recurrent a chronic condition characterized by two or more distinct episodes of severe sadness, hopelessness, and loss of interest, separated by at least two months of recovery), Spinal Stenosis (the narrowing of the spinal canal, causing pressure on the nerves and spinal cord), Chronic pain. Review of Resident #8's care plan revised 02/17/2026 addressed Resident #8's risk for falls, at risk for integument.Impairment, potential for pain. Care plan did not address the need for Scopolamine patch (prescription, skin-applied patches placed behind the ear to prevent motion sickness and post-operative nausea). Review of Resident #8's quarterly MDS assessment, dated 01/07/2026, reflected a BIMS score of 05 indicating severe cognitive impairment. Record review of Resident #8's current physician order, dated ??, did not reflect an order for Scopolamine patch. Review of Resident #8's MAR for the month of 12/2025 reflected Resident #8 was not administered Scopolamine patch. It was also reflected Resident #8 had an order for Scopolamine Transdermal Patch 72 Hour (Scopolamine) Apply 1 patch transdermally every 72 hours as needed for secretions -Start Date- 10/21/2025 -D/C Date- 01/21/2026. Review of Resident #8's progress notes, dated 01/21/2026, reflected:Medication: Scopolamine Transdermal Patch 72 HourStart date: 10/21/2025.Stop date: 01/21/2026.Stop reason: unknown. Review of Resident #68's face sheet, dated 04/08/2026, reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with hyperglycemia-high blood sugar (is a chronic condition characterized by high blood glucose (sugar) due to insulin resistance or insufficient insulin production), acute on chronic systolic (congestive) heart failure, unspecified Atrial Fibrillation (a common arrhythmia characterized by a rapid, chaotic, and irregular heartbeat originating in the heart's upper chambers (atria)), Angina Pectoris (chest pain, pressure, or squeezing caused by reduced blood flow and insufficient oxygen to the heart muscle). Review of Resident #68's care plan initiated 04/03/2026 addressed Resident #67's risk for falls, Congestive HeartFailure r/t dyspnea on exertion and lower extremity swelling, ADL Self Care Performance Deficit r/t General Weakness/Acute Chronic CHF. Resident #68's care plan did not address Type 2 Diabetes and the need for insulin administration. Review of Resident #68's TAR for the month of April 2026 reflected:Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously one time a day for diabetes -Start Date- 04/04/2026. Review of Resident #68's admission MDS assessment, dated 04/07/2026, reflected o BIMS score due to MDS not yet being completed. MDS addressed Resident #67's diagnoses. Included Type 2 Diabetes Mellitus with hyperglycemia-high blood sugar (is a chronic condition characterized by high blood glucose (sugar) due to insulin resistance or insufficient insulin production), acute on chronic systolic (congestive) heart failure, unspecified Atrial Fibrillation (a common arrhythmia characterized by a rapid, chaotic, and irregular heartbeat originating in the heart's upper chambers (atria)), Angina Pectoris (chest pain, pressure, or squeezing caused by reduced blood flow and insufficient oxygen to the heart muscle). During an observationˆof MC-D (hall 200) on 04/07/2026 at 1:14 p.m., one undated over the counter medication bottle was opened.ˆ During an observationˆof the MC-D (hall 200) on 04/07/2026 at 1:20 p.m., revealed 7 bottles of open medications did not include the appropriate labeling : month/day/year on the medication bottles. During an observation and interview 04/07/2026 12:09 p.m., with LVN F, while reviewing the 3-west nurse's medication carts, it was observed that Resident # 30 had 2 blister packets of Hydrocodone-Acetaminophen Tablet 7.5- 325 MG take 1 tablet by mouth every 6 hours as needed for severe pain with 10 pills being delivered on 03/06/2026 and the other with 25 pills delivered on 03/10/2026. It was also observed Resident # 68 had Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) on the medication cart that was not labeled with opened date. LVN F stated Resident #30 was discharged on 04/03/2026 and his (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication was kept on the cart for the resident to pick up later. LNV F stated she was not aware if the Resident #30 was notified about picking up his medication later. LVN F stated, the process was, when a narcotic medication was discontinued or a Resident was discharged home, 2 nurses would verify the medication count, sign and take it to the second-floor medication room and give to the manager for clinical service to put in the D/C box after verifying the count. LVN F stated she did not know if an insulin pen had to be labeled with the opened date. LVN F stated an insulin pen was supposed to be refrigerated if not being used. LVN F stated Resident #68's insulin pen was being used. During an observationˆof the MC-D (hall 200) on 04/07/2026 at 1:22 p.m., one white round TAB stored inside of the unlabeled medication cup. During an observationˆof the MC-D (hall 200) on 04/07/2026 at 1:36 p.m., 1 orange round TAB which was loose and unlabeled. During an observationˆof the MC-E (hall 200) on 04/07/2026 at 1:37 p.m., 1 orange round TAB revealed it loose and unlabeled. ˆ During an observationˆof the MC-E (hall 200) on 04/07/2026 at 1:20 p.m., revealed an expired bottle of Glucosamine Chondroitin with a handwritten note on the bottle indicating opened 12/17/24. During an observationˆof the MC-D (hall 200) on 04/07/2026 at 1:25 p.m., six bottles of open medications revealed did not include the appropriate labeling on the medication bottles. During an observationˆof the NC-E (hall 200) on 04/07/2026 at 2:04 p.m., two blister packs of Narcotic medications revealed (1 blister pack with 5 Norcocodone-Acet 5 MG-325 MG TABs and 1 blister pack with 20 Norcocodone-Acet 5 MG-325 MG TABs) were not removed from the cart after resident's discharge. During an observation and interview on 04/07/2026 at 3:03 p.m. with MA G, while reviewing the 3-E medication aide cart, it was observed Resident #8 had a box of Scopolamine1 mg (1.5mg) /3-day patch with delivery date of 1/14/2026 still on the cart. According to MA G, Resident #8 no longer received the patch. MA G stated if medication was discontinued, it should be removed from the medication cart immediately. MA G stated usually they would hand the discontinued medication to the charge nurse, and he was not sure why Resident #8's scopolamine patch was still on the medication cart. During an observation of medication administrationˆon 04/08/2026 at 7:20 a.m., MA C dropped Resident #68's white rounded tablet on the floor, the MA C identified the medication as Metformin. Resident #68 received another Metformin tablet and MA C left the dropped medication on the floor. The medication on the resident room's floor was picked up by the ADON after this surveyor pointed at the medication. Record review of Resident #68's undated admission face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included acute chronic systolic (congestive) heart failure (a chronic condition where the heart's left ventricle weakens and cannot contract properly), type 2 diabetes mellites with hyperglycemia (insulin resistance or failure to produce sufficient insulin), unspecified dementia (cognitive decline), unspecified atrial fibrillation (chronic arrhythmia where the heart's upper chambers beat chaotically). During an interview on 04/09/2026 at 08:20 a.m. the DON stated insulins should be labeled with open date to know when they expired and when they can no longer be used. The DON also stated based on standard practice, Narcotic medication should be removed from the cart immediately after being discontinued or discharged from the facility and taken to the appropriate place for destruction. The DON stated it was important to take D/C medications, prescription, and narcotic medications from the medication cart to prevent accidental administration to another Resident. During an interview on 04/09/2026 at 8:33 a.m. with Resident 68 she stated that if the pill dropped on the floor, she does not mind picking it up from the floor and eating it at home. She stated that she is not sure if she would take the pill after it has been on the floor here. She recalled that one of her medications fell on her lap and the staff picked up the medication and went to bring another medication for her yesterday morning. During an interview on 04/09/2026 at 11:03 a.m. the Manager for Clinical Services stated all D/C narcotics and prescription medications should be removed immediately from the medication cart, she verified the count with the charge nurse, they both sign and the medication was put in the destruction box. During an interview on 04/08/2026 at 12:38 p.m. with MA C she stated she has been working here for 4 years. She stated that she looked for the medication on the floor but could not find (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it. She stated that the resident could pick the medication from the floor and eat it. Resident #68 could get double dose of medication or an adverse reaction. MA C could not recall when she had her medication administration training last time. During an interview on 04/08/2026 at 1:02 p.m., the ADON stated she worked in the facility since December of 2025. The ADON stated that new over-the-counter medication bottles were supposed to be dated when they opened. As far as it is not beyond the label date on the bottle, if there are no instructions for how long the medication can stay. They should be dated; Months, the day it is open. I cannot answer this question until I know what my corporate wants me to say. The ADON stated that she does not know the reason for loose medications found in the medication carts, they were supposed to be discarded. They could have been given to the wrong residents and caused adverse reactions. She stated that any expired medication must be removed from the med carts. They are ineffective for residents and may cause an allergic reaction. The ADON stated that the medications of the discharged residents must be removed from the medication carts. The medication carts are to be audited by nurse managers and pharmacists. She stated, We started removing all expired medication from medication carts. The ADON stated it was not acceptable that the medication was left on the floor of the resident's room. She stated that somebody could pick it up and eat it. The DON stated that the CNA who dropped the medication on the floor should pick it up and dispense it properly. The ADON said the resident could have an adverse reaction if she picks it up and eats it. During an interview on 04/09/2026 at 10:20 a.m. interview with MA D he stated he has been working in the facility for 5 years. He stated that when opening new medication bottles the bottle must be labeled with open date: month/day/year. If the medication was pulled out for dispense it must be labeled with the name of the medication, resident's name. If it was not properly labeled there was possibility someone else would get it. The MA D stated the new over-the-counter medication bottles were supposed to be dated when they were opened. He stated that administering expired medications was ineffective for residents. He did not know the reason for loose medications were in the med carts. The MA D stated that any medications of discharged residents must be removed from the med carts, so they were not administered to the wrong resident. During an interview on 04/09/2026 at 10:39 a.m. with DON she stated she has been working in the facility for 9 days, still in training. When opening the new OTC medication bottle it must be labeled with open date: month/day/year. If the medication is pooled out for dispense the medication cup must be labeled with the name of the medication, resident's name, date, and time. If it is not properly labeled there was possibility someone else will get it. Loose medications were not supposed to be laying in the medications' carts; there is possibility the medication administered to the wrong resident. She stated that any medications of discharged residents were removed from the medication carts because they can be administered to the wrong resident and cause adverse reactions or allergies, depending on the medication. During an interview on 04/09/2026 at 11:19 a.m. with ADM he stated he has been working in this facility since November 2025. He stated If medications were not labeled correctly, it introduces residents to the possibility of med errors. It can negatively affect residents to have undated/expired meds in the med cart by the medication could lose their effectiveness. If medication is observed on the floor, it must be removed. The residents need to be kept safe. Review of facility's policy titled storage and expiration dating of medications and Biologicals revised 08/01/2024 reflected: 10. Facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for open medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.Facility staff may record the calculated expiration date based on date opened on the primary medication container.If a multi-dose vial of an injectable medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	has been opened or accessed {e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. 21. Facility should ensure medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider.22. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable laws and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued Medication). Record review of a document provided by the facility titled 5.3 Storage and Expiration Dating Medications and Biologicals with Effective date 12/01/07, Last revised: 5/2005, 10/2011/8/2025, 10/2016 reflected: 11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for open medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened. 21. Facility should ensure medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider. 22. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law, and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued 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 on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #41 and Resident #48) of 7 residents reviewed for infection control. ˆ The facility failed to ensure MA D performed hand hygiene before and after administering medications to Resident #55 and Resident #48. The facility failed to ensure LVN B performed hand hygiene before going to Resident #55 room. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: During an observation of the medications administration on 04/08/2026 approximately at 7:40 a.m. revealed MA D did not perform hand hygiene before preparing Resident 55's medications. MA D went to Resident 55's room to administer medications. MA D did not perform hand hygiene after administering medications, he left the resident's room and logged back on the facility's laptop without performing hand hygiene and started charting.ˆFurther observation on 04/08/2026 approximately at 8:10 a.m. revealed MA D did not perform hand hygiene before he pulled out Resident 48's medications and went to Resident 48's room to administer medications. Record review of Resident #55's undated admission face sheet reflected an [AGE] year-old male admitted on [DATE]. His diagnoses included essential primary hypertension (chronic high blood pressure with no single, identifiable medical cause), chronic kidney disease, stage 1ˆ(mild kidney damage with normal or high function), unspecified atrial fibrillation (chronic arrhythmia where the heart's upper chambers beat chaotically), malignant neoplasm of colon, unspecified (a cancerous tumor in the large intestine), malignant neoplasm of prostate (slow-growing cancer that begins in the prostate) Record review of Resident #55 MDS, dated [DATE], reflected BIMS score of 13 indicating the resident was cognitively intact. Record review of Resident #48's undated admission face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Chronic obstructive pulmonary disease, unspecified (incurable lung disease characterized by chronic airway obstruction), atherosclerotic heart disease of native coronary artery without angina (chronic buildup of plaque in the heart's arteries), heart failure (a chronic condition where the heart cannot pump enough blood to meet the body's needs), urinary tract infection, site not specified (UTI is confirmed, but documentation does not identify the specific location, such as the bladder or kidney). Record review of Resident #48 MDS, dated [DATE], reflected a BIMS score of 15 indicating the resident was cognitively intact. During an interview on 04/09/2026 at 8:20 a.m. with Resident #48 she stated she would not like it if staff did not sanitize or wash their hands before coming into her room. She stated that other residents might have asked staff to move their legs that have slid down of the pillow or fix their pillows or something else and then coming to her room without hand sanitizing or washing hands is not acceptable. During an interview on 04/9/2026 at 10:20 a.m. with MA D he stated he trained in infection control, his last infection control in service was last month. It covered hand hygiene like washing hands for 20-30 seconds and hand sanitizing for every resident care. and hand sanitizing; Not performing properly hand hygiene can spread infection. Putting PPE on, gloves and gown when it is required for the resident on EBP. During an interview on 04/08/2026 at 1:48 p.m., CNA E stated that it was her 4th week working in this facility. She stated she was trained in infection control. She stated she did modules for two days when she was hired, including infection control. She stated the modules covered use of hand sanitizers when in and out of the residents' rooms. Hand washing is required if the hands are visible soiled. Hands can carry a lot of germs. She stated we can get bigger problems if we do not follow the hand hygiene protocol. Wear the PPEs She stated that when going to the residents' rooms with the EBP sign on the door, gowning, gloving is required when providing direct care to resident. During an interview on 04/08/2026 at 1:50 p.m., RN A stated she worked as a clinical nurse for about two months.She stated she was trained in infection control while boarding to this job. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The infection control training covered hand hygiene, like washing hands or sanitizing them before touching another resident. Proper wear of PPEs; Gowning, gloving. Washing hands before and after touching residents when providing direct care. Hand sanitizing does not work if hands are visibly soiled. Hands must be sanitized before and after administering medications to the residents. It is important to wash and sanitize hands to prevent spread of infectious organisms between residents. Infection can be brought from outside of the facility and spreader here. During an interview on 04/9/2026 at 10:39 a.m., the DON she stated she has been working here for 9 days. She stated she completed the infection control course online. The course covered good hand hygiene practice. Washing hands when they are visible soiled. Sanitizing hands before going to the resident's room and after leaving the room. Mode of infection transmission. Proper use of PPEs. The importance of following hand hygiene protocol because infection can be transmitted quickly if it is not followed. In an interview on 04/09/2026 at 11:19 a.m., the ADM stated he has been working in this facility since November 2025. He stated he was trained in Infection control. The ADM stated he took online courses that were required by HHS every 2 years and an annual CMS course. He stated the training covered best practices of infection control, hand hygiene, and use of PPEs and wash/sanitize hands before and after providing care to residents. The ADM stated staff should sanitize hands before going to residents' rooms and sanitize hands when leaving the residents' rooms and wash visibly soiled hands. He said put PPE on if it is required before going to the residents' rooms, this is mainly required for the direct care staff. During an observation on 04/08/2026 at 9:08 a.m. hall 200 for infection control revealed LVN B did not perform hand hygiene before and after going to Resident 28's room. Resident 28's room has EBP signs on the door and plastic drawers with PPEs placed at the entrance to the room. Further observation revealed LVN B went directly to Resident 66's room without sanitizing his hands. During an interview on 04/09/2026 at 7:17 a.m., LVN B stated he worked at the facility for over 2 years. He stated he was trained in infection control, he stated he had no idea when he had his last infection control training.LVN B stated the infection control training covered hand hygiene. He stated it depends on the situation if hands must be washed or sanitized; hands must be washed before or after treatment, wound care, blood sugar check. Hand sanitizing before and after giving PRN medication. He stated he is an old school nurse; he usually attends to 3 people before sanitizing hands. Not performing hand hygiene can cause passing germs to other people. Record review of a document provided by the facility titled Policy Name: Handwashing/Hand Hygiene - CS-50-6, dated 10/2015 and revised 03/2026 reflected: G. CDC recommends using Alcohol Based Hand Sanitizer with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water during routine resident care. 3. Before preparing or handling medications. 14. Before and after entering isolation precaution settings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 2 (Resident #52 and Resident #73) of 10 residents reviewed for advance directives. 1. The facility failed to ensure Resident #52's advanced directives were clearly identified, documented in the resident's electronic medical record, and on the residents' care plan.2. The facility failed to ensure Resident #73's advanced directives were clearly identified, documented in the resident's electronic medical record, and on the residents' care plan.This failure could place residents at risk of not having their end-of-life wishes honored and having incomplete records.Findings included: 1. Record review of Resident #52's face sheet, dated 04/08/2026, revealed an [AGE] year-old male admitted [DATE]. Resident #52 had diagnoses which included muscle weakness, need for assistance with personal care, hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), history of falling, ischemic cardiomyopathy (condition where the heart muscles are weakened due to reduced blood flow), and heart disease. Record review of Resident #52's admission MDS, dated [DATE], revealed Resident #52 had a BIMS of 14, which indicated intact cognition. Record review of Resident #52's care plan, dated 03/27/2026, revealed Resident #52's advance directives were not on the care plan. Record review of Resident #52's hospital discharge papers, dated 03/27/2026, revealed Resident #52 had an advance directive of full code. 2. Record review of Resident #73's face sheet, dated 04/08/2026, revealed a [AGE] year-old female admitted [DATE]. Resident #73 had diagnoses which included metabolic encephalopathy (brain disease), protein-calorie malnutrition (inadequate intake of both protein and calories), vascular dementia (lack of blood that carries oxygen and nutrients to a part of the brain), and heart disease. Record review of Resident #73's admission MDS, dated [DATE], revealed Resident #73 had a BIMS of 03, which indicated severe cognitive impairment. Record review of Resident #73's care plan, dated 04/03/2026, revealed Resident #73's The resident has an Advanced Directive(s) and has documentation in their medical record (did not have code status). The goal was, The resident's wishes will be honored and maintained through next review date. The interventions were Honor the resident choice for code status. Record review revealed there was not a code status indicated. During an interview with the ADON on 04/09/2026 at 11:20 a.m., she said she was trained on advanced directives. She said she had not looked up the policy for advanced directives, but she said the policy might be to honor the residents wishes. She said staff were to scan the residents DNR, if they had one, into the resident's medical file. She said if the resident was a full code staff would ask if the resident wanted to have a full code status or a DNR. She said the advanced directives should be in the resident's chart on admission. She said the nurse who admitted the resident should input the advanced directives in the resident's medical file. She said if the advance directive was not in the resident's medical file, the facility would not know what the residents' wishes were. She said she was not sure who monitored to ensure the advanced directives were put in the resident's medical file. She also said she did not know why Resident #52 and Resident #73 did not have their advanced directives in their medical files. During an interview with the Admissions Coordinator on 04/09/2026 at 11:31 a.m., she said she was trained on advanced directives. She said the policy for advanced directives was that staff had three to five days to put the residents advanced directive in their medical chart. She said if the resident did not have a DNR, she entered the resident as a full code until the paperwork was provided for the DNR. She said a resident's advanced directive should be put in the resident's medical file right away. She said she was responsible for putting the advanced directive in a resident's medical file. She said if a resident's advanced directive was not in the resident's medical file staff would not know if the resident was DNR. She said it was not acceptable for the resident's advanced directive to not be in the resident's medical file. She said she monitored to ensure the advanced directives were put into (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents medical file by conducting an audit. She said she did not know why Resident #52 and Resident #73's advanced directive was not in the medical files. During an interview with the ADM on 04/09/2026 at 11:51 a.m., he said he was trained on advanced directives. He said he did not know the policy and did not want to misquote it. He said the residents had the right to have advanced directives. He said the residents' also had the right for staff to follow their wishes. He said the nurses and all licensed individuals were responsible for ensuring the resident's advanced directive was in their medical file. He said if the resident's advanced directive was not in their medical file it could affect the resident's wishes and the grieving process for the family. He said the IDT team monitored to ensure the advanced directives were in the residents medical file. He said the IDT did monthly audits to ensure all residents had the advanced directive in their medical file. He said he did not know why Resident #52 and Resident #73's advanced directives were not in their medical files. Record review of the Advanced Directives Policy, dated 03/2026, revealed, Residents have the right to make choices about their care. They are encouraged to document their wishes and provide the appropriate directives to their families/legal representative, and the HCP. Upon admission to the community or soon thereafter, the community admission coordinator or designee should obtain a copy of resident advance directives, when applicable. The community representative should verify and confirm the resident/legal representative's desire for resident code status, obtain appropriate documentation, and identify resident's desire according to the community's procedure.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs for one of 10 residents, (Residents #67), reviewed for unnecessary medications. The facility failed to ensure Resident #67 had an indication/diagnosis for an antibiotic ordered. Resident #67 was receiving Ciprofloxacin HCl Tablet 500 MG without appropriate diagnoses. This failure could place residents at risk of not receiving the appropriate interventions, monitoring, and follow-ups. Findings Included Record review[KA1] of Resident #67's face sheet, dated 04/07/2026, reflected an [AGE] year-old male, admitted [DATE], with diagnoses that included Diverticulitis of intestine (the inflammation or infection of small pouches (diverticula) that form in the colon wall, commonly causing severe lower-left abdominal pain, fever, nausea, and changes in bowel habits), other specified sepsis (sepsis is a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage, organ failure, and potential death), recurrent major depressive disorder [KA3] (a chronic condition characterized by two or more distinct episodes of severe sadness, hopelessness, and loss of interest, separated by at least two months of recovery). Record review of Resident #67's care plan, dated 04/02/2026, reflected Resident #67's risk for falls, potential impairment to skin integrity, pain, and risk for hot liquid injury. Further record review reflected no care plan completed addressing other health concerns, such as the use of antibiotics, TPN infusion, JP drains, code status, and PICC line access. Review of Resident #67's interim[KA5] care plan initiated 04/02/2026 reflected no to EBP, no to gastrointestinal issue. Record review of Resident #67's admission skin assessment, dated 04/03/2026, reflected Resident #67 had a PICC line at right arm and 2 JP drains, 1 to the left upper quadrant and the other to the right lower quadrant of the abdomen. Record review of Resident #67's admission MDS assessment dated [DATE] reflected no BIMS score due to MDS not yet being completed. MDS addressed Resident #67's diagnoses as listed above.Review of Resident #67's physician orders, dated ??, reflected the following:Ciprofloxacin HCl Tablet 500 MG Give 1 tablet by mouth every 12 hours for Infection for 7 Days. The was no specific infection identified on Resident #67's order. Record review of Resident #67's MAR for the month of April 2026 reflected:Ciprofloxacin HCl Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth every 12 hours for antibiotic until 04/03/2026 23:59 -Start Date- 04/02/2026 with no diagnosis or indication for the ABT.Ciprofloxacin HCl Tablet 500 MG Give 1 tablet by mouth every 12 hours for Infection for 7 Days -Start Date- without specific diagnosis for the ABT. Record review of facility's infection control log reporting period, dated 04/01/2026 to 04/08/2026, reflected Resident #67 was on ABT Ciprofloxacin HCl Tablet but there was no area where the infection indicated. During an interview on 04/09/2026 at 08:20 a.m., the DON stated if a resident was on ABT, the order should indicate the specific type of infection, not just infection in general. The DON stated, ABT should be specific and should have a diagnosis. Diagnosis should be specific so we can know why the resident is getting the ABT, to know how to access, follow up and if the issue was resolved. During an interview on 04/09/2026 at 08:53 a.m., the MDS Nurse stated if a resident was on ABT, the order had to be specific to enable the staff to know the type of infection to appropriately access and monitor the resident for. Review of facility's policy (no policy on unnecessary meds).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its residents were free of any significant medication errors for 1 (Resident #55) of 3 residents observed and reviewed for medications administration. ˆ The facility failed to ensure that MA D did not inaccurately chart two refused medications as administered to Resident # 55. ˆˆ These failures placed the residents at risk of harm or not receiving desired outcomes from medications not administered according to physician's orders and manufacturer's specifications. Findings included: During an observation of administration of medication, on 04/08/2026 at 5:10 PM, revealed Resident #55 refused to take his medications 50 Mg of Senna (combination of stimulant laxative and stool softener used to treat constipation) and 17 Grams of GlycoLax Powder (an osmotic laxative used to treat constipation by increasing water in the stool) were removed from Resident 55's room and properly disposed by MA D. Observation revealed these medications were documented as administered in MAR. Record review of Resident #55's undated admission face sheet reflected an [AGE] year-old male admitted [DATE]. His diagnoses included essential primary hypertension (chronic high blood pressure with no single, identifiable medical cause), chronic kidney disease, stage 1ˆ(mild kidney damage with normal or high function), unspecified atrial fibrillation (chronic arrhythmia where the heart's upper chambers beat chaotically), malignant neoplasm of colon, unspecified (a cancerous tumor in the large intestine), malignant neoplasm of prostate (slow-growing cancer that begins in the prostate). Record review of Resident #55 MDS, dated [DATE], reflected BIMS score of 13 indicating the resident was cognitively intact. Record review of Resident # 55's MAR for April 2026 reflectedˆResident #55 received 50 Mg of Senna and 17 Grams of GlycoLax Powder on 04/08/2026. During the interview on 04/09/2026 at 7:47 a.m., Resident #55 stated he did not take stool softener medications yesterday morning because his stomach was gurgling since the day before and it was an uncomfortable feeling. He stated, I am very cognitive so I know what medication I am taking and what medications I should not take. I can make an independent decision. During an interview on 04/9/2026 at 10:20 a.m., MA D stated he worked at the facility for five years. He stated that any refused medication must be documented as refused and the reason for refusal and the supervisor, or charge nurse, must be notified. MA D stated if medications were not administered to a resident but documented as given, the staff could be written up. During an interview on 04/09/2026 at 11:30 a.m., RN A started working as a clinical nurse for about two months. RN A stated if a resident refused medication the resident must be educated on the medication he or she refused. RN A stated the procedure was to discard the medication if the medication was refused after educating resident, document it, and report it to doctor, the DON, and charge nurse. RN A stated nurses must be honest if medication was not administered and it must be documented as not administered. RN A stated the resident was not receiving the treatment needed. RN A stated the reason for the refusal must be documented so the physician could make changes if needed. During an interview on 04/09/2026 at 11:37 a.m., LVN B started working at the facility for over two years. He stated any refused medications must be documented as not given and the refused medications must be reported to the NP, doctor, or nurse. He stated he could not recall anyone reporting to him a resident refused medication for a long time. LVN B stated that refused medication must be documented as refused, instead of given, because it was an ethical mistake. During an interview on 04/09/2026 at 11:49 p.m., the ADON stated residents had the right to refuse medications. The ADON said the nurse or med aid must document refused medication, discard them, and notify the nurse. The ADON stated refused medications must be documented as not given as residents were not getting treatment. During an interview on 04/09/2026 at 11:19 a.m. the ADM stated if medication was refused by a resident the medication refusal must be documented, the resident must be educated about potential health risks, such as worsening conditions/side effects, refused medication must be (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wasted, and the resident's physician must be notified about refusal. Record review of a policy provided by the facility titled Medication & Treatment- Medication Administration Record, Effective date 3/2003, revised 5/2005, 10/2011/8/2025, 10/2016 revealed: 4. After the medication is received and consumed by the resident, the associate will document the 'Administered' chart code that reflects that the medication was taken. If the medication is refused or not given/taken, the associate will document the appropriate chart code in the administration details that reflects the refusal or reason the medication was not given/taken.