STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio West Nursing and Rehabilitation	636 Cupples Rd San Antonio, TX 78237

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives, or treatment options and to choose the alternative or options he or she preferred, for four (4) of seven (7) residents (Resident #5, Resident #11, Resident #57, and Resident #86) reviewed for resident rights. 1. The facility failed to obtain signed consent for psychotropic (a medication that affects brain function and used to treat psychiatric conditions) mood stabilizer medication, Divalproex Sodium (Depakote) which was administered to Resident #5. 2. The facility failed to obtain signed consent for psychotropic antidepressant medication, Sertraline HCl (Zoloft) prior to initial administration on 01/06/2026, to Resident #57. 3. The facility failed to obtain signed 3713s for Risperdal and Depakote for Resident #11. 4. The facility failed to obtain signed Form 3713, [Nursing Facility Consent for Antipsychotic or Neuroleptic] for Ziprasidone for Resident #86. These failures could place residents at risk of receiving medications without their, or that of their responsible party's prior knowledge or consent and could place the residents at an increased risk for adverse reactions to the medications. The findings included: 1. Record review of Resident #5's admission Record, dated 04/09/2026, indicated Resident #5 was a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #5 was listed as a contact and did not have a listed guardian. Record review of Resident #5's Diagnosis Report, dated 04/09/2026, revealed diagnoses including bipolar disorder (a mental illness characterized by alternating periods of elation and depression), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #5's Annual MDS assessment, dated 03/10/2026, indicated Resident #5 had a BIMS score of 15, which indicated she was cognitively intact. The MDS indicated Resident #5 had not exhibited behavioral symptoms, including rejection of care. The MDS indicated Resident #5 had an active diagnosis of bipolar disorder. Under high-risk drug classes, mood stabilizer was not listed as an option for documenting if Resident #5 had taken a medication under the drug class and if an indication was noted. Record review of Resident #5's Care Plan Report, dated as last care plan review completed 04/02/2026, indicated Resident #5 had focus [Resident #5's name] has the Potential [sic] for drug related complications associated with use of psychotropic medications, date initiated 03/25/2025 and revised 04/10/2025, with an intervention, Obtain consent from patient/responsible party for use of psychotropic medications, date initiated 03/25/2025. Record review of Resident #5's Order Summary Report, dated 04/09/2026, revealed the order Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth three times a day related to BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MILD, noted as an active order with an order and start date of 01/17/2026 and no end date. Record review of Resident #5's Order Audit Report for order Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth three times a day related to BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MILD with order (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date 01/17/2026, revealed under Medication/Supply and Directions the medication had been dispensed three times and reordered two times. The initial date dispensed was noted as 01/18/2026 with the medication noted as exhausted on 02/09/2026 and reordered. The second date dispensed was noted as 02/09/2026 with the medication noted as exhausted on 04/01/2026 and reordered. The third date dispensed was noted as 04/01/2026. Record review of Resident #5's CMA MAR, dated 04/01/2026- 04/30/2026 and printed 04/10/2026 at 11:00 a.m., revealed the order Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth three times a day related to BIPOLAR DISORDER, CURRENT EPISODE DEPRESSED, MILD was scheduled for administration at 0900 (09:00 a.m.), 1300 (01:00 p.m.), and 2100 (09:00 p.m.). Of the 29 scheduled administrations possible prior to the document reviewed, Resident #5 had been administered Divalproex Sodium seven (7) times (at 09:00 a.m. on 04/03/2026, 04/07/2026, and 04/08/2026; at 01:00 p.m. on 04/09/2026, and at 09:00 p.m. on 04/05/2026, 04/07/2026, and 04/08/2026) and refused the medication 22 times. Record review of Resident #5's electronic medical record under Misc tab, undated and accessed 04/10/2026 at 10:58 a.m., did not reveal a consent form for Divalproex Sodium. A document titled Informed Consent for Psychoactive Medications, dated as signed 09/29/2025 was identified in Resident #5's EMR; however, the document did not include a medication name. During an observation and interview on 04/10/2026 at 01:57 p.m., LPN J stated the facility protocol for medication consents was for the nurse to call the resident's representative or speak to the resident to get approval for medication administration. She stated if the approval was over the phone, there had to be a witness to the approval, and two staff members would have to sign the consent form indicating approval. She stated the nurse would have to follow that protocol when they receive a new order from the physician or when a prior order had changed, such as the dosage or amount of medication administered. She stated the consents were checked quarterly and the ADON was responsible for following up to make sure the consents are done. LPN J was observed looking through Resident #5's EMR and stated she did not see a consent for Divalproex Sodium. LPN J stated the impact of a resident having received a medication without consent was that the medication administration would be stopped immediately and only resume once the facility received consent.During an interview on 04/10/2026 at 02:14 p.m., ADON E stated the facility protocol for medication consents was for as soon as a medication was noticed to require one, the facility staff would get it. She stated the facility staff could not give the medication without the consent. She stated either the ADON or nurses on the floor were responsible for getting the consent signed by the resident or resident's family member. She stated the ADONs encourage the floor nurses to get the consent, but the ADONs were responsible for following up and getting it. She stated she had not audited the residents' charts for medication consents. She stated that she looked in Resident #5's EMR and found a consent document where the front page was not uploaded. During an interview on 04/10/2026 at 05:21 p.m., Resident #5 stated she was currently refusing her psychotropic medications because she wanted to try to wean from them. She stated she did recall signing the consent for Divalproex Sodium but could not recall when. 2. Record review of Resident #57's admission Record, dated 04/08/2026, indicated Resident #57 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #57 was listed as a contact and did not have a listed guardian. Record review of Resident #57's Diagnosis Report, dated 04/08/2026, revealed diagnoses including Alzheimer's disease (a progressive disease that affects memory and other important mental functions) with early onset, bipolar disorder, and mood disorder (a mental health condition characterized by persistent disturbances in a person's emotional state that is more intense or prolonged than typical) due to known physiological condition with depressive features. Record review of Resident #57's admission MDS assessment, dated 01/11/2026, indicated Resident #57 had a BIMS score of 11, which indicated he was moderately cognitively impaired. The MDS indicated Resident #57 had not exhibited behavioral symptoms, including rejection of care. The MDS indicated Resident #57 had an active diagnoses of depression (other than bipolar) and mood (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder. Under high-risk drug classes, Resident #57 was documented as haven taken antidepressant medication during the last seven (7) days or since admission/entry or reentry with an indication noted. Record review of Resident #57's Care Plan Report, dated as last care plan review completed 01/23/2026, indicated Resident #57 had focus .Has potential for alteration in mood state r/t chronic disease process, mood disorder due to physiological condition with depressive features., date initiated and revised 01/18/2026, with an intervention, Administer medications as ordered by physician, date initiated 01/18/2026. An intervention to obtain a medication consent was not identified. Record review of Resident #57's Order Recap Report, dated order date 01/01/2026-01/31/2026 and printed 04/09/2026, revealed the orders:- Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Mood/anxiety/executive function related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES, noted as discontinued with an order date of 01/05/2026, a start date of 01/06/2026, and an end date of 01/09/2026. The reason for discontinuation was blank.- Sertraline HCl Oral Tablet 150 MG (Sertraline HCl) Give 1 capsule by mouth one time a day for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES, noted as discontinued with an order date of 01/09/2026, a start date of 01/10/2026, and an end date of 03/26/2026. The reason for discontinuation was not noted.Record review of Resident #57's CMA MAR, dated 01/01/2026-01/31/2026 and printed 04/09/2026 at 11:33 a.m., revealed- the order Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Mood/anxiety/executive function related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES was scheduled for administration at 0900 (09:00 a.m.) and discontinued on 01/09/2026 at 02:41 p.m. Resident #57 had been administered Sertraline HCl four (4) times, at 09:00 a.m. on 01/06/2026 to 01/09/2026. - the order Sertraline HCl Oral Tablet 150 MG (Sertraline HCl) Give 1 capsule by mouth one time a day for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES was scheduled for administration at 0900 (09:00 a.m.) and discontinued on 03/26/2026 at 12:45 a.m. Resident #57 had been administered Sertraline HCl 22 times, at 09:00 a.m. from 01/10/2026 to 01/31/2026. Record review of Resident #57's CMA MAR, dated 02/01/2026- 02/28/2026 and printed 04/09/2026 at 11:31 a.m., revealed- the order Sertraline HCl Oral Tablet 150 MG (Sertraline HCl) Give 1 capsule by mouth one time a day for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES was scheduled for administration at 0900 (09:00 a.m.) and discontinued on 03/26/2026 at 12:45 a.m. Resident #57 had been administered Sertraline HCl 28 times, at 09:00 a.m. from 02/01/2026 to 02/28/2026. Record review of Resident #57's Order Summary Report, dated 04/08/2026, revealed the order Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to ADJUSTMENT DISORDER WITH DEPRESSED MOOD, noted as an active order with an order and start date of 03/26/2026 and no end date. Record review of Resident #57's CMA MAR, dated 03/01/2026-03/31/2026 and printed 04/09/2026 at 11:30 a.m., revealed- the order Sertraline HCl Oral Tablet 150 MG (Sertraline HCl) Give 1 capsule by mouth one time a day for MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH DEPRESSIVE FEATURES was scheduled for administration at 0900 (09:00 a.m.) and discontinued on 03/26/2026 at 12:45 a.m. Resident #57 had been administered Sertraline HCl 25 times, at 09:00 a.m. from 03/01/2026 to 03/25/2026. - the order Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to ADJUSTMENT DISORDER WITH DEPRESSED MOOD was scheduled for administration at 0900 (09:00 a.m.). Resident #57 had been administered Sertraline HCl six (6) times, at 09:00 a.m. from 03/26/2026 to 03/31/2026. Record review of Resident #57's electronic medical record under Misc tab, undated and accessed 04/10/2026 at 11:07 a.m., did not reveal a consent form for Sertraline HCl.During an interview on 04/10/2026 at 01:27 p.m., Resident #57 stated he did not recall giving medication consent or having a discussion regarding his prescribed psychotropic medications. He stated the facility staff gave him his medications and he took them. He stated he did not see a problem with his being given and taking (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sertraline HCl, but stated he did not have outbursts, referring to mood disorder diagnosis.During an observation and interview on 04/10/2026 at 02:05 p.m., RN K stated the facility procedures for psychotropics, sleepers, or mood alteration medications was to let the resident know about the medication order and to call the resident representative. She stated the nurse would talk to both the resident and the resident representative about the side effects, uses, why it was being used for the resident, and the benefit. She stated the nurse would discuss how long the medication was to be used and why it was important to continue. She stated that this discussion was to be done after the medication was ordered but before the medication was started or administered. She stated the consent forms were to be completed after explaining the medication to the resident. RN K stated Resident #57's medication consent should be in the EMR and if it was not, she would have to let the doctor of the resident know that the facility had been administering medication without consent. She stated the facility staff would have been checking for harm as part of the administration protocols, but they would be required to communicate the lack of consent to the resident's physician. She stated the nurse that received the initial medication order was responsible for obtaining the resident or resident's representative consent. RN K was observed reviewing Resident #57's EMR, under Miscellaneous tab and stated she did not find a consent signed or uploaded around the time of his Sertraline HCl order, 03/26/2026. During an observation and interview on 04/10/2026 at 03:53 p.m., ADON L stated the facility procedure for medication consents was that nursing staff were supposed to get consent prior to giving medication. She stated the nurse upon admission or the nurse that received the order was responsible. She stated the following day, she or the other ADON would review the order and identify if additional consent was required. She stated for new medications, the nurse was to call the resident's family or let the resident know about the new order and get either in-person signatures or approval over the phone. For Resident #57, she stated she might have his consent. She stated she would scan completed consents to her work email and then upload it to the resident's EMR. ADON L was observed going through a box of paperwork under her desk but did not locate Resident #57's consent for Sertraline HCl. She stated she might have scanned the form but forgot to upload the form. She stated the facility was not supposed to be administering the medication if they did not get the consent. She stated she was not sure of the resident impact if the consent was taken but not available on the resident's EMR but stated the consent should be uploaded. During interview and record review on 04/10/2026 at 05:14 p.m., ADON L stated Resident #57's Sertraline HCl consent was in her email, dated 03/26/2026. Record review of Resident #57's Informed Consent for Use of Psychotropic Medication, dated and signed 03/26/2026, revealed Sertraline was consented for administration by Resident #57 for depression on 03/26/2026. ADON L stated the form was not uploaded to the resident's EMR. She stated the nursing staff should not administer the medication until the actual consent was in hand and was not sure how other nursing staff would know the consent was given if the document was not in the resident's EMR. She stated the nursing staff were not trained to look for completed consents but were supposed to hold the medication until the consent was completed. She stated there was not a consent completed for Resident #57's Sertraline HCl order in January because the order was being modified. During an interview on 04/10/2026 at 04:40 p.m., the DON stated the facility procedure for medication consents was for when the facility received an order, the staff were to get consent. She stated the medication should not start until the facility had received consent. She stated, once the facility staff received consent, the ADONs were to give the consent document to the receptionist to upload to the resident's EMR. She stated the impact of not having medication consent was that the facility would not know if the family or resident agreed to the medication. She stated it was the nurses' responsibility to obtain the resident or resident representative's consent, and the ADONs were responsible for running an order list each morning and ensuring a consent was obtained for each order. She stated there was not a standard timeline of when the consent should be uploaded to the resident's EMR. She stated the impact of Resident #5 and Resident #57 not having consents for their medications was that the facility was administering (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications to the residents without obtaining their consent or knowing if the resident consents. During an interview on 04/10/2026 at 05:28 p.m., the ADMIN stated the nurse managers or ADONs for the hall the resident resides in, and ultimately the DON, were responsible in ensuring medication consents were obtained. She stated the impact of not obtaining a consent was not knowing if the family was onboard with the residents plan of care. She stated the consent showed transparency with the residents plan of care and indicated agreement with the medications provided to their loved ones. 3. Record review of Resident #11's admission record, dated 04/07/2026, reflected resident was a [AGE] year-old male, initially admitted [DATE] and re-admitted [DATE] with diagnoses to include schizoaffective disorder and generalized anxiety disorder.Record review of Resident #11's annual MDS assessment, dated 03/23/2026, reflected that he had a BIMS score of 05 out of 15, indicating severe cognitive impairment.Record review of Resident #11's care plan, undated, reflected focus of [Resident #11] receives antipsychotic medications r/t behavior management, schizoaffective disorder, bipolar type, behaviors hallucinations., initiated 10/05/2017.Record review of Resident #11's order summary report, dated 04/07/2026, reflected Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG. Give 1 capsule by mouth two times a day related to GENERALIZED ANXIETY DISORDER, SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE., dated 03/04/2026. It further reflected Risperdal Oral Table 0.5 MG. Give 1 tablet by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, dated 06/11/2025, Risperdal Oral Table 2 MG. Give 1 tablet by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, dated 06/11/2025, Risperdal Oral Table 2 MG. Give 2 mg by mouth in the morning related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE.During an interview on 04/08/2026 at 11:41 AM, Resident #11 revealed the facility managed his medication. He revealed he had no concerns about the medication he received and the facility was good about giving him his medication on time.During an interview on 04/10/2026 at 03:20PM, the DON revealed Resident #11 did not sign form 3713 for Risperdal and Depakote. She revealed he did sign a medication consent form but not a 3713. She revealed it was important to have a 3713 signed because it was a state regulation. 4. Record review of Resident #86's admission Record, dated 04/08/2026, revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Resident was not listed as his own responsible party with his [family member] listed as Emergency Contact #1.Record review of Resident #86's Medical Diagnoses, undated and access on 04/08/2026 at 6:02 p.m., revealed diagnoses including seizures (a sudden surge of abnormal electrical activity in the brain that temporarily affects awareness, behavior, or muscle control), bipolar disorder (mental health condition characterized by significant mood swings), and schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking).Record review of Resident #86's quarterly MDS, dated [DATE] and signed 03/15/2026 as completed, reflected a BIMS score of 03, indicating moderate cognitive impairment. Resident #86 was documented as having not exhibited any behavioral symptoms. Resident #86's functional abilities were documented as requiring partial/moderate assistance to set up or clean-up assistance.Record review of Resident #86's care plan, undated, and accessed on 04/08/2026 at 6:10 p.m., revealed Resident #86 had been identified as having PASRR positive status related to an intellectual disability.Record review of Resident #86's order summary report, dated 04/08/2026, reflected Ziprasidone HCl Oral Capsule 40 MG, Antipsychotics/Antimanic Agents, ordered 01/13/2024.Record review of Resident #86's Psychotropic Medication Consent., undated, and accessed on 04/08/2026 at 6:05 p.m., revealed consent was not signed by physician and was not the appropriate form for psychotropic medication required, Form 3713, Nursing Facility Consent for Antipsychotic or Neuroleptic.During an interview on 04/07/2026 at 12:00 p.m., Resident #86 revealed the facility managed his medication. He revealed he had no concerns about the medication he received and the facility was good about giving him his medication on time.During an interview on 04/10/2026 at 2:20 p.m., LVN C stated the charge nurses are expected to obtain psychotropic medication consents during new admissions of a resident. She stated psychotropic medications need consents from the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a sanitary, orderly, and comfortable interior by housekeeping and maintenance services, which were necessary to maintain a sanitary, orderly, and comfortable interior for 4 of 8 resident rooms (room [ROOM NUMBER], 6, 11, and 13) and 1 of 1 hallway of the secured unit reviewed for homelike environment. The facility failed to ensure resident room [ROOM NUMBER] in the secured unit had repaired the door frame with dents, cracks, black scuff marks, wall with peeled paint, worn out paint, torn furniture, chipped baseboard trim lifting from the wall, light fixture with plastic border loose and hanging, windowsill cracked, peeling paint, missing caulking.The facility failed to ensure resident room [ROOM NUMBER], resident room [ROOM NUMBER], and resident room [ROOM NUMBER] located in the secured unit, repaired the door frame with dents, cracks, black scuff marks, with peeled pain, baseboard trim lifting from the wall.The facility failed to ensure resident rooms [ROOM NUMBERS], which was connected by a bathroom, located in the secured unit, repaired both door frames with dents, cracks, black scuff marks, broken ceiling vent fixture, baseboard trim lifting throughout the bathroom, missing caulking around the toilet bowl and sink, missing tile around the toilet bowl, sheetrock cracked above the sink, peeling paint, and used brief was left on the floor.The facility failed to ensure the secured unit hallway ceiling adjacent to room [ROOM NUMBER]'s, EXIT sign fixture was not loose and hanging from the ceiling, floor plan signage was not separating from the wall, and the walls did not have numerous black scuff marks. These failures could place residents at risk of diminished self-worth.The findings include: During observation of the secured unit on 04/07/2026 1:30 p.m. to 04/09/2026 5:40 p.m., revealed the following: a. Resident room [ROOM NUMBER], located in the secured unit, had a door frame with dents, cracks, black scuff marks, wall with peeled paint, worn out paint, torn furniture, chipped baseboard trim lifting from the wall, light fixture with plastic border loose and hanging, windowsill cracked, peeling paint, missing caulking. b. Resident room [ROOM NUMBER], resident room [ROOM NUMBER], and resident room [ROOM NUMBER] located in the secured unit, the door frame had dents, cracks, black scuff marks, with peeled paint, and baseboard trim was lifting from the wall. c. Resident room [ROOM NUMBER], located in the secured unit, the door frame had dents, cracks, black scuff marks, peeled paint, and baseboard trim was lifting from the wall.d. Resident room [ROOM NUMBER], located in the secured unit, the door frame had dents, cracks, black scuff marks, peeled pain, and baseboard trim was lifting from the wall. e. Resident rooms [ROOM NUMBERS] which were connected by a bathroom, located in the secured unit, both door frames had dents, cracks, black scuff marks, broken ceiling vent fixture, baseboard trim was lifting throughout the bathroom, missing caulking around the toilet bowl and sink, missing tile around the toilet bowl, sheetrock cracked above the sink, peeling paint, and a used brief was left on the floor. f. On the secured unit hallway ceiling adjacent to room [ROOM NUMBER] the EXIT sign fixture was loose and hung from the ceiling, the floor plan signage was separating from the wall, and the walls had numerous black scuff marks. During an observation and interview on 04/09/2026 at 1:45 p.m., CNA R revealed resident room [ROOM NUMBER] that had warped paint and stains would be a maintenance issue and noted he was not sure if a maintenance request was submitted previously. CNA R was observed repairing the loose and hanging light fixture. He stated if the light fixture was to worsen it could pose a danger to the residents in the room and he was observed repairing it immediately.During a subsequent interview on 04/09/2026 at 1:52 p.m., CNA R revealed there had been no maintenance staff at the facility for almost two weeks and a temporary maintenance staff from corporate was onsite this week. He stated, to be honest he had not submitted maintenance repair requests for resident rooms requiring minor repairs and paint touchups and had no reason for not following up.During an observation and interview on 04/09/2026 at 2:07 p.m., Housekeeping revealed she had (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio West Nursing and Rehabilitation	636 Cupples Rd San Antonio, TX 78237

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	only been employed for two weeks at the facility. She said she had not made any reports for repairs and said she believed staff were already aware of the condition of the hallway and resident rooms. She said she could go in and take a rag and clean the walls, she could not make repairs, and she was not aware of how to submit a maintenance request. Housekeeping was observed entering resident room [ROOM NUMBER] and wiping brown stains off the walls.During an interview on 04/09/2026 at 2:20 p.m., LVN X revealed she had not submitted a maintenance request for the secure unit's condition of chipped paint, black marks on hallway walls and doorways and broken blinds. She said the facility did not have maintenance staff to submit requests to at this time.During an interview on 04/09/2026 at 2:40 p.m., CNA S revealed she notified the charge nurse on the unit of maintenance concerns in specific rooms and said several resident rooms looked like they were falling apart. She said she reported maintenance concerns to the charge nurse who was responsible for submitting requests to maintenance staff. She stated you could only report the concern a few times without follow-up, and you must move on.During an observation on 04/09/2026 at 2:47 p.m. Resident of room [ROOM NUMBER] was not present in his room for an interview. During an observation on 04/09/2026 at 2:47 p.m. Resident of room [ROOM NUMBER] was not present in his room for an interview.During an observation on 04/09/2026 at 2:47 p.m. Resident room [ROOM NUMBER] was vacant and did not have a resident assigned to the room. During an interview on 04/09/2026 at 3:00 p.m., the ADMIN revealed the maintenance director resigned from his position about two weeks back as he became overwhelmed with the plumbing issues at Nursing Facility H. She noted she was aware of the need for repairs, minor maintenance, touch ups, walls, and sprucing up the secured unit, but her focus since she started in her role as ADMIN was to get Nursing Facility H up to code to pass inspections. She stated she planned to work on the secured unit touchups next as this was the resident's home and it should feel and look comfortable and homelike. She stated she planned to take a walk through the rooms in the secured unit with corporate staff to note the minor repairs.Record review of the facility's policy titled, State of Resident's Rights in Texas, dated 08/2022, revealed .You have a right to: 2. Safe, decent, and clean conditions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 10 residents (Resident #10, Resident #15, Resident #82) reviewed for care planning. The facility failed to ensure Resident #10's comprehensive care plan included safety interventions related to the use of an electronic cigarette (vape).The facility failed to ensure Resident #15's comprehensive care plan included elopement risk and safety interventions related to placement in a secure unit.The facility failed to ensure Resident #82's comprehensive care plan included elopement risk and safety interventions related to placement in a secure unit. This failure could place residents at risk of inappropriate use of the device resulting in injury or not receiving appropriate care and services.Findings included: 1. Record review of Resident #10's admission Record dated 4/10/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included paraplegia (the loss of sensory and/or motor function in the lower extremities). Record review of Resident #10's quarterly MDS submitted 1/28/2026 reflected a BIMS score of 15, which indicated intact cognition. Section J1300 reflected Resident #10 was a smoker.Record review of Resident #10's Smoking Evaluation dated 9/23/2024 reflected Resident #10 was identified as a smoker, and no safety issues were identified. Record review of Resident #10's Care Plan Report, undated/ printed 4/08/2026, did not reveal care planning related to smoking. Record review of Resident #10's progress notes revealed the following entry dated 3/19/2026 at 11:30 AM by LVN C:This nurse went to room to inform resident that had got footrest for his wheelchair, noted smoke in room asked resident if could show what he was smoking, resident showed this nurse a vape machine, asked resident if could have it, resident stated no, mentioned to resident that cannot be smoking in his room, resident stated that he did not get a chance to go outside, again encouraged resident not to be smoking in his room and mentioned to DON and social worker of resident smoking in room and was advised not to smoke in room.In an interview with Resident #10 on 4/07/2026, he denied that he was a current smoker. In an interview with LVN C on 4/10/2026 at 12:15 PM, she said Resident #10 routinely used a vape and was allowed to keep the device in his possession. She said she had caught Resident #10 using the vape in his room on several occasions and had reported the findings to the DON. She said Resident #10 knew not to use the vape in his room, and the facility policy was to remind him that he could use the vape only in designated smoking areas. She said there were no other safety concerns regarding using the vape. In an interview with the MDS nurse on 4/10/2026 at 12:35 PM, she said she was also responsible for updating care plans after completing MDS assessments. She said Resident #10's should contain care planning related to smoking and any safety concerns. She said the potential harm of not including this information in the care plan was the resident or someone else could get injured. Record review of the facility policy Smoking Policy- Residents dated 2001, revised October 2023, revealed the following: .10. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues . 2. Record review of Resident #15's admission Record dated 04/08/2026 reflected a [AGE] year-old female admitted [DATE]. Resident #15 was not listed as her own responsible party.Record review of Resident #15's Medical Diagnoses, undated and accessed 04/08/2026 at 6:38 p.m., revealed diagnoses including Alzheimer's Disease (a progressive disease that affects memory and other important mental functions), vascular dementia (cognitive impairment caused by reduced or blocked blood flow to the brain, leading to memory, thinking, and behavioral problems), cognitive communication deficit (condition where impairments in cognitive processes, rather than language or speech mechanics, disrupt a person's ability to communicate effectively), altered mental status (broad term describing any change in a person's normal cognitive function, awareness, or behavior, ranging from mild confusion to complete unresponsiveness), anxiety (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	listed as her own responsible party with her (family member) listed as Emergency Contact #1.Record review of Resident #82's Medical Diagnoses, undated and accessed 04/08/2026 at 4:48 p.m., revealed diagnoses including Alzheimer's Disease (a progressive disease that affects memory and other important mental functions), cognitive communication deficit (condition where impairments in cognitive processes, rather than language or speech mechanics, disrupt a person's ability to communicate effectively), muscle weakness (condition in which muscles are unable to generate the expected amount of force, resulting in reduced strength or difficulty performing normal movements), and major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems).Record review of Resident #82's annual Minimum Data Set (MDS), dated [DATE] and signed 03/23/2026 as completed, reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #82 was documented as having exhibited physical and behavioral symptoms directed toward others and other behavioral symptoms not directed toward others. Resident #82 was documented as not having exhibited wandering behaviors. Resident #82's functional abilities were documented as requiring supervision or touching assistance to independent.Record review of Resident #82's care plan, undated and accessed 04/08/2026 at 5:05 p.m., did not reveal mention of secure unit placement, risk for elopement, or wandering interventions. The care plan revealed Resident #82 had Cognitive impairment as evidenced by Impaired decision making, and Alzheimer's dementia. The care plan focus was created and initiated on 05/16/2025 and revised on 03/21/2026.Record review of Resident #82's MD, NP Progress Notes, dated 06/16/2025 and written by NP W documented PT [Resident #82] IS SEEN IN SECURE UNIT FOR THE FOLLOWING MEDICAL CONDITIONS: ALZHEIMER'S DISEASE: PT [Resident #82] RECENTLY MOVED FROM D HALL TO SECURE UNIT, DUE TO WANDERING IN THE ROOM OF OTHER RESIDENTS. PT [Resident #82] IS CONFUSED AND NEEDS FREQUENT REDIRECTING BY STAFF. NO EXIT-SEEKING, AGGRESSION OR AGITATION.During an observation of Resident #82 on 04/07/2026 at 2:08 p.m., she was noted to be lying down in her bed with her eyes wide open. Her bed was noted to be in a low position. Resident #82 was dressed well, groomed appropriately, no odors, call light within reach, and a few personal items were noted in her room. Attempted interview with Resident #82 revealed she was not interviewable.During an observation on 04/08/2026 at 5:19 p.m., Resident #82 was noted to be asleep in bed. Her bed was noted to be in a low position.During an observation and interview of Resident #82 on 04/09/2026 at 1:35 p.m., she was noted to be lying down in her bed facing the window. Her bed was in a low position, and a crossword book was lying beside her. She sat up on her bed and began speaking in Spanish. She was noted to have a large hematoma with bruising to the right side of her forehead. She said she was a new resident in the facility, she did not know what happened to her forehead, stated she recalls going to the hospital, and does not take medications, she eats a little because this is her preference. Resident #82 was noted to be dressed well, groomed appropriately, no odors. Resident struggled to find the right words, to follow the conversation, express her thoughts, recalling details, and was confused.During an observation of Resident #82 on 04/09/2026 at 2:04 p.m., she was noted as alert and walking out of her room, ambulated without a device, walking up and down the hallway searching for the music she heard playing throughout the unit.Attempted interview on 04/09/2026 with Resident #82's [family member] and responsible party at 7:04 p.m. but they did not return the call.During an observation and interview on 04/09/2026 at 7:26 p.m., the DON revealed Resident #82 was transferred to the secure unit on 06/19/2025 because she had behaviors with a roommate. She said on 05/08/2025 and 05/09/2025 Resident #82 was making statements of wanting to leave and go home, she was angry, and she packed her belongings and headed for the door. She said on 05/19/2025 a care conference to discuss Resident #82's behaviors and if she would benefit from a WanderGuard transpired. She said Social Services was having difficulties with Resident #82's placement. She stated the exit seeking behavior determined the resident's need for secure unit placement. The DON was observed to review Resident #15's care plan, 06/17/2025 IDT, care plan summary, social service progress notes and nursing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress notes from 05/07/2025 (admission date) to 06/19/2025 (transfer to secure unit) and stated she could not find documentation of IDT discussion for secure unit placement, responsible party consenting of transfer to secure unit, and interventions for secure unit placement. She stated Social Services would have been responsible for documenting the transfer to secure unit, updating the care plan, and progress notes with follow up discussion of Resident #15's care; however, she [Social Services] was new to her role so she would not have documented well. She said the appropriate consent for Resident #82 was obtained prior to her transfer to the secure unit and interventions were in place for this resident; however, not documented in Resident #82's EMR. She said the facility is not in compliance with documentation requirements and the team will work on this moving forward. During an interview on 04/09/2026 at 1:52 p.m., CNA R stated care plans provide staff with specific information of care a resident requires and not being updated or accurate can be harmful to a resident.During an interview on 04/09/2026 at 2:20 p.m., LVN X stated care plans give the staff vital information on resident care and are necessary to provide interventions needed for behaviors.During an interview on 04/09/2026 at 2:40 p.m., CNA S stated care plans will list interventions needed to separate residents who have behavior issues and updated care plans are necessary as staff rely on interventions in the secure unit.During an interview on 04/10/2026 at 2:00 p.m., Social Services said she was responsible for psychosocial assessments, checking on the emotional well-being of each resident, assisting with IDT, sending referrals to psych services, participating in PASRR meetings, quarterly meetings, new admission meetings, and to follow-up on resident-to-resident incidents. She stated the importance of documenting and updating resident care plans was to provide nursing staff with interventions to help avoid resident behaviors and to de-escalate incidents. She stated the impact of not updating care plans or inaccurately documenting care plans would be that staff may not have the required information to help a resident de-escalate behaviors and potential of incidents occurring.During an interview on 04/10/2026 at 1:35 p.m., CNA, V stated he utilized care plans as they communicate vital information on how to care for a resident to be well and thrive, maintain a healthy lifestyle. He stated that inaccurate care plans could keep a resident from receiving the necessary care and thereby cause a decline of their health.During an interview on 04/10/2026 at 1:47 p.m., CNA U stated she received daily reports during shift change and the expectation is to review the care plans daily to provide the best care possible to the residents assigned to her hallway. She stated inaccurate care plans can cause a delay in care.During an interview on 04/10/2026 at 2:20 p.m., LVN C stated she and the aides she oversees rely on the care plans and their accuracy to provide specific care for a resident. She stated if care plans are not updated or inaccurate a resident could negatively suffer.During an interview on 04/10/2026 at 3:00 p.m., the MDS revealed that care plans should be updated every quarter and as needed. She noted that a change of condition would require the care plan to be updated. She stated mental health services are documented in the care plan along with determination of PASRR services. The MDS stated care plans are to alert the nursing staff, residents, and families of specialized services being provided. She stated if care plans are not updated or inaccurate could cause harm to residents and those around them. The MDS noted that residents residing in the secured unit would require IDT discussion to ensure all staff involved in resident's care are on the same page with their care. She noted that ADON E, ADON L, DON, Social Services, and herself make up the IDT. She noted that she could not say the IDT discussed secured unit placements quarterly but noted that there are verbal discussions constantly taking place and cannot say that the discussions are documented in the resident EMR.During an interview on 4/10/2026 at 3:36 p.m., the ADMIN revealed at times she will participate in more challenging care plan meetings. She noted that residents placed in the secured unit should have information documented in their care plan. She noted that she is aware that secured unit resident care plans do not reflect their status in the secured unit or their interventions. She noted that the IDT does discuss secured unit placements but would need to verify if these discussions are being documented in the resident EMR as she could not recall at this time. The ADMIN noted that care plans should be person-centered and describe the services that are (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be provided to attain or maintain the resident's physical, mental, and psychosocial well-being. She noted that not developing and implementing person-centered care plans could negatively impact the social and mental well-being of a resident.During an interview on 4/10/2026 at 5:20 p.m., ADON E revealed the nursing staff rely on the resident's EMR task bar and care plan for specific care to provide to a resident. She noted that if a care plan is not updated or accurate it could have a negative impact on a resident as staff would not be informed of interventions to redirect their behaviors. Record review of policy titled, Care Planning - Interdisciplinary Team, dated Qtr. 3, 2018, revealed .Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.Record review of policy titled, Comprehensive Care Plans, date revised 05/05/2025, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASRR recommendations. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive, quarterly MDS assessment and when a resident experiences a status change 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress . Record review of policy titled, Secure unit placement, date revised 06/10/2025, revealed .3. Written findings and the factual basis for the placement are documented in the health information record.5. The IDT team to evaluate place of a resident in a secure environment.6. The evaluation team shall re-evaluate as needed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 2 of 5 residents (Residents #95 and #89) reviewed for medication administration. The facility failed to ensure Resident #95 received his anti-seizure medication as ordered by the physician on 4/9/2026. The facility failed to ensure Resident #89 received the correct dose of insulin on 4/10/2026. These failures could result in residents not receiving the intended therapeutic effects of medications, including seizures or low blood sugar levels.Findings included: 1. Record review of Resident #95's admission Record reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included epilepsy, unspecified, not intractable, without status epilepticus [a chronic neurological disorder characterized by unprovoked seizures caused by abnormal electrical activity in the brain; the seizures are able to be treated with medication and are not continuous]. Record review of Resident #95's significant change MDS submitted 3/2/2026 reflected a BIMS score of 11, which indicated moderately impaired cognition. Section I5400 of the MDS reflected Resident #95 had a diagnosis of seizure disorder or epilepsy. Record review of Resident #95's Order Summary Report dated 4/10/2026 reflected an order dated 8/29/2025 for Lacosamide oral tablet 100mg to be administered orally two times a day for seizures. Record review of Resident #95's Medication Administration Record dated 4/10/2025 reflected Resident #95 did not receive the morning or evening doses of Lacosamide on 4/09/2026, documented by CMA F. In an observation and interview on 4/10/2026 at 8:07 AM, MA F was observed preparing Resident #95's morning medications for administration. She could not locate Resident #95's Lacosamide, and she said the medication was re-ordered the day prior from the pharmacy and should have been delivered in the evening. She said Resident #95 did not get the medication yesterday because it was out of stock, and she was unsure why it had not been reordered previously because she had not been scheduled to work during that time. She said if Resident #95 did not receive his medication, it could result in him having seizures. MA F was able to locate the medication in a different cart, and Resident #95 received the ordered dosage as ordered. In an interview with the DON on 4/10/2026 at 10:00 AM, she said all medication should be reordered when the stock has 7 days remaining. She was unsure why Resident #95's medication had not been reordered, and she was unaware that he had not received the medication on 4/09/2026. She said Resident #95 had not experienced any seizures on 4/9/2026 or 4/10/2026. 2. Record review of Resident #89's admission Record dated 4/10/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included type 2 diabetes mellitus with hyperglycemia [when the body develops resistance to insulin, leading to elevated blood sugar levels]. Record review of Resident #89's significant change MDS submitted 3/17/2026, reflected a BIMS score of 08, which indicated moderately impaired cognition. Section N0350 of the MDS reflected Resident #89 received insulin injections for 5 days of the 7-day assessment period. Record review of Resident #89's Order Summary Report dated 4/10/2026 reflected an order dated 3/13/2026 for Lantus subcutaneous solution 100 unit/mL (Insulin Glargine) Inject 8 unit [sic] subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA [sic]. In an observation and interview on 4/10/2026 at 7:34 AM, LVN C was observed preparing to administer the insulin to Resident #89. The insulin was drawn into a syringe, and LVN C approached Resident #89 to notify him of the medication administration. She told Resident #89 she was going to administer the medication into his left arm, and she cleansed the upper arm with an alcohol pad to prepare the site for administration. The surveyor requested to see the syringe immediately prior to administration, and the syringe was observed to contain 10 units of insulin. LVN C was asked how many units Resident #89 was ordered to receive, and she said 8 units. She inspected the syringe and said the syringe contained 8 units. She then left Resident #89's room and inspected the syringe in the hall, and said she needed to expel 2 units. She said the writing on the syringe was difficult to see. In (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview with the DON on 4/10/2026 at 10:00 AM, she said insulin should be double-checked prior to administration, and the potential risk of not checking was administering the wrong dosage of insulin to a resident and possible hypoglycemia (low levels of blood sugar that require treatment). Record review of the facility provided a policy titled Administering Oral Medications did not contain guidance related to injections or insulin.

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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 observation, interview, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one (1) of one (1) kitchen (Kitchen 1) reviewed for food safety requirements. 1. Food service staff failed to ensure an internal thermometer was present in the reach-in refrigerator #1. 2. Food service staff failed to ensure a facility contracted food supplier representative wore hair restraints while in the kitchen during meal preparation. 3. The facility failed to ensure a package of pork ribs was labeled and dated in the walk-in freezer. 4. [NAME] P failed to ensure the walk-in freezer temperature log was filled out for the morning of 04/07/2026. These failures could place residents at risk for the spread of infections, food contaminations, food-borne illnesses, and diminished quality of life. The findings included: During an observation and interview on 04/07/2026 at 10:47 a.m., an internal thermometer for the reach-in refrigerator #1 could not be located. [NAME] P and Dietary Svr were observed searching the reach-in refrigerator and a thermometer was not found. The Dietary Svr stated the staff were supposed to use the thermometer inside the refrigerator or freezer to confirm the temperature. [NAME] P stated she used the temperature gauge on the outside of the refrigerator that morning. During an observation on 04/07/2026 at 10:56 a.m., a food supplier representative was observed to walk into the facility kitchen from the kitchen exit door and walked through the kitchen without wearing a hear restraint. The food supplier was noted to have a full head of hair, which was loose. Uncovered cooked or ready to eat food items were observed to be on the stove and hot service table in preparation for lunch service. The Dietary Svr was observed to immediately direct the food supplier representative out of the kitchen and discourage her from walking into the kitchen without a hair restraint. During an observation on 04/07/2026 at 11:30 a.m., a package of pork ribs was observed on the bottom shelf of the walk-in freezer. The package was unlabeled and undated. During an observation and interview on 04/07/2026 at 11:35 a.m., the walk-in freezer temperature log was observed to not have a documented temperature for 04/07/2026 morning. [NAME] P stated she did not check today, 04/07/2026. She stated she missed it. During an interview on 04/10/2026 at 03:37 p.m., the Dietary Svr stated the dietary staff could not determine what happened to the prior internal thermometer for refrigerator #1. He stated his expectation was for staff to use the internal thermometer to check the refrigerator and freezer temperatures because the staff needed to be able to confirm the internal temperature was safe. He stated he trained his staff to use internal thermometers. He stated the risk of using the temperature gauges on the outside of the equipment was that gauges could be faulty. He stated the risk of a staff member or facility guest coming into the kitchen without a hair restraint was that it could result in food contamination due to the possibility of hair in the food. The Dietary Svr stated the pork ribs had been previously labeled; however, the label must have come off. He stated he was able to verify the item's delivery date from purchase invoices. He stated there was not an impact on resident food safety because the required information for the food item was known. He stated his expectation was for staff to check the freezer and refrigerator temperatures first thing in the morning. He stated the task was on the cook's workflow sheet. He stated the impact of not checking the refrigerator and freezer temperatures in the morning was he could not know if the food was at a safe temperature overnight. During an interview on 04/10/2026 at 02:55 p.m., the RDN stated her expectation was for there to be a thermometer in each refrigerator and for staff to use the internal thermometer for the temperature logs. She stated the impact of using the external temperature gauge was that it was not as accurate as an internal thermometer and the internal thermometer was more dependable. She stated she expected the cook to take the temperatures of the refrigerator and freezers when they got there in the morning and right before they left. She stated the impact of taking the freezer temperature later in the day was the temperature could be impacted by staff having been in there. She stated she checked food labels when she (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed her monthly kitchen tours. She stated she did not know if there would be a negative impact if a frozen food item, still frozen, was unlabeled. She stated she had not observed anyone coming into the kitchen with unsecured hair, but the impact would be the person could have had some kind of communicable disease and therefore infection control would be a concern. During an interview on 04/10/2026 at 05:28 p.m., the ADMIN stated the impact of not having an internal thermometer in a refrigerator was that the internal thermometer made sure the facility captured the proper temperature of the food, allowing food temperatures to be monitored and stored appropriately. She stated she expected facility guests to come to the front, check in as a guest, and when going to the kitchen, to follow proper hand hygiene and wear hair restraints. She stated the possible impact of a guest not following the protocol could be that hair and improper hygiene could negatively affect the residents' food. She stated the impact of not taking the walk-in freezer temperature in the morning was the food might not have been stored at appropriate temperatures. She stated the impact of not having a label on the pork ribs was the label allowed staff to ensure it was in a date range that ensured the food was safe for the facility to serve. Record review of the facility's policy, Food Receiving and Storage, dated as revised October 2017, revealed Policy StatementFoods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation.8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (?use by' date).12. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements. Record review of the facility's policy, Food Safety Requirements, dated as copyright 2026, revealed Policy:It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.Policy Explanation and Compliance Guidelines: .7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contaminating food. e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad.8. Additional strategies to prevent foodborne illness include, but are not limited to: a. Preventing cross-contamination of foods. Record review of the FDA Food Code 2022, https://www.fda.gov/food/retail-food-protection/fda-food-code, accessed 04/13/2026 revealed: 4-204.112 Temperature Measuring Devices.The placement of the temperature measuring device is important.Therefore, the temperature measuring device must be placed in a location that is representative of the actual storage temperature of the unit to ensure that all time/temperature control for safety foods are stored at least at the minimum temperature required.2- 402 Hair restraints2-402.11 Effectiveness.(A) Except as provided.Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.(B) Label information shall include:(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; .(3) An accurate declaration of the net quantity of contents; .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the secured unit in the facility was free of pests and rodents. The facility failed to ensure the building was free of insects. This failure could lead to contamination and/or decreased quality of life. Findings include:In an observation on 4/7/2026 at 12:35 PM, approximately 10 small flying insects that resembled gnats were observed flying in the dining area and hallway adjacent to the dining area during lunch. In an observation on 4/9/2026 at 12:14 PM, revealed Resident #44 received lunch during an interview in the dining room. Approximately 5 small flying insects that resembled gnats were flying above his food. He was observed swatting the flies away from his food as he ate lunch. In an observation and interview on 4/10/2026 at 11:21 AM, LVN E stated the flying insects observed in the secured units nursing station were gnats. She stated that issues with gnats have been ongoing and sometimes it's worse. She could not give the length of time the gnats had been observed. She stated she had not reported the issue but everyone knew about it. She revealed she was unaware of treatment for the gnats. In an interview with the ADMIN on 4/10/2026 she revealed she was aware of intermittent issues with insects in the facility. She was unaware of the flying insects observed in the secured unit hallway and dining area. She provided the Pest Control policy and the last 3 treatment invoices. Record review of the pest sighting log on 4/10/2026 revealed gnats in the following areas: B Hall room [ROOM NUMBER] on 2/18/2026, room [ROOM NUMBER]A on 3/11/2026, and room [ROOM NUMBER] on 3/31/2026. Record review of the 2/27/2026 and 3/25/2026 pest control invoices reflected past treatment for gnats by the contracted pest control company with fly boards and pressurized fly bait. Record review of a facility policy entitled Pest Control, revised May 2008, read: Policy StatementOur facility shall maintain an effective pest control program.I. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of needs and preferences for one (1) of seven (7) residents (Resident #77) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #77's room was in a position accessible to the resident on 04/07/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.The findings included: Record review of Resident #77's admission Record, dated 12/30/2025, revealed a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #77's Diagnosis Report, dated 04/08/2026, revealed diagnoses including cerebral infarction (a disruption in the brain's blood flow), legal blindness, and repeated falls. Record review of Resident #77's Quarterly MDS, dated [DATE], revealed Resident #77 was rarely/never understood. She was documented to have short-term and long-term memory problems with severely impaired cognitive skills for daily decision making. She used a walker and required partial/moderate assistance to transfer from sitting to lying or lying to sitting on the side of the bed, from sitting to standing, and from chair/bed-to-chair. Record review of Resident #77's Care Plan Report, dated last care plan review completed 01/29/2026, revealed Resident #77 had Visual Impairment r/t legally blind, date initiated 04/03/2025 and revised 03/03/2026, with an intervention Will be oriented to environment and placement of things in the room, date initiated 04/03/2026. She was noted to have had an Actual Fall with five (5) falls noted, including a fall on 01/24/2026 with noted on floor in room and a fall on 04/05/2026 r/t self transfer[sic], date initiated 01/08/2026 and revised 04/06/2026. Interventions included Assist with ambulation when attempting to ambulate, date initiated 01/12/2026 and Review room for environmental hazards, date initiated 01/26/2026. During an observation and attempted interview on 04/07/2026 at 01:32 p.m., Resident #77, was observed in her bed asleep. Her call light cord was observed to be lying across the bottom part of her bed, next to her feet, and the call light button had fallen off the bed and down between the right side of the bed and the wall. Resident #77 was unrousable (could not be awakened or respond to her name) and did not wake up enough to follow directions or attempt to demonstrate if she could have reached the call light. During an observation on 04/07/2026 at 02:03 p.m., Resident #77 and her call light were observed in the same position. Resident #77 remained asleep. During an observation and interview on 04/07/2026 at 02:04 p.m., MA M stated Resident #77 could use the call light, but Resident #77 was blind, so staff had to put it on her. MA M stated Resident #77's call light was not in reach, and she did not know how long the call light had been in its current position. MA M was observed to pick up Resident #77's call light, set it next to Resident #77's hand, and clip it to Resident #77's pillow. During an interview on 04/10/2026 at 01:57 p.m., LPN J stated Resident #77 did not use her call light and was rarely in her room because Resident #77 was an extreme fall risk and staff were tying to keep her within sight, while monitoring Resident #77 for signs of when she had to use the restroom. LPN J stated the call light should be within reach and it was the responsibility of anyone who goes into the resident's room and sees the resident. LPN J stated the impact of Resident #77's call light having been out of reach was that there would not be an impact since Resident #77 could not use it. During an interview on 04/10/2026 at 01:48 p.m., CNA N stated Resident #77 did not use her call light. She stated Resident #77 would sit on her bed and wait or call out. CNA N stated Resident #77 could use the call light but rarely did. She stated the call light was usually within reach and staff were supposed to have the call light right next to her. She stated Resident #77 will sometimes knock the call light off the bed because she moves a lot. She stated Resident #77 would not try to get up, but she had fallen a couple of times because she could not see and would sometimes stand when trying to find her family. CNA N stated there was not an impact of the call light having been out of Resident #77's reach because Resident #77 would check (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her surroundings and would call out to staff if the call light was out of reach. During an interview on 04/10/2026 at 02:14 p.m., ADON E stated her expectation for Resident #77's call was for her call light to be on the bed or pillow, or somewhere where Resident #77 could reach it. ADON E stated she had never observed Resident #77 using the call light. ADON E stated the impact of Resident #77's call light having been out of reach was hard to say because Resident #77 did not use it, but it should be there anyway. During an interview on 04/10/2026 at 04:40 p.m., the DON stated Resident #77 did not use her call light, but her expectation was that call lights were within reach and answered. The DON stated the CNAs were responsible for ensuring to check every two to three (2-3) hours, by going into the room and ensuring the call light was in reach. She stated the impact on Resident #77 for her call light having been out of reach was none, since Resident #77 did not use it. She stated the impact for a resident that did use their call light was that it could be an issue if the resident had to look or reach for it and might fall trying to look for the call light. During an interview on 04/10/2026 at 05:28 p.m., the ADMIN stated all residents needed to have their call light within reach. She stated everyone was responsible for that. She stated she was not very familiar with Resident #77; however, the impact of the call light having been out of reach was that the resident was not able to call for assistance. Record review of facility policy, Call Lights: Accessibility and Timely Response, dated as revised 05/13/2025 and implemented 05/16/2025, revealed Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: .5. Staff will ensure the call light is within reach of resident and secured, as needed.6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's care planning for 1 of 3 residents (Resident #16) reviewed for PASARR services. The facility failed to ensure Resident #16's PASRR Level 1 Screening was completed accurately with mental illness diagnosis to secure a Level 2 Evaluation by the Local Authority. This deficient practice could place residents at risk of not receiving services identified by the local authority.The findings included: Record review of Resident #16's admission Record, dated 04/10/2026, revealed a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Resident #16 was not listed as her own responsible party with her [friend] listed as Emergency Contact #1.Record review of Resident #16's Medical Diagnoses, undated and accessed 04/10/2026 at 12:30 p.m., revealed diagnoses including major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), bipolar disorder (mental health condition characterized by significant mood swings), and schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking).Record review of Resident #16's quarterly MDS, dated [DATE] and signed 03/05/2026 as completed, reflected a BIMS score of 15, indicating intact cognition. Resident #16 was documented as having not exhibited any behavioral symptoms. Resident #16's functional abilities were documented as requiring setup or clean-up assistance to independent.Record review of Resident #16's care plan, undated and accessed 04/10/226 at 12:32 p.m. did not reveal mention of PASRR determination or services.Record review of Resident #16's PASRR Level 1 Screening, dated 03/11/2024, reflected yes was selected for .is there evidence that dementia is the primary diagnosis for this individual? and no was selected for .is there evidence or an indicator this is an individual that has a Mental Illness? The Medical Diagnoses for Resident #16 did not include dementia as a diagnosis and listed mental illness diagnoses of schizophrenia and bipolar disorder.Record review of Resident #16's EMR Misc tab on 04/10/2026 did not reveal documentation of PASRR Level 2 Evaluation (a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC). During an interview on 04/07/2026 at 12:10 p.m., Resident #16 managed her psych services, and she received counseling and visits with a psychiatrist often.During an observation and interview on 04/10/2026 at 3:00 p.m., the MDS nurse revealed new admission requires a PL1. She stated PL1 was required to be reviewed for accuracy. She stated she was expected to review clinicals to verify the PL1 for a new admission was as accurate as possible. She stated if incoming PL1 was inaccurate she would notify the transfer facility to submit a corrected one. If unable to reach the transfer facility she will make corrections and update the PL1 and re-submit it to LTC Online Portal. The MDS nurse stated the impact of not verifying the incoming PL1 for accuracy could impact a resident by not receiving the mental health services they are entitled to, such as therapy. The MDS nurse stated if she were made aware of an inaccurate PL1 or a change of condition occurs she would submit Form 1012 (is used by Texas nursing facilities to review residents with a negative PASRR Level 1 screening to determine if further evaluation for mental illness or dementia is needed.) She stated that care plans are updated with determination and PASRR services. The MDS nurse was observed to review Resident #16's incoming PL1 for accuracy. She noted that Resident #16's PL1 was inaccurate as dementia was not the resident's primary diagnosis and the diagnosis of schizoaffective disorder, major depressive disorder, and bipolar disorder should have (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulted in a positive PL1, and PE completed by the Local Authority. The MDS nurse noted she would complete Form 1012 and notify the Local Authority to conduct a PE. She stated that once a determination was obtained, she would update the resident's care plan.During an interview on 4/10/2026 at 3:36 p.m., the ADMIN revealed the expectation was for PASRR referrals to be sent to the Local Authority to determine if a resident qualifies for services. She stated she wants to ensure residents have access to benefits they qualify for and the potential impact of this failure would be a loss of beneficial services. Record review of policy titled, Comprehensive Care Plans, date revised 05/05/2025, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and services that are identified in the resident's comprehensive assessment and meet professional standards of quality. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASRR recommendations. Record review of policy titled, admission Criteria, date revised December 2016, revealed .8. Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-admission Screening and Resident Review program (PASARR) to the extent practicable. 9. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State mental health agency has determined (through the pre-admission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility.Record review of policy titled, Conducting an Accurate Resident Assessment, date revised 05/05/2025, revealed .The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of theresident's status at the time of the assessment, by staff qualified to assess relevant care areas.8. To ensure accuracy in the MDS coding of a diagnosis of schizophrenia, supportive documentation must be present in the medical record and should include, but is not limited to, evaluation(s) of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, change in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASRR) evaluation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles for 1 of 3 medication carts (A- hall medication cart) reviewed for medication storage.The facility failed to ensure a vial of insulin was labeled with the expiration date. This failure could result in residents receiving expired medications.Findings included: In an observation and interview on 4/10/2026 at 7:46 AM, a vial of insulin (a medication used to treat elevated blood sugar levels) was observed in the top drawer of the A-hall medication cart without an expiration date. LVN C was unsure when the vial had been opened. She said all insulin vials and pens should be labeled with the date they are opened and the date they expire to ensure residents do not receive expired medications. In an interview with the DON on 4/10/2026 at 10:00 AM, she said the facility policy is to label all insulins with the date they are opened and the date they expire, and the nursing staff was primarily responsible for this duty. She said the potential harm to residents was receiving expired insulin that is ineffective for treating elevated blood sugar. Record review of the facility titled Storage of Medication dated 10/3/2018, reflected the following: .9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly.The policy did not contain guidance regarding the labeling of medication to indicate expiration.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received therapeutic diets that were prescribed by the attending physician for 1 of 21 residents (Resident #2) reviewed for therapeutic diets.The facility failed to ensure Resident #2 received large protein portions instead of large portions at every meal per RD recommendations, which were approved by Dr. Q.This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity.Findings Included: Record review of Resident #2's admission record, dated 04/07/2026, reflected resident was a [AGE] year-old male, initially admitted [DATE] and re-admitted [DATE] with diagnoses to include type 2 diabetes mellitus with hyperglycemia (elevated blood sugar levels due to the body's inability to self-regulate levels), onset date 01/29/2026. When Resident #2 was first admitted on [DATE], Type 1 Diabetes (a condition in which the body no longer produces the enzyme to reduce blood sugar levels) was not added to his admission record upon his admission. Record review of Resident #2's quarterly MDS assessment, dated 02/25/2026, reflected he had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. He further had an active diagnosis of diabetes mellitus. Record review of Resident #2's care plan, undated, reflected focus of [Resident #2] is at risk for alteration in nutrition r/t DMII, initiated 01/23/2026, with an intervention of Serve diet as ordered by physician. large portions at meals, revised 03/03/2026. Record review of Resident #2's Dietitian Recommendations reflected . Change diet to CCD/Regular/regular with large protein portions all meals, dated 02/12/2026 and signed by the RDN and Dr. Q. Record review of Resident #2's order summary report, dated 04/07/2026, reflected Consistent Carbohydrate Diet (CCD).Regular texture, thin (regular). with large portions all meals, dated 01/28/2026. During an observation on 04/09/2026 at 06:20PM reflected Resident #2 received extra tater tots and an additional half a hamburger for his dinner and his meal tray ticket reflected large portions all meals. During an interview on 04/10/26 at 02:50PM, the RDN revealed Resident #2 needed large protein portions because his calorie needs were a little bit more than the normal diet could provide. She revealed she did not want to recommend to increase carbohydrates because he was diabetic it and it could increase his blood sugars, which could increase his a1c. She confirmed that Resident #2's current diet order included large portions at all meals, which was incorrect, and it should be large protein portions at all meals. During an interview on 04/10/2026 at 03:20PM, the DON revealed Resident #2's doctor's orders included large portions at every meal. She revealed she reviewed Resident #2's EMR for his diet and it was recommended by the RDN on 02/04/2026 for Resident #2's diet to include large protein portions, which was approved by the doctor. The DON revealed it was important to follow the RDN (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations/physician's orders. She further revealed large portions could cause high blood sugars and large protein portions would not affect his blood sugars, which could improve his blood glucose control. Record review of the facility's policy Therapeutic Diets, revised October 2017, reflected . 2. A therapeutic diet must be prescribed by the resident's attending physician. The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law. 4. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as a part of treatment for a disease or clinical condition, to modify specific nutrients in the diet.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for one (1) of one (1) residents (Resident #14) reviewed for hospice services. The facility failed to maintain the current hospice plan of care to ensure Resident #14 received adequate end-of-life care. This failure could place residents at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: Record review of Resident #14's admission Record, dated 04/09/2026, revealed Resident #14 was initially admitted the facility on 01/12/2024 and readmitted on [DATE]. Resident #14 was noted to be [AGE] years old and received hospice services. Record review of Resident #14's Diagnosis Report, dated 04/09/2026, revealed Resident #14 was diagnosed with encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke), Parkinson's disease (a disorder of the nervous system that affects movement) without dyskinesia (uncontrollable and involuntary movements), and chronic obstructive pulmonary disease (a group of lung diseases causing constriction of the airways and difficulty breathing). Record review of Resident #14's Quarterly MDS assessment, dated 03/11/2026, revealed Resident #14 had a BIMS of 7, which indicated severe cognitive impairment. She had an active diagnosis of Parkinson's Disease and received hospice care while a resident and within the last 14 days. Record review of Resident #14's Care Plan Report, dated last care plan review completed 03/19/2026, revealed Resident #14 received Hospice Care due to diagnosis of PARKINSONS with [Hospice G], date initiated 01/06/2025 and revised on 01/16/2025. Record review of Resident #14's Order Summary Report, dated 04/09/2026, revealed orders:- Admit resident to [Hospice G] under the care of [MD I]. Order dated 01/06/2025 and status noted as Active.- Administer Oxygen at 2-3 LPM via nasal cannula PRN [NAME] shortness of breath or O2 saturation <90% every shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED. Order dated 03/06/2026 and status noted as Active. Record review of Resident #14's physical hospice binder on 04/10/2025 at 09:50 a.m. revealed initial hospice Delineation of Duties-Plan of Care document, signed 01/06/2025, a Who to notify when starting oxygen therapy: document, and ten (10) completed [Hospice G] Staff Sign - In Log documents. The Delineation of Duties- Plan of Care document noted Resident #14 was admitted to the hospice on 01/06/2025 with a diagnosis of Parkinsons. Under Communication/Coordination and Hospice Responsibilities, 3. The Hospice RN will coordinate and discuss changes in a patient's Plan of care with the Facility at least every 15 days. The Who to notify when starting oxygen therapy: document noted the utility company, Resident #14's name, that oxygen signs and no smoking signs were posted, that there were functioning smoke detectors in the home, that the oxygen tanks would be stored safely, and that the oxygen was located in a well-ventilated area. Documentation did not include oxygen administration notes or orders. During an interview on 04/07/2026 at 01:42 p.m., Resident #14's Responsible Party stated her communication with Resident #14's hospice was good. Resident #14's Responsible Party stated Resident #14 was referred to hospice while a resident at Nursing Facility H, and she did not have concerns regarding the referral process. Resident #14's Responsible Party stated she had some concerns regarding Resident #14's oxygen administration since she believed the hospice nurse tested Resident #14's need for oxygen supplementation and discontinued Resident #14's oxygen order. She stated she observed Resident #14 without oxygen on Thursday, 04/02/2026, but then observed Resident #14 to be back on oxygen on Saturday, 04/04/2026. She stated she believed the oxygen was administered on Saturday, 04/04/2026 due to a lack of communication between Nursing Facility H (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekday and weekend nursing staff. During an interview on 04/10/2026 at 09:53 a.m., LPN J stated she spoke with Resident #14's hospice nurse every time they came in. She stated Resident #14 used to be on continued oxygen but was now PRN. LPN J stated she did not touch Resident #14's hospice binder because it was the hospice's records. During an interview on 04/10/2026 at 02:14 p.m., ADON E stated she did not know who was responsible for monitoring and coordinating the hospice care plan. She stated the impact of not having a current hospice care plan was that it was possible the facility or hospice could have information that would be useful for the other and without sharing that information, there could be a delay. During an interview on 04/10/2026 at 03:15 p.m., RN O, Resident #14's care manager for Hospice G, stated she was Resident #14's hospice care manager since the middle to late October 2025. RN O stated Resident #14's oxygen had not been discontinued but changed from continuous to PRN. RN O stated she was not sure of Nursing Facility H's protocol, but some facilities wanted the hospice care plans either faxed or emailed. She stated she was not the one typically responsible for faxing those documents over. She stated the most recent hospice care plan for Resident #14 was dated Wednesday, 04/08/2026. She stated she did not send the care plans over but would give the facility nurse the most recent order if she received the order prior to her weekly visit, otherwise the orders would be given verbally to the nurse. She stated Resident #14's most recent order was dated 04/08/2026, which she was given by the physician after her weekly visit, so she let the nurse, LPN J know. She stated she did not have a copy of the order. She stated the impact of the facility not having Resident #14's most recent hospice care plan was Resident #14 may not be receive the proper medication if the facility and hospice were not on the same page with medications; however, Resident #14 had been stable. During an interview on 04/10/2026 at 04:40 p.m., the DON stated there was a hospice binder located at the nurses' station that the hospices delivered. She stated she could not state if anyone checked the binders for documentation. She stated she did not know who was responsible and had forgotten about that task. She stated the impact of a resident not having a current hospice care plan was if the hospice care plan had changed and the facility was not updated on the change, then the facility was not following the same plan of care. During an interview on 04/10/2026 at 05:28 p.m., the ADMIN stated the nurse managers, the ADONs and the DON, were responsible for coordinating with the hospices for changes in their resident's plan of care and were responsible for holding the hospices accountable in providing the documentation. Record review of Hospice G contract with Nursing Facility H, dated as contract was entered into on 01/05/2025, by Nursing Facility H and Hospice G. The contract revealed under Definitions.Plan of Care (POC): A written individualized plan of services necessary to meet the patient-specific needs. It includes all patient care physician orders, and planned interventions for problems identified during patient assessments, to ensure that care and services are appropriate to the severity level of each patient and family's needs.Under I. Responsibilities of Hospice: .F. Information/Documentation provided to Facility on admission and ongoing: 1. Most recent Hospice plan of care, .G. Coordination/Continuity of Care: . 5. Ensure that each resident's written plan of care includes both the most recent Hospice plan of care and a description of the services furnished by the Facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Under II. Responsibilities of Facility: .H. Maintain an accurate medical record that all services furnished and events regarding care that occurred at the facility. All services will be furnished according to the agreement. Required documentation provided by Hospice will be included in a designated area/section. Facility will ensure that these forms are not removed. On 04/10/2026 at 07:01 p.m., an emailed request for a facility policy on Hospice was sent. A policy was not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #89) reviewed for infection control. The facility failed to ensure LVN C utilized proper PPE when administering insulin to Resident #89. This failure could result in the spread of infection. Findings included: Record review of Resident# 89's admission Record dated 4/10/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included type 2 diabetes mellitus with hyperglycemia [when the body develops resistance to insulin, leading to elevated levels of blood sugar]. Record review of Resident #89's significant change MDS submitted 3/17/2026 reflected a BIMS score of 08, which indicated moderately impaired cognition. Record review of Resident #89's Order Summary Report dated 4/10/2026 reflected the following:Enhanced Barrier Precautions r/t indwelling medical device: indwelling foley catheter every shift [sic] (order date 3/13/2026) In an observation and interview on 4/10/2026 at 7:34 AM, Resident #89's doorway was observed to have a sign indicating Resident #89 required EBP. A caddy on the door was observed to contain PPE supplies, including disposable gowns. LVN C was observed administering insulin to Resident #89 without donning a disposable gown upon entry to the room. LVN C stated Resident #89 was on EBP due to the presence of the foley catheter, and she should have worn a gown before administering the insulin. She said she forgot because was overthinking the observation. She said the risk to residents of not wearing PPE as required was the spread of infection. In an interview on 4/10/2026, ADON E said she is also the Infection Preventionist for the facility. She said LVN C should have worn PPE when administering insulin to Resident #89, and the risk was the spread of infection. In an interview on 4/10/2026 at 10:00 AM, the DON said the facility policy was to don PPE before providing care to residents on EBP. She said the failure to wear PPE could lead to infection. Record review of the facility policy titled Enhanced Barrier Precautions dated 4/11/2025, reflected the following: .b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room .