STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455876	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Nursing and Rehabilitation Center	4650 S Panther Creek Drive The Woodlands, TX 77381

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for one of eight residents (Resident #5) reviewed for resident rights. The facility failed to provide care in a manner that promoted maintenance of a resident's quality of life on 1/27/26 when Resident #5 was left in the shower alone, cold, and unclothed for approximately 5 minutes and was unable to call for help. This deficient practice could place residents at risk of fearfulness, helplessness and loss of dignity.Findings included:Record review of Resident #5's admission Record generated on 4/13/26 revealed he was admitted to the facility on [DATE]. He had diagnoses of multiple sclerosis (a chronic, often disabling autoimmune disease of the central nervous system (brain and spinal cord) where the immune system destroys the myelin sheath protecting nerves), major depressive disorder (a serious mental health condition characterized by at least two weeks of persistent, severe sadness, loss of interest in activities, fatigue, and sleep/appetite changes that interfere with daily life) and quadriplegia (paralysis affecting all four limbs and the torso, caused by damage to the cervical spinal cord or brain). He was [AGE] years of age. Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 15, indicating he had no cognitive impairment. He used a wheelchair for mobility. He required substantial/maximal assistance with personal hygiene and was dependent on others for bathing, including washing, rinsing and drying self. He had functional limitations in range of motion in his upper extremities with impairment on one side and had limitations in lower extremities with impairments on both sides. Record review of Resident #5's Care Plan dated 2/14/23 revealed Resident #5 had an ADL self-care performance deficit related to multiple sclerosis and hemiplegia. The resident's goal was to maintain his current level of function in ADLs through the review date of 6/29/26. Interventions included providing bathing/showering and personal hygiene assistance. The resident requires total assistance with 2 person (sic) with tub bath/shower 3x week as necessary. the resident requires extensive assistance of 1 person with personal hygiene and oral care.In a telephone interview on 4/13/26 at 12:39pm 12:39pm, CNA R said she cared for Resident #5 three times. She said the last time she cared for him, she gave him a shower. She said herself and CNA E helped him get into the shower chair. She said they went to the shower room and it was occupied. CNA R got him a blanket. She said when the other resident left, CNA R and Resident #5 went into the shower room. She said she got him situated in the shower, put the call light in reach, and asked if he needed help. Resident #5 responded that he needed help with his legs and feet. She said she told Resident #5 that she would give him privacy and return to help. She said she went to the restroom and returned about 5 minutes later. She said when he returned he was upset and thought she had been gone for too long. She said he had not started giving himself a shower. She said Resident #5 was safe in the shower without supervision and was not a fall risk. She said she thought he could wash himself. She said she left to give him privacy. In an interview, observation and record review on 4/13/26 at 2:15pm, Resident #5 let me read a note on his phone that described being left alone in the (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 0550 Level of Harm - Actual harm Residents Affected - Few	shower room. He said during the shower he could not reach the faucet, could not do anything himself and was sitting there with no cover and was cold. He reached for his phone that was on his lap. His left hand was contracted and he could not move his fingers. He used the back of his left hand to stabilize his phone. He operated his phone using his right arm and hand. Record review of the note in his phone indicated it was dated 1/27/26 and read, [CNA R] came to my room at 4:15 pm to shower me. It was the worst shower that I have ever had in my life. When (CNA R) put me in the shower, she took the sheet and hospital gown that I had on. This left me naked. Next, [CNA R] said, I'm going to the bathroom, I'll be right back. I didn't think anything about it. [CNA R] was gone for over an hour. This left me naked and cold, unable to do anything to help myself. [CNA R] didn't bother to hang my catheter bag up anywhere, she left it in my lap. This caused me to urinate on my leg. She didn't leave me a towel or anything to cover up with. There was no hot water and since it was January, it was cold. I used the shower head to bang on the wall and yelled as loud as I could but [CNA R] was gone. The note said he reported it to Former ADON C.In an interview on 4/13/26 at 2:58pm, the Administrator stated he was not aware of a complaint regarding Resident #5 related to being left alone in the shower room unattended.Surveyor attempted to contact Former ADON C and CNA E by phone on 4/13/26 without success. In an interview on 4/13/26 at 4:00pm, the DON said she had worked at the facility for a few weeks. When asked if residents could be in the shower room independently, she said it would depend on the resident's capabilities, and gave examples as to whether they were alert and oriented, how much care they needed, and if they wanted privacy. She said she was a little familiar with Resident #5 and talked to him for the first time today. She said he would need assistance in the shower, but said if Resident #5 was yelling at the caregiver, was noncompliant with care, then the CNA may decide to leave. She said they tried to meet his needs. State surveyor explained that did not seem to be the case during an incident a few months ago, and she said there was no way of knowing what was said between the resident and CNA. In an interview on 4/13/26 at 4:20pm, when asked if Resident #5 should be left alone in the shower room when being bathed, LVN I said Resident #5 was alert and oriented. He said they would do the shower how he wanted it, including closing the curtain if he requested privacy and checking on him every 3-5 minutes. Record review of the facility's policy for Activities of Daily Living dated 5/26/23 read, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's ability in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing, dressing, groom and oral care. a resident who is unable to carry out activities of daily living will received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the physician when resident arrived to the facility for 1 of 14 residents (CR#1) reviewed for resident rights.1. The facility failed to contact the physician when CR#1 had an unwitnessed fall on 1/17/2026 that resulted in a head injury.2. The facility failed to notify physician of CR#1 unwitnessed fall with head injury3. The facility failed to call 911 emergency services when initially requested by family4. CR #1 was hospitalized from [DATE] to 01/25/26 with the admitting diagnosis being fall, initial encounter. These failures could place residents at risk of decline in health status, increase level of pain, and could lead to more serious injuries. Findings Included:Record review of CR #1 face sheet revealed a [AGE] year-old female who arrived at the facility on 1/16/26 with a diagnosis of grade 4 glioblastoma multiforme with chemo treatment and brain resection (brain cancer), cerebral edema s/p brain resection (fluid in the brain), left hemiparesis s/p cerebral infarct (weakness on left side), CAD x2 stents (coronary artery disease), diabetes mellitus (insufficient insulin), hypertension (high blood pressure), seizure disorder (unprovoked seizures), arthritis affecting left wrist (inflammation in the joints), and multiple falls at home. She was discharged [DATE].Hospital after visit summary record review of medication list dated 1/16/26 revealed the following needed:Albuterol 90 mcg/act inhaler (as needed)Alcohol Swabs for glucometerAmlodipine 5 MG (Wait until 1/17 take 1 tablet) (treat high blood pressure)Aspirin EC 81 MG EC tablet take 1 by mouth daily (last given 1/16/26 at 9:07am)Azelastine (treat runny nose) 0.1% nasal spray (commonly known as Astelin. Administer 1 spray into each nostril in the morning and 1 spray in evening as directed).Centrum silver vitamin (1 tablet by mouth 1 time daily)Cyclosporine (treat chronic eye disease) 0.05% administer in both [NAME] in the morning and 1 drop in the evening (last time given was 1/16/26 at 6:12am).Dexamethasone (treat severe inflammation, allergies, asthma, autoimmune conditions, and certain cancers) 4 mg_start taking 1/17/26 (last time given 1/16/26 at 6:12am) take 1 tablet in morning and 1 in the evening.Fluticasone (used to treat asthma and reduce inflammation) 50 MCG/ACT (flonase) nasal spray administer I spray in morning and 1 in the evening.Furosemide (treat fluid retention caused by heart failure, liver disease, or kidney disorders) 20 MG (commonly known as Lasix) tablet take by mouth 1time each day.Lacosamide (treat seizures) 200 Mg Tablet (Known as Vimpat) take 1 tablet in morning and 1 table in eveningLancet Device with Ejector (use to check sugars once day due to type 2 diabetes)Metformin (used to treat diabetes) XR 500 MG 24-hour tablet (take in the evening)Ondansetron 8 MG (known as Zofran_as needed for nausea_take at bedtime)Pantoprazole (treat excessive stomach acid) 40 MG (known as ProtoNix_start taking on 1/17/26_last time given 1/16/26 at 6:12amRosuvastatin (used to treat high chloresterol) 10MG (take 0.5 tablets by mouth 1 time each day_Last time given was 1/16/26 at 9:07am)Trelegy Ellipta (used to treat COPD, which limis airflow in the lungs) 100-62.5-25 MCG aerosol powder_Inhale 1 puff 1time daily)Valsartan (used to treat high blood pressure, and heart failure) 320 MG tablet (known as Diovan start taking 1/17/26_last time given 1/16/26 at 9:07am Record Review of EMS Run Report revealed the following:2:17 am blood pressure 198/114 2:24 am blood pressure 198/114 Pulse 652:24 am blood pressure 207/110 Pulse 612:34 am blood pressure 207/110 Pulse 642:34 am blood pressure 99/70 Pulse 622:37 am blood pressure 1961/98 Pulse 652:44 am blood pressure 196/98 Pulse 612:46 am blood pressure 173/95Record Review of CR#1's Vitals in nursing notes revealed:Blood Pressure taken 1/16/26 at 6:32pm 133/77Temp 1/16/26 at 6:32pm 97.7Pulse 1/16/26 at 6:32pm 88 bpmRespirations 1/16/26 at 18 Breaths/min O2 1/16/26 at 6:32pm 97.0%Record Review of nursing notes dated 1/16/26 at 7:57pm revealed CR#1 was admitted via stretcher with dx of left sided weakness & Cerebral edema. Vitals taken by LVN A were Temp 97.4, Pulse 70, Blood Pressure 164/100, O2 Sats 98% room air. Incontinent of b/b.Record Review of nursing notes dated 1/16/26 at 8:49pm CMA A (continued on next page)

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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 0580 Level of Harm - Actual harm Residents Affected - Few	wrote dexamethasone tablet 4 mg_Give 1 tablet by mouth two times a day for inflammation. Medication Unavailable.Record Review of nursing notes dated 1/16/26 at 8:50pm CMA A wrote CycloSporine Emulsion 0.05% Instill 1 drop in both eyes two times a day for dry eyes due to inflammation. Medication Unavailable.Record Review of nursing notes dated 1/17/26 at 1:20am, RN A wrote, Around 1:20 AM the resident was seen on the floor and brought back to bed and had V/S assessed. No swelling or bruising upon initial assessment. 30 minutes later the resident had a small swelling the left side of her forehead.Record Review of nursing notes dated 1/17/26 at 4:18am, RN Awrote, Change of Condition. Resident fell and had a bruise on her left forehead. Resident transferred to hospital.Record Review of email sent to facility and corporate office from the FM on 1/17/26 at 4:21am revealed the following:[ATTN: Administrator, Director of Nursing, and Risk Management]Demand for Action:Your staff has created a dangerous environment. You have an inexperienced nurse admitting to sleep deprivation and an inability to manage his caseload, and support staff who prioritize their phones over patient safety.[CR#1] is currently at the emergency room being evaluated for head trauma-an injury sustained because your staff failed to ensure she had a call light or safe surroundings.I require an immediate response from the [Director of Nursing] regarding:1. Why I was not called immediately upon the fall.2. Why a patient with a seizure history was left without a call button.3. Why a nurse is on the floor admitting to being sleep-deprived and unable to care for his assigned patient load.I expect a call immediately to discuss how you intend to rectify this liability.[FM][Contact Number]Record review of Hospital Notes dated 4/1/26 revealed CR#1 was hospitalized from [DATE] to 01/25/26 with the admitting diagnosis being fall, initial encounter. On 3.31.26 at 10:45am, during a telephone interview with the FM, she stated the incident report was somewhat accurate with a lot of inaccuracies, which was why she sent the email. She stated on 1/17/26, a little after 1:00am, her mother had fallen on the floor while trying to go to the restroom as she was unable to locate her call light, and her phone was not within reach. She stated CR#1's call light was behind her bed and not in reach. The FM stated no staff member called her from the facility. She stated she became aware of the fall and medication issue from CR#1, which was why she arrived that early morning to find CR#1 with a horrendous swollen knot on the left side of her head from falling. The FM stated when she arrived at the facility, a CNA, later Identified as CNA A, escorted the FM and her boyfriend down to CR#1's room. The FM stated she arrived at the facility at 1:40am, and RN A was nowhere to be found. The FM stated CNA A called RN A on the phone and the call went to voicemail. The FM stated CNA A located RN A outside in his car, which time she informed RN A that CR#1's FM needed to speak with him. The FM stated she asked RN A what happened to CR#1's head and RN A appeared shocked that CR#1's head was swollen. The FM stated she told RN A she left CR#1 in his care and she was neglected. The FM stated RN A was passive aggressive, elevated his voice and told her that he was responsible for more residents than CR#1 and that the number of residents he had was overwhelming. The FM stated, during the conversation exchange with RN A, he stated CR#1 was not the only resident who had fallen in the facility. The FM stated this statement is what really upset her and she demanded her mother be sent to hospital for further examination. She stated the RN A refused to call 911 stating he needed permission from the DON. The FM stated RN A called the DON to see if he could call the regular ambulance service and not 911 and was given permission. She stated the ambulance arrived between 3:25am - 3:40am. The FM stated no medication arrived at 3:00am for CR#1. On 3.31.26 at 6:35pm in a telephone interview with RN A he stated he vaguely remembered the incident with CR#1. He stated he remembered CR#1 falling. RN A stated he called the doctor and FM and did not get an answer from either one, so he called the Former DON to get authorization and was given permission to send CR#1 out 911. RN A stated the negative of not sending resident out 911 could have been CR#1 could have sustained a brain bleed or stroke. RN stated protocol was followed when caring for CR#1.On 4/13/26 at 2:53PM in an interview with the Admin he stated the expectations of a nurse when a resident experienced a fall, especially an unwitnessed fall, is to do an assessment, neuros, and vital signs before picking resident off the floor. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	The family and doctor should be contacted immediately afterwards. The negative effect of picking up the resident could cause more injury. The Admin stated the assessment should be completed as soon afterwards. The Admin stated if a family request resident to be sent out to hospital, then the resident should be sent out. The Admin stated all residents should be treated with dignity and respect at all times.On 4/13/26 at 3:00pm in a telephone interview with MD he stated he would have to check his charts to see if he received a message from the facility. The MD stated if he had received a message from the facility then his NP would have knowledge of it. MD stated he would call his NP and have her return the call with results. On 4/13/26 at 3:46pm in a telephone interview with NP she stated that when a new resident arrived to the facility she gets a text from the facility that says, new patient admitted room number so-and-so. she stated that she had not received a call from the facility regarding CR#1 nor had she received a call, message or text from LVN A regarding medication review or from RN A regarding CR#1's fall with head injury. NP stated on 1/20/26 she received a voicemail from DON A asking if she was notified about CR#1's allegations. NP stated that she was not. On 4/14/26 at 3:09pm in a telephone interview with LVN A, she stated she was working at the time the resident arrived at the facility. She stated the resident came into the facility on a stretcher with her family members accompanying her. She stated she called the doctor to verify the meds. She stated she did not call the pharmacy and that the call to the pharmacy was typically for residents who entered the facility with pain medication (narcotics). When asked if she got a voicemail when she called the doctor or left a message, LVN A stated she did not leave a message on voicemail, she is sure that she either spoke with the MD or the NP. LVN A stated her calling the MD or NP should have been documented in her nursing notes. She stated she followed protocol. LVN A stated she would have to look at the nursing notes and can't remember much about the admission process due to the elapsed time. However, she stated all of what she did is in the nursing notes. LVN A stated the adverse effect of not documenting what occurred is It didn't happen. LVN A stated the blood pressure was 164/100 (she could not say if this was a mistake or not) during the time resident was admitted , but no interventions were put in place. She stated she worked the 6:00am - 6:00pm shift and stayed later, which is when CR#1 arrived at the facility. Record review of facility's Promoting/Maintaining Resident Dignity policy dated 1/13/23 revealed the following: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.Compliance Guidelines:1. All staff members are involved in providing care to residents to promote and maintain resident dignityand respect resident rights.2. During interactions with residents, staff must report, document and act upon information regardingresident preferences.5. When interacting with a resident, pay attention to the resident as an individual.10. Speak respectfully to residents; avoid discussions about residents that may be overheard.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that residents received treatment and necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with professional standards of practice and resident choices, for 1 to 14 (CR#1) residents reviewed for Quality of care.The facility failed to ensure that appropriate preventative measures, monitoring, and interventions were consistently implemented to reduce the risk of falls and ensure CR#1's safety in accordance with accepted standards of nursing practice.The facility failed to respond timely to CR#1 who was in distress after a fall on 1/17/26. The facility failed to conduct appropriate post-fall assessments for CR #1 after a fall on 1/17/26 resulting in multiple breakdowns in care, including failure to respond timely to a resident in distress, which resulted in delayed treatment. CR #1 was hospitalized from [DATE] to 01/25/26 with the admitting diagnosis being fall, initial encounter. These failures could place residents at risk for avoidable injuries and compromised quality of care resulting in hospitalization.Based on interview, and record review, the facility failed to ensure that residents received treatment and necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with professional standards of practice and resident choices, for 1 to 14 (CR#1) residents reviewed for Quality of care. The facility failed to ensure that appropriate preventative measures, monitoring, and interventions were consistently implemented to reduce the risk of falls and ensure CR#1's safety in accordance with accepted standards of nursing practice.The facility failed to respond timely to CR#1 who was in distress after a fall on 1/17/26. The facility failed to conduct appropriate post-fall assessments for CR #1 after a fall on 1/17/26. These failures could place residents at risk for avoidable injuries and compromised quality of care resulting in hospitalization. Findings Included Record review of CR #1 face sheet revealed a [AGE] year-old female who arrived at the facility on 1/16/26 with a diagnosis of grade 4 glioblastoma multiforme with chemo treatment and brain resection (brain cancer), cerebral edema s/p brain resection (fluid in the brain), left hemiparesis s/p cerebral infarct (weakness on left side), CAD x2 stents (coronary artery disease), diabetes mellitus (insufficient insulin), hypertension (high blood pressure), seizure disorder (unprovoked seizures), arthritis affecting left wrist (inflammation in the joints), and multiple falls at home. She was discharged [DATE]. Record review of CR#1's physician orders dated 1/16/26 revealed resident was to be administered:Cyclosporine (treat chronic eye disease) 0.05% administer in both [NAME] in the morning and 1 drop in the evening 1/16/26;Azelastine (treat runny nose) 0.1% nasal spray (commonly known as Astelin. Administer 1 spray into each nostril in the morning and 1 spray in evening as directed) Start dated 1/16/26 at 6:00pm;Monitor for pain every shift. Use 0-10 scale(A) for Alert resident Used Pain AD (B) for confused residents document which pain scale used to assess residents pain rating every shift (start dated 1/16/26 6:00pm-D/C date 1/20/26 8:59am;Vital signs every shift_Start date 1/16/26 at 6:00pm- 1/20/26 8:59am) Record Review of nursing notes dated 1/16/26 at 8:49pm CMA A wrote dexamethasone tablet 4 mg_Give 1 tablet by mouth two times a day for inflammation. Medication Unavailable. Record Review of nursing notes dated 1/16/26 at 8:50pm CMA A wrote CycloSporine Emulsion 0.05% Instill 1 drop in both eyes two times a day for dry eyes due to inflammation. Medication Unavailable. Record review of CR#1's Hospital after visit summary medication list dated 1/16/26 revealed the following:Albuterol 90 mcg/act inhaler (as needed)Alcohol Swabs for glucometerAmlodipine 5 MG (Wait until 1/17 take 1 tablet) (treat high blood pressure)Aspirin EC 81 MG EC tablet take 1 by mouth daily (last given 1/16/26 at 9:07am)Azelastine (treat runny nose) 0.1% nasal spray (commonly known as Astelin. Administer 1 spray into each nostril in the morning and 1 spray in evening as directed).Centrum silver vitamin (1 tablet by mouth 1 time daily)Cyclosporine (treat chronic eye disease) 0.05% administer in both [NAME] in the morning and 1 drop in the evening (last time given was 1/16/26 at (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	6:12am).Dexamethasone (treat severe inflammation, allergies, asthma, autoimmune conditions, and certain cancers) 4 mg_start taking 1/17/26 (last time given 1/16/26 at 6:12am) take 1 tablet in morning and 1 in the evening.Fluticasone (used to treat asthma and reduce inflammation) 50 MCG/ACT (flonase) nasal spray administer 1 spray in morning and 1 in the evening.Furosemide (treat fluid retention caused by heart failure, liver disease, or kidney disorders) 20 MG (commonly known as Lasix) tablet take by mouth 1time each day.Lacosamide (treat seizures) 200 Mg Tablet (Known as Vimpat) take 1 tablet in morning and 1 table in eveningLancet Device with Ejector (use to check sugars once day due to type 2 diabetes)Metformin (used to treat diabetes) XR 500 MG 24-hour tablet (take in the evening)Ondansetron 8 MG (known as Zofran_as needed for nausea_take at bedtime)Pantoprazole (treat excessive stomach acid) 40 MG (known as ProtoNix_start taking on 1/17/26_last time given 1/16/26 at 6:12amRosuvastatin (used to treat high cholesterol) 10MG (take 0.5 tablets by mouth 1 time each day_Last time given was 1/16/26 at 9:07am)Trelegy Ellipta (used to treat COPD, which limits airflow in the lungs) 100-62.5-25 MCG aerosol powder_Inhale 1 puff 1time daily)Valsartan (used to treat high blood pressure, and heart failure) 320 MG tablet (known as Diovan start taking 1/17/26_last time given 1/16/26 at 9:07am Record review of Hospital Notes dated 4/1/26 revealed CR#1 was hospitalized from [DATE] to 01/25/26 with the admitting diagnosis being fall, initial encounter. Record review of the facility's Investigation Summary revealed the facility was made aware on 1/28/26 by CR#1's FM who alleged CR#1 was verbally abused by CNA A by telling CR#1 to go to sleep because she was bothering the other resident in the room. Additional allegation was made by CR#1's FM who indicated CR#1 had not received all her medications on the night of her admission 1/16/26. The summary report revealed the following:CR#1 was discharged at the report.The accused (CNA A) did not show up for the scheduled meeting regarding these abuse and neglect allegations. The facility conducted life satisfaction rounds on 3 rooms and no issues noted.Facility staff were all reeducated on abuse and neglect, customer service, appropriate redirection of residents with behaviors, notification to families & physician on new admission medication arrival & scheduling; accordingly, staff interviews, RP informed, MD informed, and Ombudsman aware.Facility Investigation Interview with RN A who stated CR#1 was admitted around 4:30pm on 1/16/26 and began exhibiting erratic behavior and speaking incoherently, requiring frequent assistance. RN A stated CR#1 was shown all of her medications ordered, and informed she would receive what was available in the facility that night, and other medications would be in after early morning delivery. RN A stated at no time during his shift and or he entered the room with CNA A did he hear her be verbally abusive to CR#1, and CR#1 did not report or verbalize any concerns regarding verbal abuse or missed medications.Facility (Previous) Investigation Interview with CNA A regarding CR#1 indicated she arrived for her shift at 10:00pm and answered CR#1's call light. CNA A stated CR#1 was leaning off the bed and told her she had to pee. CNA A stated she assisted CR#1 to the restroom then back to bed, with her call light, water, and phone next to her and within CR#1's reach. CNA A stated CR#1's roommate complained about traffic in and out of the room and noise from resident. CNA A stated she used a calm approach to communicate/redirect CR#1 that her roommate was trying to get some sleep and she should try and get some sleep too.11 days after the abuse and neglect allegations, the facility Investigation in-service training reports were (Abuse and Neglect, medication availability, reconciling medications and admission orders, change in condition and timely notification, and customer service), completed 2/3/26. Record Review of EMS Run Report revealed the following:2:17 am blood pressure 198/114 2:24 am blood pressure 198/114 Pulse 652:24 am blood pressure 207/110 Pulse 612:34 am blood pressure 207/110 Pulse 642:34 am blood pressure 99/70 Pulse 622:37 am blood pressure 1961/98 Pulse 652:44 am blood pressure 196/98 Pulse 612:46 am blood pressure 173/95 Record Review of CR#1's Vitals in nursing notes revealed:Blood Pressure taken 1/16/26 at 6:32pm 133/77Temp 1/16/26 at 6:32pm 97.7Pulse 1/16/26 at 6:32pm 88 bpmRespirations 1/16/26 at 18 Breaths/min O2 1/16/26 at 6:32pm 97.0% Record Review of nursing notes dated 1/16/26 at 7:57pm revealed CR#1 was admitted via stretcher with dx of left sided (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	weakness & Cerebral edema. Vitals taken by LVN A were Temp 97.4, Pulse 70, Blood Pressure 164/100, O2 Sats 98% room air. Incontinent of b/b. Record Review of nursing notes dated 1/17/26 at 1:20am, RN A wrote, Around 1:20 AM the resident was seen on the floor and brought back to bed and had V/S assessed. No swelling or bruising upon initial assessment. 30 minutes later the resident had a small swelling the left side of her forehead. Record Review of nursing notes dated 1/17/26 at 4:18am, RN A wrote, Change of Condition. Resident fell and had a bruise on her left forehead. Resident transferred to hospital. Record Review of email sent to facility and corporate office from the FM on 1/17/26 at 4:21am revealed the following: ATTN: Administrator, Director of Nursing, and Risk Management, I am writing to formally document the appalling neglect, unsafe environment, and gross unprofessionalism experienced by [CR#1], within less than 24 hours of her admission to the facility.CR#1 was admitted on Friday, January 16, 2026, at approximately 5:15 PM. By early Saturday morning, your facility had already failed in its duty of care, resulting in a fall, head trauma, and an emergency transfer to the hospital.The Timeline of Negligence (Saturday, [DATE]): 1:16 AM: I received a distress call CR#1, not your staff, stating she had fallen, hit her head, and was bleeding. She begged me to come get her. The fact that the family was notified by the traumatized patient and not the nursing staff is an immediate failure of protocol. Arrival (~1:40 AM): Upon entering the facility, I found a staff member named [CNA A] at the nurses' station with her feet up, on her personal phone. She was completely disengaged. The Incident: [CNA A] escorted me to the room, admitting she had cleaned blood from my mother's head and applied a cold towel. However, she had not escalated the issue to the nurse. Cause of Fall: CR#1 was left with no access to a call button and her phone had been unplugged and moved out of reach. When she attempted to retrieve it to call for help, she fell. Verbal Abuse: CR#1 reported that after she fell, [CNA A] told her she needed to go to sleep because she was bothering the other patient. This lack of empathy is reprehensible. Medical Neglect: [CNA A] informed me she had not received her scheduled night medications.Conduct of RN A:After waiting 15 minutes for the Nurse on Duty to appear, I witnessed RN A entering from a side door carrying a bag of food, appearing annoyed.1. Lack of Awareness: He asked RN A what happened, despite being the nurse on duty. He then contradicted himself, claiming he had already evaluated her and she was fine, yet he was unaware of her critical medical history (seizures and brain tumor).2. admission of Incompetence: When I questioned his assessment, RN A became passive-aggressive. He explicitly stated that: Patients fall all the time here. He has only been a nurse for four months. He is sleep-deprived and responsible for 30 patients.3. Aggression: When I challenged his lack of empathy and aggressive tone, he raised his voice at me.Demand for Action:Your staff has created a dangerous environment. You have an inexperienced nurse admitting to sleep deprivation and an inability to manage his caseload, and support staff who prioritize their phones over patient safety.CR#1 is currently at the emergency room being evaluated for head trauma-an injury sustained because your staff failed to ensure she had a call light or safe surroundings.I require an immediate response from the Director of Nursing regarding:1. Why I was not called immediately upon the fall.2. Why a patient with a seizure history was left without a call button.3. Why a nurse is on the floor admitting to being sleep-deprived and unable to care for his assigned patient load.I expect a call immediately to discuss how you intend to rectify this liability.[FM][Contact Number]On 3.31.26 at 10:45am during a telephone interview with FM She stated the incident report was somewhat accurate with a lot of inaccuracies, which is why she sent the email. She stated on 1/17/26 a little after 1:00am her mother had fallen on the floor while trying to go to the restroom as she was unable to locate her call light, and her phone was not within reach. She stated CR#1's call light was behind her bed and not in reach. FM stated CR#1 told her it took staff a while to help her up. And while she was there, CR#1 informed her she didn't get all of her medication and the facility has brushed it under the rug. She stated she never heard anything about the RN A doing any follow-up assessments on CR#1 or checking on her medication. FM stated no staff member called her from the facility. She stated she became aware of the fall and medication issue from CR#1, which is why she arrived that early morning to find CR#1 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	with a horrendous swollen knot on the left side of her head from falling. FM stated when she arrived at the facility, a CNA, later Identified as CNA A, escorted FM and her boyfriend down to CR#1's room. FM stated she arrived at the facility at 1:40am. FM stated RN A was nowhere to be found. FM stated CNA A called RN A on the phone and the call went to voicemail. FM stated CNA A located RN A outside in his car, which time she informed RN A that CR#1's FM needed to speak with him. FM stated she asked RN A what happened to CR#1's head and RN A appeared shocked that CR#1's head was swollen. FM stated she told RN A she left CR#1 in his care and she was neglected. FM stated RN A was passive aggressive, elevated his voice and told her that he was responsible for more residents than CR#1 and that the number of residents he had was overwhelming. FM stated RN A stated he cleaned CR#1 up after picking her up from the floor and at this time CNA A interjected and stated CNA A cleaned her up, but the CNA said she said she did. FM stated during the conversation exchange with RN A he stated CR#1 was not the only resident who had fallen in the facility. FM stated this statement is what really upset her and she demanded her mother be sent to hospital for further examination. FM stated while waiting for the ambulance, CR#1 informed RN A she had not been administered her medication. She stated RN A told her because she arrived at the facility so late she would have to wait for her medication to arrive around 3:00am. She stated the RN refused to call 911 stating he needed permission from the DON. FM stated RN A called DON to see if he could call the regular ambulance service and not 911 and was given permission. She stated the ambulance arrived between 3:25am - 3:40am. She stated no medication arrived at 3:00pm for CR#1. On 3.31.26 at 12:29pm during a telephone interview with DON A Stated she was out of the facility when she received the call from RN A. RN a told her that CR#1 had fallen and had bumps and bruises. DON stated CR#1 had also fallen daily at the hospital. DON A stated FM initially issued a complaint regarding CR#1's fall to the facility, which was reported to the state, investigated and unsubstantiated. DON stated CR#1 was so disruptive the roommate requested to leave. DON A stated CR#1's behavior was not documented in the nursing notes and should have been. DON A stated the LVN who received CR#1 should have completed a medication review with the doctor or nurse practitioner. DON A stated at anytime if a family asked the facility to send the resident out there request should automatically sent out. DON A stated RN A said while he completed his Neuros, CR#1 was beginning to show signs of swelling. DON A stated RN A called the on-call nurse. On 3.31.26 at 1:00pm during a telephone interview with CNA A who stated she is no longer employed with the facility. CNA A stated 1/16/26 was busy night for her and CR#1 appeared to need more of her assistance than other residents on the hall. CNA A stated CR#1 would not use her call light but would verbally call for nursing assistance when she needed help CNA A stated this is the night she found CR#1 on the floor. She was on night shift and met CR#1 and her roommate soon after arriving for her shift. CNA A stated CR#1 roommate wanted to ask her a question and during this time CR#1 informed her she did not get water during her evening meal. CNA A stated that she began to give care to the roommate, and the roommate wanted to transfer rooms because she stated CR#1 makes a lot of noises. CNA A stated she politely asked CR#1 if she could quiet it down because the noise was disturbing her roommate. CNA A stated she did not know why CR#1 was making a lot of noise and did not report this to the charge nurse. CNA A stated shortly after leaving the residents' room, she was called back again. CNA A stated she observed CR#1 had moved herself on the bed where her legs were hanging off the side of the bed. CNA A stated she took CR#1 to restroom, which is next to CR#1's bed; then assisted her back to bed. CNA A stated after assisting CR#1 to bed she ensured the call light was on the side table with a cup of water and her phone. CNA A stated prior to her going into CR#1 room she observed RN A was on the phone standing just outside of CR#1's door. CNA A stated CR#1 told her that she was calling the guy who was standing right outside of her door for assistance, but he and was on the phone talking and laughing. The guy was later identified as RN A. CNA A stated CR#1 was cognizant enough to know her needs. CNA A stated she was in another residents room on the same hall. She stated after about 15 minutes she heard CR#1 screaming for help. She stated she (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	left the residents room she was giving care to and went to CR#1's room, which she observed CR#1 on the floor. CNA stated she called out to RN A and didn't get a response. CNA A stated she walked up to the nursing station and informed RN A that CR#1 was on the floor. RN A told her he needed to input information in the computer regarding a resident's medication and would get to her shortly. CNA A stated RN A did not get up right away. CNA stated she returned to CR#1's room and attempted to help her up herself, but CR#1 told her she was too heavy and she needed someone else. CNA A stated about 5 minutes later RN A arrived to CR#1's room and the two of them put resident back in bed then RN A left the room without completing any type of assessments before or after picking CR#1 off the floor. CNA A stated at this time, CR#1 was extremely upset and asked CAN A to help her look for her phone as the outgoing CAN had unplugged it and placed it out of her reach CNA A located the cell phone was able to assist CR#1 in calling her daughter. CNA A stated when CR#1 was on phone with FM she did not observe the swelling. CNA A stated FM arrived about 30 minutes later and wanted to immediately speak with RN A who was not in the building. CNA A stated she located RN A outside in his vehicle on the phone and eating and told him that CR#1's FM was in the facility. CNA A stated RN A did not do vitals prior to the two of them picking CR#1 up off the floor nor did she see RN A check CR#1's vitals afterwards. CNA A stated after FM arrived she was upset because she did not received a call from RN A or anyone in the facility that CR#1 had fallen and sustained a head injury. CNA A stated if RN A had really completed Neuros he would have noticed the swelling on CR#1's head, which is why FM was upset. RN A told FM he did not see the bruise on CR#1's head and at this time RN A began to get defensive and dismissive in his response to FM. RN A told FM that CAN A would not use her call light for assistance; however, CR#1 informed FM, and RN A that her roommate pushed her call light for CR#1 as her call light was located behind the bed.On 3.31.26 at 6:35pm during a telephone interview with RN A he stated he vaguely remembered the incident with CR#1. He stated he remembered CR#1 falling. RN A stated CNA A came and reported to him that CR#1 had fallen. RN A stated he did not remember what position CR#1 was in because it has been a while since the incident occurred. He stated CNA A assisted him in getting CR#1 in the bed. RN A stated he took vitals after putting CR#1 back in the bed. RN A stated he did not do range and motion with CR#1 (assessment evaluation) while CR#1 was on the floor. RN A stated he can't remember if he checked to see if resident was on an anticoagulant before picking her up and putting her in bed. At the time of the incident, he stated he was only on the job for 2-3 months. He stated he did not believe he made any mistakes. He stated he went to the room and checked her vital signs. He stated he completed the vital signs right away, and completed the neuro checks every 15 minutes. RN A stated he recorded on a sticky note or he charted them and he couldn't remember. RN A then stated he reported on both, sticky notes and nursing notes. RN A stated he called the doctor and FM and didn't get an answer from either one, so he called DON A to get authorization and was given permission to send CR#1 out 911. RN A stated the negative of not sending resident out 911 could have been CR#1 could have sustained a brain bleed or stroke. RN stated he believed he did everything he was supposed to do. He stated he followed proper protocol.On 4/13/26 at 2:53PM in an interview with the Admin who stated the expectations of a nurse when a resident experienced a fall, especially an unwitnessed fall, is to do an assessment, neuros, and vital signs before picking resident off the floor. The family and doctor should be contacted immediately afterwards. The negative effect of picking up the resident could cause more injury. The assessment should be complete as soon afterwards. The Admin stated if any family request resident to be sent out to hospital, then send resident out. Admin stated all residents are to be treated with dignity and respect at all times.On 4/13/26 at 3:00pm in a telephone interview with he MD who stated he would have to check his charts to see if he received a message from the facility. He stated if he had received any message his NP would have knowledge of it. He stated he would call his NP and have her return the call with results. On 4/13/26 at 3:46pm in a telephone interview with NP she stated that when a new resident arrived to the facility a text is received from the facility that says, new patient admitted room number so-and-so. she stated that she had not (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	received a call from the facility regarding CR#1 nor had she received a call, message or text from LVN A regarding medication review. NP stated she had not received a call from RN A regarding CR#1's fall with head injury. NP stated on 1/20/26 she received a voicemail from DON A asking if she was notified about CR#1's allegations. NP stated that she was not. On 4/14/26 at 3:09pm in a telephone interview with LVN A, she stated she was working at the time the resident arrived at the facility. She stated the resident came into the facility on a stretcher with her family members accompanying her. She stated she called the doctor to verify the meds. She stated she did not call the pharmacy and that the call to the pharmacy was typically for residents who entered the facility with pain medication (narcotics). When asked if she had gotten a recorder when she called the doctor or left a message. LVN A stated she either spoke with the MD or the NP, but she stated she did not leave a message. LVN A stated her calling the MD or NP should have been documented in her nursing notes. She stated she followed protocol. LVN A stated she would have to look at the nursing notes and can't remember much about the admission process due to the elapsed time. However, she stated all of what she did is in the nursing notes. LVN A stated the adverse effect of not documenting what occurred is It didn't happen. LVN A stated the blood pressure was 164/100 (she could not say if this was a mistake or not) during the time resident was admitted , but no interventions were put in place. She stated she worked the 6:00am - 6:00pm shift and stayed later, which is when resident had arrived at the facility. On 4/14/26 at 3:50pm in a telephone interview with CMA, she stated she was employed as a CMA. She stated when a new resident enters into the facility, the charge nurse calls the doctor to do a medication review and then administer the resident their initial dose of medication. After that process, the CMAs are notified of medication ordered, and what medication is not available in the facility and which medication are waiting to be delivered. She stated all PRN medication is administered by the charge nurses. She stated she does not remember CR#1 because there were so many residents that come to the facility. However, if she came, then the charge nurse should administer the initial dose of medication. She stated there is an issue with nurses ordering medication for residents. She stated when a resident's medication is low enough to be reordered, the CMA would let the nurse know the medication needs to be ordered. She stated sometimes, the resident would be out of the medication, then there is a rush to order.On 4/20/26 at 5:30pm in a telephone interview with the Pharmacy, she stated there were medications ordered on 1/16/26 for CR#1. However, they were returned to stock because they were not picked up after 14 days. She stated there is a store closer to the facility and medications would need to be transferred to the store closest to the facility. However, there is no record of any medication transfer request. She stated the pharmacy does not deliver medication to the patient in the nursing home.Record review of facility's Promoting/Maintaining Resident Dignity policy dated 1/13/23 revealed the following: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.Compliance Guidelines:1. All staff members are involved in providing care to residents to promote and maintain resident dignityand respect resident rights.2. During interactions with residents, staff must report, document and act upon information regardingresident preferences.5. When interacting with a resident, pay attention to the resident as an individual.10. Speak respectfully to residents; avoid discussions about residents that may be overheard.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 7 emergency exits (dining room exit doors #1 and #2) reviewed for physical environment.- The facility failed to ensure the area beyond dining room exit door #2 were unobstructed. On 3/31/26 and 4/13/26, there was a large pallet of medical supply boxes on the sidewalk that obstructed the only ramp accessible to the dining room exit door #2. - The facility failed to ensure the area beyond dining room exit door #1 was free of clutter. On 3/31/26, the sidewalk area outside of the door was cluttered with crates, wood furniture, a grill, ice cooler, and trash bin. This deficient practice could place residents at risk of falls, injuries, and confusion during evacuations. The findings included:In an observation on 3/31/26 at 12:04pm, an exit door behind the dining room, dining room exit door #1, was obstructed by items. On the sidewalk just outside the door, the following items were observed: a cooler on wheels, bucket and mop, scrubbing brush, a piece of wood furniture, a grill, 2 crates stacked on top of each other, another mop bucket and a large trash bin on wheels next to the ramp. In an observation on 3/31/26 at 12:11pm, an exit door behind dining room, dining room exit door #2, was obstructed by a pallet of boxes. On the sidewalk just outside the door on the left, there was a pallet of boxes of medical supplies approximately 3 boxes across and 5 boxes tall with three more rows behind it. The sidewalk led to the only ramp. There was approximately one foot of space between the edge of the pallet to the edge of the sidewalk that then drops off (the curb). In an observation and interview on 4/13/26 at 12:10pm, Central Supply Staff A was observed putting boxes away in the central supply closet in the administrative office area. She said she received deliveries on Monday. She said she had 4 pallets of boxes delivered that day. She said she put supplies out at the nurses' stations twice a week. She said she used to have supplies delivered to a shed at the back of the facility. She said the shed was condemned by a governmental entity about 8 months ago. She said now they delivered supplies at the back of the facility. She said she tried to process as much as she could to get the supplies inside. A pallet of boxes was observed outside on the sidewalk next to the dining room exit door #2. She said she could not put all the boxes inside in one day. She said she knew she could not leave supplies outside like that. She stated she recognized that the blocked ramp was a problem. She said she had not been given directions on where to put the supplies, so she did the best she could. In an observation and interview on 4/13/26 at 1:26pm, the Maintenance Director said the medical supply company delivered the supplies and placed them outside of the facility. He said he needed to talk to them because they should not deliver the boxes on the walkway. The surveyor and Maintenance Director observed a pallet of boxes on the sidewalk leading to the ramp outside of dining room exit door #2, and he said the area was obstructed and should not be that way. He said he had a pallet jack and could move the boxes. He said central supply brought the supplies inside as quickly as she could. In an interview on 4/13/26 at 2:58pm, the Administrator said dining room exit doors #1 and #2 were designated as exits because they had an exit sign above the doors. He said the ramp was mainly used for deliveries of food and supplies. He said if the residents or staff could not use the ramp due to an obstruction, they would use another exit door. Record review of the policy's Evacuation: Emergency Preparedness Plan dated 4/2025 read, Any disaster or emergency which directly affects this facility will require a decision either to evacuate residents or not to evacuate residents. Therefore, evacuation because a prime consideration. While gathered in the assembly area, the Facility will conduct a complete audit of all residents, staff and visitors. All people assembled in the area should remain alert for instructions from emergency responders.