STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections for 1 of 1 facility reviewed for infection prevention. The facility failed to develop and implement a system of infection surveillance program for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff. These failures could result in the spread of illness or infection. Findings included: Record review of the facility documents titled Signs/Symptoms of Urinary Tract Infection (UTI) WITHOUT [sic] an Indwelling Urinary Catheter, Signs/Symptoms of Skin and Soft Tissue Infection (SSTI) or Scabies, and Signs/Symptoms of Respiratory Tract Infections (RTI): Common Cold or Influenza-like Illness dated 12/1/2025 through 3/20/2026 reflected 10 worksheets from the facility pharmacy indicating symptoms of residents that required antibiotic treatment, and the antibiotic prescribed. Record review of an e-mail dated 3/27/2026 at 9:21 AM from the Admin. to the surveyor reflected the 10 worksheets were the entirety of the infection surveillance documentation maintained by the facility. Record review of the facility document titled Anti-Infective Utilization [facility] Units: All, [pharmacy] February 1, 2026, through February 28, 2026 reflected an undated report created by the facility's pharmacy summarizing the antibiotic treatments prescribed for residents during February 2026. The report included names of residents, the medication name, administration directions, and prescriber. Record review did not reveal information regarding the reason for antibiotics, type of infection, or infection rates. In an interview with CRN on 3/27/2026 at 10:39 AM, she said she served as the Infection Preventionist for the facility. She said she does not use a specific method to track infections at the facility. She said she used the antibiotic usage report from the pharmacy to monitor infections. She said she knew what type of infection a resident has based on the antibiotic prescribed, and she knew which residents had frequent infections because she is familiar with their medical history. After deducing the type of infection based on the prescription, she said she would then mentally calculate the current rate of infection based on the census. She was unsure how she uses this report to compare and monitor overall infection rates at the facility for extended time periods. She was unsure what the overall infection rates were for the facility since the prior survey, and she was unsure if there were any trends in infections since the prior survey. In an interview with the DON on 3/27/2026 at 11:05 AM, she said she manages the QAPI meetings and the agendas for the meeting. She said the QAPI team will review residents who have an active infection, but they do not discuss overall infection rates, trends, or other surveillance data. She said the CRN is the Infection Preventionist and manages the surveillance of infections. Policies for infection control and infection surveillance were requested from the facility from the CRN on 3/27/2026 at 10:39 AM and by e-mail to the Admin. on 3/27/2026 at 11:20 AM, but the documents were not provided prior to survey exit.

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to implement policies and procedures to ensure each staff member is offered the COVID-19 vaccine for 1 of 1 facility reviewed for infection prevention. The facility failed to offer staff members the 2025-2026 COVID-19 vaccination.This failure could result in illness and the spread of infection.Findings included: Records were requested in e-mails dated 3/25/2026 at 10:45 AM and 3/27/2026 at 8:34 AM to the Admin. for evidence of staff acceptance or declination of the COVID-19 vaccination for 2025-2026. These records were not provided by the facility prior to survey exit. In an interview with CRN on 3/27/2026 at 9:26 AM, she said the facility does not offer COVID-19 vaccinations to the staff. She said the staff were able to utilize the services provided to residents by the contracted pharmacy, but the staff must provide payment or insurance information in order to receive the vaccination. She said most staff members elected to obtain the vaccinations privately, outside of the facility. She was unsure if the facility maintained records of staff vaccinations for each year. In an interview with RN A on 3/27/2026 at 11:35 AM, she said the facility does not provide COVID-19 vaccinations to the staff, but she wished that they would so it would be easier to obtain the vaccination every year. She said she received her annual vaccinations at a local pharmacy without assistance from the facility. In a subsequent interview with the CRN on 3/27/2026 at 5:00 PM, she said she felt the facility met the requirement to provide COVID-19 vaccinations to staff because staff were able to obtain the vaccination from the facility pharmacy by providing their own health insurance. She was unsure how staff would obtain the vaccination if they did not have health insurance coverage or the financial ability to pay for the vaccination. She said expecting the facility to provide the vaccination was like going to a restaurant and reading the menu and ordering but expecting somebody else to pay. Record review of the facility policy titled Staff Vaccination dated 2003/revised March 2003, did not reveal guidance or policy related to COVID-19 vaccinations.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the development and implementation of an effective discharge planning process that focuses on the resident's discharge goals for 4 of 4 residents (Residents #3, #16, #2, #1) reviewed for discharge planning.The facility failed to ensure Resident #3's discharge goals were reviewed and implemented during an attempted facility transfer in December 2025. The facility failed to ensure Resident #16's care plan included discharge plans. The facility failed to ensure Resident #2's care plan included discharge plans.The facility failed to ensure Resident #1's care plan included discharge plans.These failures could result in loss of residents' autonomy and rights to determine care.The Findings: 1.Record review of the facility document titled Resident Master Information dated 4/02/3035 reflected Resident #3 was a [AGE] year-old male admitted to the facility on the 3/02/2022. Relevant diagnoses included bipolar disorder (a mental health disorder characterized by significant mood swings) and dementia (a progressive neurological disorder affecting memory and judgement). Record review of Resident #3's quarterly MDS submitted 2/9/2026 reflected a BIMS score of 06, which indicated severely impaired cognitive status. Record review of the facility document titled Interdisciplinary Team Care Conference for Resident #3 dated 12/12/2025 did not reveal care planning related to discharge planning. Record review of an undated voicemail transcript provided by Resident #3's family member on 3/26/2026 at 7:35 PM reflected a message from the Admin. requesting to speak to Resident #3's family member so that he could sweet talk her into reconsidering the transfer from the facility. He said the facility was accepting a reduced co-pay, and the proposed facility would expect the entire amount. He acknowledged receipt of the records request from the proposed facility. Record review of a text message dated 1/13/2026 reflected a message from the Admin. to Resident #3's family member that read as follows: Good morning [Resident #3's family member], [MR] counted the pages of medical records requested and she counted 224 pages. We charge $25 for the work plus .40 cents a page, which equals $114.60, which we require in advance of making copies. Record review of a facility document titled Authorization to Disclose Protected Health Information dated 12/3/2025 reflected a request signed by Resident #3's family member for medical records from the facility to be sent to the proposed facility for treatment/continuing medical care. Evidence of Resident #3's documented discharge planning was requested from the facility on 3/27/2026 at 8:34 AM but was not provided prior to survey exit. Resident #3 declined to participate in an interview attempted on 3/24/2026 at 11:21 AM. In an interview with Resident #3's family member on 03/27/2026 at 7:30 AM, she said she had not been invited to care plan meetings for Resident #3. She said she had not discussed discharge planning with anyone at the facility for Resident #3. She said she in December 2025, she had attempted to (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfer Resident #3 to a different nursing facility because she was unhappy with the service provided by the current facility. She said the receiving facility requested records from the current facility, but the records were never provided, and Resident #3 was not accepted. She said she asked multiple staff members about the records request, and they told her they were not aware of a request from the other facility. She said she asked the Admin. about the records request for transfer of Resident #3, and he discouraged her from transferring Resident #3 because it would result in increased expenses for Resident #3. She said she did not have further communication with the Admin. about the transfer, and she was unsure why the records were not sent. She said she still wanted to transfer Resident #3 to another facility, but she felt discouraged because the facility was creating barriers to prevent transfer and she was worried about the cost. In an interview on 3/27/2026 at 9:45 AM, the LSW said she did not routinely attend care plan meetings. She said she did not review discharge goals with residents unless the staff made a request for a specific resident. She said she had not reviewed discharge or transfer goals with Resident #3 or his family, and she was not aware of a transfer request for the resident. In an interview on 3/27/2026 at 11:00 AM, the DON said Resident #3's family member had not been invited to any care plan meetings for Resident #3. She said she was not aware of any discharge or transfer goals for Resident #3, and she was unaware that Resident #3's family member wanted to transfer him to another facility. She said when records were requested from another facility, they were sent by fax and not duplicated from the paper charting system that was in place at the facility. She said any fees attached to the process were managed by the Admin., and she was unsure of the facility policy or procedure for charging residents for records associated with discharge planning. In an interview on 3/27/2026 at12:47 PM, MR said the Admin. reviewed requests for medical records and determined if there was a fee. She was unsure how the fee was calculated or determined. She said medical records requests made by a physician's office or hospital did not have a fee. She was unsure if record requests for a transfer required payment before processing. In an interview with the Admin. on 3/27/2026 at 12:50, he said requests for medical records that required a lot of time or volume of copies had an associated fee. He was unsure of the specific time or number of pages that constituted an associated fee. He said the fee was applied to any request, including records that were not intended for personal use. He said he was aware of the proposed transfer for Resident #3, but Resident #3's family member failed to pay the fee for the records request, so the documents were not sent. He was unsure of the discharge planning process for residents, and he said the policy for records request fees was in the facility admission packet. Record review of the facility's admission packet (undated) included a document titled Notice of Privacy Practices (undated) reflected the following: You have the right to inspect and copy your health information, such as your medical and billing records that we use to make decisions about your care and services. In order to inspect and/or copy your health information, you must submit a written request to the Administrator of this Facility [sic]. If you request a copy of your medical information, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in fulfilling your requests. We will provide you with information concerning the cost of copying your health information prior to performing such service . 2. Record review of Resident #16's admission Record dated 4/3/2025 revealed he was [AGE] years old, was admitted on [DATE] with diagnoses of elevated myocardia, (the thick, middle muscular layer (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the heart wall responsible for contracting to pump blood throughout the body) weakness, vitamin D deficiency and reduced mobility. Record review of Resident #16's Quarterly MDS dated [DATE] was documented that his BIMS was 15/15 (cognitively intact), and no history of falls. Record review of Resident #16's care plan conference dated 3/13/2026 did not include the residents or representatives. Record review of Resident #16's care plan dated 3/13/2026 revealed it did not include discharge planning. 3. Record review of Resident #2's admission Record (no date) revealed she was [AGE] years old, was admitted on [DATE] and readmitted on [DATE] with diagnoses with depressive disorder, diabetes II, anxiety, and bipolar disorder. Record review of Resident #2's Quarterly MDS dated [DATE] revealed her BIMS score was 15/15 (cognitively intact). Record review of Resident #2's care plan conference dated 2/13/2026 did not include the residents or representatives. Record review of Resident #2's care plan dated 3/27/2026 revealed the care plan did not include discharge planning. 4.Record review of Resident #1's admission Record dated 2/11/2026 revealed she [AGE] years old, and was admitted on [DATE] with diagnosis of anxiety, schizophrenia and depressive disorder. Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMs score of 15/15 (cognitively intact). Record review of Resident #1's care plan conference dated 2/27/2026 did not include the residents or representatives. Record review of Resident #1's care plan dated 2/27/2026 revealed Resident #1's care plan did not include discharge planning. In an interview with the DON on 3/27/2026 at 11:00 AM, she said she stated she did not have discharge care plan for the residents #16, #2 and #1. DON had no other comments. In an interview on 3/27/2026 at 9:45 AM, the LSW said she did not review discharge goals with residents unless the staff make a request for a specific resident, and she did not routinely attend care plan meetings. She said she had not reviewed discharge or transfer planning goals for residents on care plans and the DON was responsible for resident care plans. She said she had not reviewed discharge or transfer goals with Resident #3 or his family, and she was not aware of a transfer request for the resident. Record review of the facility policy titled Discharge Planning dated January 2022, reflected the following: (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain, as a minimum: a. A description of the resident's and family's preferences for care: [sic] b. A description of how the resident and family will access such services .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that the facility must ensure that the residents' environment remains free of accident hazards for 1 of 8 (16) residents in that: 1.Resident #16 had in his room a sink with 3 razors, a bottle of rubbing alcohol and in the medicine cabinet, 2 containers of mouth wash. Resident #16 also kept drinking alcohol in his room that he drank at his leisure. 2. The A hall shower room door was open and the cabinet was unlocked and had razors in the cabinet. The failures could place residents at risk for harm and injuries. The Findings:1.Record review of Resident #16's admission Record dated 4/3/2025 revealed he was [AGE] years old, was admitted on [DATE] with diagnoses of elevated myocardia, (the thick, middle muscular layer of the heart wall responsible for contracting to pump blood throughout the body) weakness, vitamin D deficiency and reduced mobility.Record review of Resident #16's Quarterly MDS dated [DATE] revealed his BIMS was 15/15 (cognitively intact), and no history of falls. Record review of Resident #16s consolidated orders for March 2026 reveaeld his orders included: May have 1 glass of wind daily as needed (12 ounces).Record review of Resident #16's care plan dated 3/13/2026 revealed he was a fall risk, unsteady gait, weakness, impaired mobility, able to transfer self, and visions improved related to cataract surgery. Observation on 3/24/2026 at 11:13 AM in Resident #16's room revealed over the sink were 3 razors, a 16-ounce plastic bottle of rubbing alcohol, and in the medicine cabinet there were 2 containers of mouth wash (8 ounces each). Observation revealed a cabinet in Resident #16's room that was locked. Interview on 3/24/2026 at 11:14 AM with Resident #16, in his room, he stated he shaved himself in the room, that was why he had razors. Resident #16 stated he had bought alcohol and wine from the store and drink and kept it in his locked cabinet in his room. Interview on 3/25/2026 at 11:17 AM Resident #16 stated he got the wine from a convenience store and locked it up in his room. Resident #16 stated the ADM gave him permission to keep the wine in his room. 2. Observation on 3/24/2026 at 11:19 AM of the A hall shower room in A hall revealed the door was open and the cabinet with a lock was wide open and contained 1 razor and the medicine cabinet had 2 razors. Interview on 03/24/2026 at 11:38 AM LVN D charge nurse stated she was not aware Resident #16 had razors in his room, rubbing alcohol, and mouth wash. LVN D stated they were safety hazards and not sure if another resident would enter the room, who was confused. LVN D stated Resident #16 went to the store on his own and did not always tell staff. Interview on 3/25/2026 at 5:40 PM the ADM and the CRN stated Resident #16 bought alcohol when out on pass, and he kept it in his locked cabinet. The ADM and CRN stated Resident #16 was alert and orientated, able to make his own decisions, and no one could get to the alcohol because it was locked. The ADM stated he was allowed to have it in his room as long as it was locked up. No other policies. Interview on 3/27/2026 at 9:10 AM LVN B stated the shower cabinet should be locked, if razors were in it and the razors should be kept at the nurse's station. LVN B stated if a nurse wanted a razor to shave a resident, the CNA would have to ask the nurse. LVN B stated the shower room should be closed and the cabinet in the shower with razors in it should be locked. Interview on 3/27/2026 at 9:30 AM CNA C stated Resident #16 shaved himself and got razors from the shower room. CNA C stated residents were not have sharp objects because they could hurt themselves. CNA C stated the cabinet in the shower room should be locked, and it contains razors. Interview on 3/27/2026 at 10:15 AM CNA E stated with razors/sharp objects residents could cut themselves and cause an accident. Record review of a policy, Razors in resident room and Showers (no date), revealed razors in resident rooms and shower was documented. The facility will maintain razors in a safe manner. All razors will be stored in secure locations so that residents will not be able to access them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to ensure Food safety requirements store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 (1 kitchen) in that: The kitchen ice machine had black specks on the ice machine shaft, and the Maintenance Assistance was not wearing a beard guard while in the kitchen. This could affect all residents that eat from the kitchen and could cause gastric problems. The Findings: 1.Observation on 03/24/2026 10:00 AM with the FSM, revealed during initial rounds, the ice machine had black specks on the ice machine shaft, and Maintenance Assistance was not wearing a beard guard, while in the kitchen. Observation of the Maintenance Assistant revealed he had a short beard and was near the microwave area. 2.Observation on 3/25/2026 at 12:20 PM in the kitchen, the Maintenance Assistant was not wearing a beard guard. Interview on 3/25/2026 at 12:21 PM the Maintenance Assistantconfirmed he was not wearing a beard guard while in the kitchen. The Maintenance Assistant stated he forgot and only went into kitchen for a bit. Observation on 3/25/2026 at 12:27 PM the Maintenance Supervisor told Maintenance Assistant to wear a hairnet, while seen in kitchen. Interview on 3/25/2026 3:03 PM with the FSM confirmed the ice machine black specks may be dirt and resident can get sick. The FSM stated that any person that went into kitchen needed to have on, a hair restraint. The FSM stated staff not wearing a hairnet/beard guard could affect the residents by hair going into the food. Interview on 3/25/2026 at 5:23 PM the ADM stated the ice machine needed to be kept maintained and it could cause contamination of the ice and could cause residents to have stomach issues. The ADM stated when the Maintenance Assistant was not wearing a beard guard, because he forgot to put it on. The ADM stated all staff should wear hair restraints in the kitchen. Record review of policy, (no date) revealed Kitchen-.Ice Machine Cleaning and Hairnet policy, the ice machine will be regularly maintained (both the ice bin and the ice making section), and staff will wear hairnets and beard nets in the kitchen at all times.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the medical records on each resident were complete and contained physician and other licensed professional's progress notes for 7 of 7 residents (Residents #7, #5, #3, #22, #29, #30, and #33) reviewed for resident records. The facility failed to ensure progress notes from physicians and other licensed professionals were included in the charts of Residents #7, #5, #3, #22, #29, #30, and #33.This failure could result in miscommunication between health care providers and inaccurate care provided to residents. Findings included: Record review of Resident #7's Resident Master Information [face sheet] dated 6/19/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included dementia (a progressive neurological condition affecting memory and reasoning) and hypertension (high blood pressure). Record review of Resident #7's paper medical chart did not reflect an admission history and physical or any progress notes from subsequent visits by Resident #7's primary care provider. Record review of Resident #5's Resident Master Information [face sheet] dated 4/3/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included dementia and schizoaffective disorder (a mental health disorder in which a person has difficulty distinguishing reality from delusions).Record review of Resident #5's paper medical chart reflected documentation of the most recent history and physical by Resident #5's primary care provider was dated 4/7/2025. There was no documentation present in the chart of any evaluations from Resident #5's PCP since 4/7/2025. Record review of Resident #3's Resident Master Information [face sheet] dated 4/3/2025 reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included dementia and hypertension.Record review of Resident #3's paper medical chart reflected documentation of the most recent history and physical by Resident #3's primary care provider was dated 4/22/2025. The document included a large watermark of the word draft and reflected THIS NOTE HAS NOT BEEN SIGNED in the footer of the documents. Record review of Resident #22's Physician's Orders for March 2026 dated 2/27/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included cerebral palsy (a neurological condition affecting development, movement, and muscle control). Record review of Resident #22's paper medical chart reflected documentation of the most recent history and physical by Resident #22's primary care provider was dated 4/22/2025. The document included a large watermark of the word draft and reflected THIS NOTE HAS NOT BEEN SIGNED in the footer of the documents. Record review of Resident #29's Resident Master Information [face sheet] dated 7/28/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included dementia.Record review of Resident #29's paper medical chart reflected documentation of the most recent history and physical by Resident #22's primary care provider was dated 4/22/2025. The document included a large watermark of the word draft and reflected THIS NOTE HAS NOT BEEN SIGNED in the footer of the documents. Record review of Resident #30's Resident Master Information [face sheet] dated 4/03/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included dementia.Record review of Resident #30's paper medical chart reflected documentation of the most recent history and physical by Resident #30's primary care provider was dated 4/7/2025. There was no documentation present in the chart of any evaluations from Resident #30's PCP since 4/7/2025. Record review of Resident #33's Resident Master Information [face sheet] dated 4/13/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included schizophrenia (a mental health disorder in which a person has difficulty distinguishing reality from delusion).Record review of Resident #33's paper medical chart did not reflect an admission history and physical or any progress notes from subsequent visits by Resident #33's primary care provider. In an interview with the DON on 3/25/2026 at 1:30 PM, she said the progress notes were sent by e-mail to the Admin., and he would print them out and give them to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the nursing staff to be filed in the residents' charts. She said she did not have access to the progress notes and had previously requested that she be allowed to receive the documentation in order to maintain accurate and current charts. She said the health care team is made aware of the current status of residents by the nursing notes, conversations with providers, and the physicians' orders. She said she felt the current progress notes were important to include in the charts in order to provide accurate communication of a resident's condition and needs. She was unaware of any circumstances in which residents were harmed due to missing documentation from providers. In an interview with the Admin. on 3/26/2026 at 1:30 PM, he said he received documentation from residents' primary care providers visits by e-mail, and he printed them out to be in the paper medical charts. He said he had requested documentation of the visits for all residents in January 2026 but he had not received a response from the provider group. He said he had not made additional attempts to obtain the documentation. In an interview with the CRN on 3/26/2026 at 1:34 PM, she said the responsibility of maintaining the admission history and physical documentation and documentation of provider's progress notes was of hers and the DON's. She said, the doctor's progress notes are based on what the nurses tell them, so they're not useful. She was unaware the documentation was required to be maintained in residents' charts, and she felt the documents did not need to be maintained in the charts because the Admin. could provide the information to any requesting health care staff quickly. She was unsure how the information would be accessed and provided if the Admin. was unavailable, overnight, or if the Admin. was on vacation/leave. A policy for medical records was requested on 3/25/2026 at 10:45 AM but not provided prior to survey exit.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 (1 microwave) microwave in the kitchen in that: The microwave in the kitchen had a spot in the corner, rusting and exposing the inner area of the microwave. This deficient practice could affect all residents' foods and could cause illness to residents. The Findings:Observation on 3/24/2026 at 10:00 AM in the kitchen, with the FSM revealed the microwave, in the corner was rusted and exposing the inner area of microwave. Interview on 3/25/2026 at 3:03 PM with FSM confirmed she did not know the microwave, in the corner was rusted, and the stove had to be restrained. The FSM was new to the position and covering for the permanent FSM. The FSM stated the effect would be it could make residents sick. The FSM stated she was not sure how long it had been like that; she was new to the kitchen. FSM stated she would notify the maintenance department to fix the problem. Interview on 3/25/2026 at 5:23 PM with ADM stated he was not aware the kitchen microwave was rusted inside of it. Record review of policy, Kitchen Essential Equipment, (no date), reflected the facility will maintain all kitchen-essential equipment in good repair.

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F 0550 Level of Harm - Minimal harm or potential for 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 observations, interviews and record reviews, the facility failed to ensure the resident has a right to be treated with respect and dignity for 1 of 8 (Resident #2) residents in that:Resident #2 had facial hair on her upper lip and chin area. The failure placed residents at risk of embarrassment and low self-esteem. The Findings:1.Record review of Resident #2's admission Record (no date) revealed she was admitted on [DATE] and readmitted on [DATE] with diagnoses with depressive disorder, diabetes II, anxiety, and bipolar disorder. Record review of Resident #2's MDS based summary dated 2/9/2026 revealed short-term/long-term memory, and personal hygiene was dependent. The MDS revealed independent eating, impaired vision, and communicated verbally and orientation/memory was good. Record review of Resident #2's Quarterly MDS dated [DATE] revealed her BIMS score was 15/15 (cognitively intact), she had impairment on one side of her upper extremity, impairment on both sides on her lower extremities, mobilized with an electric wheelchair, and was dependent on personal hygiene. Record review of Resident #2's care plan dated 3/27/2026 revealed she required extensive assistance with self-care, had a communication deficit, and poor vision.Observation on 3/25/2026 at 12:01 PM revealed Resident #2 had upper lip and chin hairs. Resident #2 was sitting in her mobilized wheelchair in the dining room. Interview on 3/25/2026 at 12:02 PM Resident #2 stated she was not aware she had upper lip and chin hairs and would like staff to help her and make her aware of facial hair, next time.Observation on 3/25/2026 at 3:55 PM revealed Resident #2 and LVN F revealed Resident #2 had upper lip and chin hairs. Observation of Resident #2 revealed she had facial hair on her upper lip and chin area.Interview on 3/25/2026 at 3:56 PM with Resident #2 and LVN F confirmed facial hair on upper lip and chin. LVN F stated she was not aware and would let a CNA take care of it. LVN F stated the nursing staff should groom residents and offer to assist with grooming facial hair.Interview on 3/25/2026 at 5:50 PM the ADM and CRN stated residents' facial hair was important for resident self-esteem. The ADM stated nursing staff would be responsible for resident facial hair and offering to groom them. Interview on 3/27/2026 at 9:10 AM LVN B stated the aides should offer groom residents' hair, face, nails etc.Interview on 3/27/2026 at 9:30 AM CNA C (that worked with Resident #2) stated they should offer all residents facial grooming.Record review of a policy on Resident Rights/Grooming (no date) revealed, Residents will be groomed on at least a daily basis, including .face/body hair shaven for those women and men who do not want facial/body hair.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to participate in the development and implementation of his or her person-centered plan of care for 1 of 7 residents (Resident #3) reviewed for resident rights. The facility failed to ensure Resident #3's family member/POA was included in care plan meetings.This failure could result in loss of independence and decreased quality of life. Findings included:Record review of the facility document titled Resident Master Information dated 4/02/3035 reflected Resident #33 was a [AGE] year-old male admitted to the facility on the 3/02/2022. Relevant diagnoses included bipolar disorder (a mental health disorder characterized by significant mood swings) and dementia (a progressive neurological disorder affecting memory and judgement). Record review of Resident #3's quarterly MDS submitted 2/9/2026 reflected a BIMS score of 06, which indicated severely impaired cognitive status. Record review of the facility document titled Interdisciplinary Team Care Conference dated 12/12/2025 reflected a sign in sheet for Resident #3's quarterly care plan meeting, and it included the signatures of the DON, LSW, Activity Director, and a fourth, illegible signature. Further record review of the care plan did not reveal care planning related to Resident #3's capacity to make decisions or involvement of his family in the care planning process. Resident #3 declined to participate in an interview attempted on 3/24/2026 at 11:21 AM.In an interview with Resident #3's family member on 3/27/2026 at 7:30 AM, she said Resident #33 had mental health issues that made him unable to care for himself or make decisions for himself. She said she was his legal POA for medical and financial decisions. She said she had not been invited to a care plan meeting for Resident #3 since he was admitted to the facility. She said she called the facility or talked to a nurse when she has questions about Resident #3's care, but she felt the process was frustrating because it was difficult to get answers for her questions. In an interview with the DON on 3/27/2026 at 11:00 AM, she said she coordinated care plan meetings for residents, and she did not routinely invite family members to attend or participate in the formulation of the care plan. She said if she had questions about a resident's care, she would call the family members on the telephone. The facility provided a document titled Your Rights in a Nursing Facility published by the State Log-Term Care Ombudsman Program (January 2025) when a policy for resident rights was requested. Record review of the document reflected the following: .You have the right to: make your own choices regarding personal affairs, care, benefits and services .Designate a guardian or representative to ensure quality stewardship of your affairs if protective measures are required .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including misappropriation of resident property, are reported not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 7 residents (Resident #3) reviewed for abuse, neglect, and exploitation. The facility failed to report an allegation of exploitation of Resident #3 to the SSA when Resident #3's POA alleged the Admin. stole money from Resident #3's bank account in the fall of 2025. This failure could result in lack of oversight of abuse, neglect, or exploitation of residents. Findings included: Findings included: Record review of the facility document titled Resident Master Information dated 4/02/3035 reflected Resident #33 was a [AGE] year-old male admitted to the facility on the 3/02/2022. Relevant diagnoses included bipolar disorder (a mental health disorder characterized by significant mood swings) and dementia (a progressive neurological disorder affecting memory and judgement). Record review of Resident #3's quarterly MDS submitted 2/9/2026 reflected a BIMS score of 06, which indicated severely impaired cognitive status. Resident #3 declined to participate in an interview attempted on 3/24/2026 at 11:21 AM. In an interview with Resident #3's family member on 03/25/2026 at 3:10 PM, she said she was the legal POA for financial and medical issues for Resident #3 due to his inability to care for himself. She said that in the fall of 2025, she became aware that Resident #3's bank account had approximately $500 removed, and she felt it was suspicious because Resident #3 only went to the bank when she took him. She said she was told by the bank that the Admin. had been added to the bank account as a second POA by Resident #3, and the money was removed from the account by the Admin. She said she confronted the Admin. and the DON about the withdrawal of the money without her consent, and she was not given a clear answer what the money was used for and why it was withdrawn from the account. She said she told the Admin. and DON that she felt like the act was theft, and she later wrote her concerns in a letter to the State Attorney General's office. In an interview with the DON on 3/26/2026 at 1:45 PM, she said she was present when Resident #3's family member alleged the Admin. was stealing money from Resident #3. She said she was unsure why the Admin. had taken money out of Resident #3's account, and she was unsure if the Admin. was added to Resident #3's bank account. She was unsure why the Admin. did not report the allegations to the SSA. In an interview with the Admin. on 3/26/2026 at 1:53 PM, he said he was the Abuse and Neglect Coordinator for the facility. He said he recalled the conversation with Resident #3's family member in which she accused him of stealing Resident #3's money. He said Resident #3 had financial issues that led to a lapse in his Medicaid coverage, so he took Resident #3 to the bank and was added as a POA to his account so he could assist Resident #3 with paying his applied income. He said Resident #3's (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family member declined to assist with Resident #3's financial affairs at the time, so that was the only option. He said he removed $500 from the account in October 2025, but he had not withdrawn any additional funds since Resident #3's family member accused him of stealing, and thus the facility had not been paid the co-payment for Resident #3's care. He said he did not report the allegations to the SSA because the allegations were false, and he felt it did not warrant reporting. He said he thought Resident #3's family member was exploiting Resident #3 financially, but he did not report his concerns to the SSA because he wanted to believe that she was not stealing from the resident. Record review of the facility policy titled Abuse Policy dated 10/2004 revealed the following: .3. Reporting concerns/incidents/grievances by residents providing residents/family/staff with information on reporting and resolving concerns/grievances. Identifying those residents at risk, correcting situations in which abuse/neglect [sic]. Misappropriation may occur. [sic.] .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations of abuse, neglect, and exploitation are thoroughly investigated, and the results of the investigation are reported to the SSA within five working days for 1 of 7 residents (Residents #3) reviewed for abuse, neglect, and exploitation.The facility failed to have evidence of an investigation of alleged exploitation of Resident #3.This failure could result in continued mistreatment of residents or lack of oversight.Findings included: Record review of the facility document titled Resident Master Information dated 4/02/3035 reflected Resident #33 was a [AGE] year-old male admitted to the facility on the 3/02/2022. Relevant diagnoses included bipolar disorder (a mental health disorder characterized by significant mood swings) and dementia (a progressive neurological disorder affecting memory and judgement). Record review of Resident #3's quarterly MDS submitted 2/9/2026 reflected a BIMS score of 06, which indicated severely impaired cognitive status. Resident #3 declined to participate in an interview attempted on 3/24/2026 at 11:21 AM. In an interview with Resident #3's family member on 03/25/2026 at 3:10 PM, she said she confronted the Admin. on or around October 2025 with concerns that he was stealing money from Resident #3's bank account. She said the Admin. admitted to taking the money, but he said the money was for business expenses. She said he did not follow up with the conversation, but no additional funds had been withdrawn from the bank account since then. In an interview with the DON on 3/26/2026 at 1:45 PM, she said she was present when Resident #3's family member alleged the Admin. was stealing money from Resident #3. She was unsure why the Admin. did not report the allegations to the SSA, and she was not aware of any further investigation into the allegations by the Admin.In an interview with the Admin. on 3/26/2026 at 1:53 PM, he said he was the Abuse and Neglect Coordinator for the facility. He said he recalled the conversation with Resident #3's family member in which she accused him of stealing Resident #3's money. He said he did not report the allegations to the SSA because the allegations were false, and he felt it did not warrant reporting. He said that he did not conduct an investigation into the allegations because he already knew the allegation was untrue. Record review of the facility policy titled Abuse Prohibition Regulations (undated, provided by the facility on 3/27/2026), reflected the following: .3. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Comprehensive Care Plans, A comprehensive care plan must be to the extent practicable, the participation of the resident and the resident's representative. An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not to be practicable for the development of the resident's care plan for 2 of 8 (#2,#16) residents in that:Resident #2 and 16 Resident/Families were not offered to attend their care plan meetings. This could affect residents and could cause residents to decrease self-esteem. The Findings: 1. Record review of Resident #2's admission Record (no date) revealed she was admitted on [DATE] and readmitted on [DATE] with diagnoses with depressive disorder, diabetes II, anxiety, and bipolar disorder. Record review of Resident #2's Quarterly MDS dated [DATE] revealed her BIMS score was 15/15 (cognitively intact), impairment on one side of upper extremity, impairment on both sides on lower extremity, mobilized with an electric wheelchair, and was dependent with personal hygiene. Record review of Resident #2's MDS 2/9/2026 revealed she mobilized in an electric wheelchair, independent in eating, impaired vision, and communicates verbally orientation/memory was good. Record review of Resident #2's care plan dated 3/27/2026 revealed she required extensive assistance with self-care, communication deficit, and poor vision. No record of residents or staff signatures documented on the care plan conference sheet. Interview on 3/27/2026 at 1:15 PMˆwith Resident #2 stated she had not been invited to care plan meetings.ˆ 2.Record review of Resident #16's admission Record dated 4/3/2025 revealed he was [AGE] years old, was admitted on [DATE] with diagnoses of elevated myocardia, (the thick, middle muscular layer of the heart wall responsible for contracting to pump blood throughout the body) weakness, vitamin D deficiency and reduced mobility.Record review of Resident #16's Quarterly MDS dated [DATE] revealed that his BIMS was 15/15 (cognitively intact), and no history of falls. Record review of Resident #16's care plan dated 3/13/2026 revealed he was a fall risk, unsteady gait, weakness, impaired mobility, able to transfer self, and visions improved related to cataract surgery. In an interview on 3/27/2026 at 9:45 AM, the LSW said she did not routinely attend care plan meetings. In an interview with the DON on 3/27/2026 at 11:00 AM, she said she coordinated care plan meetings for residents, and she did not routinely invite family members to attend or participate in the formulation of the care plan. She said if she had questions about a resident's care, she would call the family members on the telephone. DON had no comments. Interview on 3/27/2026 at 2:15 PM Resident #2 stated she had not been invited to care plan meetings. Record review of policy, Care Plan Comprehensive, (no date) revealed an individualized comprehensive care plan that includes measurable objective and timetables to meet the resident's [NAME], nursing, mental and psychological needs is developed for each resident. 1. Our facility's care planning/interdisciplinary team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident ay be expected to attain.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide routine dental services for 1 of 2 residents (Resident #3) reviewed for dental services. The facility failed to ensure Resident #3 received routine dental care in 2025 and 2026. This failure could result in tooth decay or loss, infection, and decreased quality of life. Findings included: Record review of the facility document titled Resident Master Information dated 4/02/3035 reflected Resident #3 was a [AGE] year-old male admitted to the facility on the 3/02/2022. Relevant diagnoses included bipolar disorder (a mental health disorder characterized by significant mood swings) and dementia (a progressive neurological disorder affecting memory and judgement). Resident #3's insurance was identified as Medicaid.Record review of Resident #3's quarterly MDS submitted 2/9/2026 reflected a BIMS score of 06, which indicated severely impaired cognitive status. Section L of the MDS (oral/dental status) was not assessed. Record review of Resident #3's paper chart did not reveal documentation from a dental provider for routine and/or emergency care. Record review of an e-mail from the facility's contracted dental provider to the Admin. dated 12/13/2023 reflected an e-mail from the Admin. requesting an evaluation for Resident #3 due to dental pain. Record review of the document titled New Patient Registration and Consent dated 3/7/2024 reflected Resident #3 had a non-life threatening urgent dental need of c/o hot/cold sensitivity [and] tooth pain. In an observation and attempted interview on 3/24/2026 at 11:21 AM, Resident #3 was observed to have multiple missing teeth to the upper and lower jaws, and there was brown discoloration to the remaining teeth. Resident #3 declined to be interviewed for the survey. In an interview with the Admin. on 3/27/2026 at 10:33 AM, he said Resident #3 had not received dental care since 2024 because he had not complained of any new dental issues. He said he was not aware that the facility was required to assist residents with obtaining routine dental care, including residents with Medicaid insurance coverage. He said the current contracted dental provider would only provide dental care for several residents during each visit, and the lack of routine care was their fault. He said he had not attempted to find an alternative or additional dental provider. A policy regarding dental care was requested from the Admin. during the interview on 3/27/2026 at 10:33 AM but was not provided prior to survey exit.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews and record review the facility failed to dispose of garbage and refuse properly for 1 of 1 (1 dumpster) in that: There was no plug for the garbage dumpster, and the side door was open 1/4 of the way. This deficient practice could increase pests and rodents in the area. The Findings:Observation on 3/24/2026 at 10:00 AM with FSM revealed the dumpster had no dumpster plug and the door was 1/4 open on the side of the dumpster. Observation on 3/25/2026 at 3:30 PM with FSM revealed the dumpster did not have a plug. Interview on 3/25/2026 at 3:31 PM with FSM stated she was not aware the dumpster had to have a plug and was not sure who opened the side door for the dumpster. FSM was not aware of how it would affect the residents. Interview on 3/25/2026 at 5:23 PM with ADM stated the dumpster door should be closed, and the garbage dumpster should have a plug to prevent rodents. No policy on keeping dumpster doors closed. Record review of policy, (no date) Garbage Dumpster policy, reflected The Garbage Dumpster will have a plug in the bottom drain at all times to prevent vermin from entering and liquids waste for escaping.