STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675071	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yorktown Nursing and Rehabilitation Center	670 W Fourth St Yorktown, TX 78164

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure assessments accurately reflected the resident's status for 3 of 16 residents (Residents #6, #28 and #34) reviewed for resident assessments. 1.The Facility failed to ensure Resident #6's active diagnosis of depression and her number of falls between assessments was accurately reflected on her quarterly MDS assessment, dated 01/12/2026. 2. The facility failed to ensure Resident #28's oxygen use was accurately reflected on her Significant Change MDS assessment, dated 01/16/2026. 3. The facility failed to ensure Resident #34's active diagnosis of dysphagia was accurately reflected on his quarterly MDS assessment, dated 12/29/2025 These deficient practices could place residents at risk of missed or inaccurate care. The findings include: Record review of Resident #6's electronic face sheet dated 02/17/2026 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: pressure ulcer of sacral region (lower part of the spine), unstageable (depth of the ulcer cannot be determined due to the presence of necrotic tissue or eschar requiring specialized care and management), neuromuscular dysfunction of bladder (condition where the normal communication between the bladder and the nervous system is disrupted, leading to bladder control issues such as incontinence), urinary tract infection (infection in any part of the urinary system which can cause pain and burning with urination), cerebral infarction (medical condition occurs when blood flow to a part of the brain is obstructed which leads to the death of brain cells due to lack of oxygen and essential nutrients), aphasia (language disorder that affects a person's ability to speak, understand, read, or write due to brain damage), anxiety (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to rapid cell death and potentially permanent neurological impairment), dysphagia (difficulty swallowing) 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 #6's quarterly MDS assessment dated [DATE] reflected that she was not a candidate for a BIMS which signified her cognitive status was severely impaired. She was dependent on staff for her ADLS. She did not have a diagnosis of depression coded and she was noted to have 1 fall from her last MDS assessment to the present. She had an indwelling urinary catheter and a colostomy. Record review of Resident #6's comprehensive person-centered care plan dated 02/17/2026 reflected Focus, requires antidepressant medication r/t DX of depression, Interventions/Tasks, give antidepressant medications ordered by the physician. Monitor/document side effects and effectiveness, Focus, is at risk for falls r/t unaware of safety needs dated)1/14/2026. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's Active Orders as of: 02/17/2026 reflected Fluoxetine (antidepressant) HCL oral solution, give 10 ml via G-Tube one time a day for depressive disorder, start date 09/24/2025. Record review of Resident #6's Psychological Services Progress Note dated 12/20/2025 reflected she was being seen for Major depressive disorder, Mood: Depressed, Anxious. Record review of Resident #6's FRA dated 02/15/2026 reflected she was assessed to be high risk for falls. Record review of the facility's accident and incidents list reflected Resident #6 had falls on 11/26/2025 and 12/09/2025 after her quarterly assessment dated [DATE] and before her quarterly assessment dated [DATE]. Observation on 02/17/2026 at 10:00 am revealed Resident #6 laying in a low bed in her room. She was positioned on an air mattress, had wedges for support behind her back, her feet were elevated, and she had a fall mat on the floor on each side of her bed. Her urinary catheter drainage bag was covered which rested in a basin by her bed. She was not interview able. 2. 3.Record review of Resident #34's electronic face sheet dated 02/18/2026 reflected he was an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), malaise (general feeling of discomfort, illness, or uneasiness), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs) and major depressive disorder (persistently low mood, or decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy and poor concentration). Record review of Resident #34's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood by others He scored 14 of 15 on his BIMS which signified his cognitive status was intact. He required moderate assistance with his ADLs. Dysphagia was not noted as an active diagnosis. He was noted to be on a mechanically altered diet while a resident. Record review of Resident #34's comprehensive person-centered care plan dated 05/19/2025 reflected Focus, Nutrition, at nutritional risk related to gastro esophageal reflux disease (happens when stomach acid flows up int the esophagus, and causes heartburn, intervention diet as ordered regular, mechanical soft texture with thin liquid consistency. Record review of Resident #34's Occupational Therapy Evaluation and Plan of Treatment dated 05/12/2026-07/06/2025 reflected Hx/complexities-PMHx: Esophageal structure s/p dilatation (an esophageal stricture is a narrowing of your esophagus. It can make swallowing become increasingly difficult. Record review of Resident #34's Active Orders as of: 02/18/2026 reflected regular diet, mechanical soft texture, regular consistency, start dated 07/17/2025. Observation on 02/17/2026 at 12:30 pm of Resident #34 revealed he was eating in the lunchroom, and his tray had a regular diet and his baked chicken thigh was of mechanically soft texture. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 02/17/2026 at 12:35 pm, Resident #34's lunch ticket reflected Regular, mechanical soft, thin liquids. During an interview on 02/17/2026 at 12:37 pm, Resident #34 stated his food was ground because it was easier for him to eat and swallow. During an interview on 02/20/2026 at 08:31 am, the DON stated MDS accuracy was important because the information was related to the resident's care and what they required. She stated inaccurate MDS assessments could result in missed or inaccurate care. During an interview on 02/20/2026 at 09:42, the MDS Coordinator stated she was not aware of the missed fall for Resident #6 or her depression diagnosis having been missed. She did not say why it was missing. She stated she did not have evidence of Resident #34's dysphagia as being an active diagnosis even though he had the diagnosis and was on a mechanically altered diet. During an interview on 02/20/2026 at 10:45 am with the ADM, she stated she was responsible for the MDS's and stated the accuracy was important related to the care needed by the resident. The ADM said residents' care could be missed or not communicated if the MDS was inaccurate. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, dated October 2025 reflected The RAI process has multiple regulatory requirements. Federal regulation required the assessment accurately reflects the resident's status. Record review of Resident #28's face sheet dated 02/18/2026, revealed Resident #28 was admitted to the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease, unspecified (a progressive, incurable, yet treatable lung disease that obstructs airflow and makes breathing difficult). Record review of Resident #28's Significant Change MDS assessment, dated 01/16/2026 Section O Special Treatments, Procedures, and Programs revealed C1 Oxygen Therapy was not coded for Resident #28's oxygen use while a resident. Record review of Resident #28's care plan, revision date of 02/17/2026, revealed Resident #28 had a focus of The resident has Asthma and interventions/task of Give nebulizer treatments and oxygen therapy as ordered. Record review of Resident #28's physician order summary dated, 02/18/2026, read, O2 via nasal cannula at 2L/min for shortness of breath/O2>89 with an order date of 01/09/2026. Record review of Resident #28's O2 Sats Summary dated, 02/19/2026, read, 01/13/2026 06:52 96% Oxygen via Nasal Cannula, 01/14/2026 08:26 99% Oxygen via Nasal Cannula, 01/15/2026 08:41 98% Oxygen via Nasal Cannula, 01/16/2026 08:03 97% Oxygen via Nasal Cannula. Observation and interview on 02/17/2026 at 11:12 a.m. revealed Resident #28 sitting in recliner wearing a nasal cannula with the oxygen concentrator set at 3.5. LPM Resident #28 stated she did not know what the oxygen concentrator was supposed to be set at and she would like to go home. However, she said she was passing out at home. Observation on 02/18/2026 at 9:12 a.m. revealed Resident #28 lying in her bed talking on the phone (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and wearing oxygen cannula. During an interview on 02/18/2026 at 9:25 a.m. LVN D stated Resident #28 was supposed to have her oxygen concentrator set at 2 liters continuously. Observation and interview on 02/19/2026 at 4:43 p.m., the MDS Coordinator stated she did not believe she coded Resident #28 for oxygen because there was no order for the oxygen use at the time of the MDS review and she further stated she had reviewed it and resident was receiving oxygen PRN, but did not believe during the look back period that the resident was using oxygen. The MDS Coordinator stated she reviewed Resident #28's MAR/TAR to see what the nurse had administered but it was not documented. The MDS Coordinator stated the nurses had not been checking off on the MAR for oxygen. The MDS Coordinator stated usually the MAR would tell the nurses to check the O2 sats and the nurses would document if they had to administer oxygen or not. The MDS Coordinator was observed reviewing Resident #28's O2 SATS summary in the Vitals section of Resident #28's EMR and stated the nurses had documented Resident #28 had been receiving oxygen by nasal cannula however she did not typically review the resident vitals when completing the MDS assessments. The MDS Coordinator stated the MDS Assessment coding was to show an accurate picture of the resident and care being provided. The MDS Coordinator stated that when the MDS Assessment was not coded properly it could affect the reimbursement for the care of the residents but did not have a direct effect to the care of the residents. During an interview on 02/19/2026 at 5:18 p.m., the RCN stated she had spoken to the MDS Coordinator and the MDS Coordinator said it was an oversight when she miscoded the oxygen use for Resident #28. The RCN stated the MDS Coordinator was new to the job. The RCN stated oxygen use while a resident should have been coded on the MDS for Resident #28. The RCN stated the MDS Coordinator could have seen in physician orders had Resident #28 had oxygen orders. The RCN stated when completing the MDS assessment they wouldn't necessarily look at the vitals because for the MDS the orders were where they would look. The RCN stated the MDS Coordinator was responsible for the coding accuracy of the MDS assessments. During an interview on 02/20/2026 at 9:16 a.m., the DON stated the MDS assessment was supposed to reflect the resident. The DON further stated money could be taken back if it was not coded properly. The DON stated the MDS Coordinator she believed was responsible for ensuring the MDS Assessments were properly coded, however that was only her 5th day working at the facility. During an interview on 02/20/2026 at 11:30 a.m., the Administrator stated the MDS coordinator was responsible for the coding of the MDS assessment and further stated it could affect the claiming rate or reimbursement for the resident's care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 2 of 7 residents (Residents #6 and#10) reviewed for infection control. 1. The facility failed to ensure CNA B took off her soiled gloves, sanitized her hands, and put on clean gloves prior to placing a clean brief on Resident #6 during catheter care. 2.The facility failed to ensure the ADON took off and replaced her gown after leaving the room to get more gloves when she performed wound care for Resident #6 who was on EBP. 3. The facility to ensure Resident #10 was on EBP by not having PPE outside his door and a sign on his door when he had a diabetic ulcer which required a dressing. These deficient practices could place residents at risk of cross contamination and infections.The findings included: 1. Record review of Resident #6's electronic face sheet dated 02/17/2026 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: pressure ulcer of sacral region (lower part of the spine), unstageable (depth of the ulcer cannot be determined due to the presence of necrotic tissue or eschar requiring specialized care and management), neuromuscular dysfunction of bladder (condition where the normal communication between the bladder and the nervous system is disrupted, leading to bladder control issues such as incontinence), urinary tract infection (infection in any part of the urinary system which can cause pain and burning with urination), cerebral infarction (medical condition occurs when blood flow to a part of the brain is obstructed which leads to the death of brain cells due to lack of oxygen and essential nutrients), aphasia (language disorder that affects a person's ability to speak, understand, read, or write due to brain damage), anxiety (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to rapid cell death and potentially permanent neurological impairment), dysphagia (difficulty swallowing) 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 #6's quarterly MDS assessment dated [DATE] reflected that she was not a candidate for a BIMS which signified her cognitive status was severely impaired. She was dependent on staff for her ADLS. She had an indwelling urinary catheter and a colostomy. She was noted to have a Stage 4 pressure sore (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). Record review of Resident #6's comprehensive person-centered care plan dated 05/19/2025 reflected Focus, alteration in elimination of bowel and bladder, indwelling urinary catheter and colostomy, Interventions/Tasks, indwelling catheter care every shift and as needed. Further review, dated 10/29/2025, Focus, actual pressure ulcer, Interventions/Tasks, treatments as ordered, Focus, resident is on enhanced barrier precautions (dated 02/17/2026), Gloves and gown should be donned if any of the following activities occur, wound care. Record review of Resident #6's Active Orders as of: 02/17/2026 reflected Enhanced barrier precautions, r/t peg tube, urinary catheter and wound every shift, start date 02/17/2026. Wound care: stage 4 pressure injury to sacrum-cleanse with wound cleanser, apply promogran prisma (collagen matrix wound dressing) skin prep surrounding tissue or peri wound apply border dressing, start date 12/25/2025. Observation on 02/18/2026 at 2:48 pm of CNA B performing catheter care for Resident #6, revealed she cross contaminated the field when she took off the resident's dirty brief and applied a clean brief and did not change her gloves and sanitize her hands. During an interview on 02/18/2026 at 2:55 pm, CNA B stated she forgot and then realized she had not removed her soiled gloves, sanitized her hands, or then put on Resident #6's clean brief. She stated she had infection control training, and she knew her actions could cause transmission of bacteria and could cause infection. Observation on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/20/2026 at 09:00 am of the ADON performing wound care for Resident #6 revealed Resident #6 had an EBP sign outside her room by the door and a 3 drawered bin filled with PPE. The ADON put on a gown, sanitized her hands, put on gloves and proceeded to the room where the wound care supplies were waiting on a cleaned bedside table. She proceeded to perform wound care as ordered. During the procedure, the ADON stated she needed more gloves which were on the treatment cart outside the room in the hallway. She stopped what she was doing, removed her gloves and went to the door, left the room and retrieved more gloves from the treatment cart without changing her gown prior to returning to the room. She completed the wound care. During an interview on 02/20/2026 at 09:30 am, the ADON stated she should have changed her gown when she left the room because Resident #6 was on EBP. She stated in not changing her gown, cross contamination could occur from outside the room and be brought in the room. 3.Record review of Resident #10's electronic face sheet dated 02/20/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: unspecified dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), chronic obstructive pulmonary disease (certain types of irreversible lung and airway damage that block the airways and make it hard to breathe), major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems.), and type 2 diabetes mellitus (chronic condition characterized by insulin resistance and high blood sugar levels, often manageable through lifestyle changes and medication). Record review of Resident #10's quarterly MDS assessment dated [DATE] reflected he was understood by others and could usually understand others. He scored 04 of 15 on his BIMS which signified his cognitive status was severely impaired. He required moderate to extensive assistance with his ADLs. He was noted to have a diabetic foot ulcer. He had a pressure reducing device for bed and application of dressings to feet with or without topical medication. Record review of Resident #10's comprehensive person-centered care plan dated 12/17/2026 reflected Focus, has a diabetic ulcer r/t diabetes on right heel, Interventions/Tasks, treat wound as facility protocol. Record review of Resident #10's Weekly-Ulcer Assessment dated 02/12/2026 reflected location of area, right heel, type of ulcer, diabetic, area resolved, no, 1.40 cm x 1.40 cm x 1.96 cm. Record review of Resident #10's Active Orders as of: 02/20/2026 reflected Clean Rt heel with wound cleanser apply Promogran Prisma (collagen wound dressing), then apply Betadine (povidone iodine solution) moistened gauze and wrap with kerlix. Every other day and prn, start date 02/17/2026. Observation on 02/20/2026 at 10:00 am revealed Resident #10 did not have a sign outside his door or a bin with PPE. Observation of the ADON performing woundcare treatment for Resident #10 revealed she only sanitized hands, put on clean gloves and did not wear a gown. During an interview on 02/20/2026 at 10:30 am, the ADON stated she did not know why Resident #10 had not been placed on EBP since he had an open wound which required a dressing. During an interview on 02/20/2026 at 10:43 am, the DON stated she was not aware Resident #10 was not on EBP, and his wound was contained. She stated CNA B should have changed her gloves and sanitized her hands when she removed the soiled brief and applied the clean brief to Resident #6. She stated CNA B was trained in infection control. She stated when the ADON left Resident #6's room to get more gloves, she needed to change out her PPE and come in with clean PPE, not wear the same PPE she had on in the resident's room to prevent spreading infection. During an interview on 02/20/2026 at 10:45 am, the ADM stated Resident #10 had a chronic wound and after she reviewed the facility policy and procedure stated she thought Resident #10 needed to be on EBP to prevent any spread of infection. She stated staff needed to follow the facility's policies and procedures for infection control. Record review of CNA B's Proficiency Audit dated 07/01/2025 reflected she satisfactorily completed Infection Control Awareness competency. Record review of CNA B's training report dated 07/19/2025 reflected she satisfactorily completed Infection Control training. Record review of the facility's policy and procedure titled Enhanced Barrier Precautions, dated 04/01/2024 reflected has a chronic wound or indwelling medical device, without secretions, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use EBP, yes. Record review of the facility's policy and procedure titled Fundamentals of Infection Control Precautions dated 2018 reflected A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions, hand hygiene, after handling soiled or used linens, gowns are removed before the personnel leave the resident's environment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. for 1 resident (Resident #10) of 2 residents observed for wound care. The facility failed to ensure the ADON followed physician orders when she performed Resident #10's diabetic ulcer (slow-healing open sore or wound, most commonly on the feet, that occurs as a complication of diabetes due to nerve damage and poor blood circulation) treatment. This deficient practice could result in a lack or delay in wound healing.The findings included: Record review of Resident #10's electronic face sheet dated 02/20/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: unspecified dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), chronic obstructive pulmonary disease (certain types of irreversible lung and airway damage that block the airways and make it hard to breathe), major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems.), and type 2 diabetes mellitus (chronic condition characterized by insulin resistance and high blood sugar levels, often manageable through lifestyle changes and medication). Record review of Resident #10's quarterly MDS assessment dated [DATE] reflected he was understood by others and could usually understand others. He scored 4 of 15 on his BIMS which signified his cognitive status was severely impaired. He required moderate to extensive assistance with his ADLs. He was noted to have a diabetic foot ulcer. He had a pressure reducing device for the bed and received the application of dressings to his feet with or without topical medication. Record review of Resident #10's comprehensive person-centered care plan dated 12/17/2026 reflected Focus, has a diabetic ulcer r/t diabetes on right heel, Interventions/Tasks, treat wound as facility protocol. Record review of Resident #10's Weekly-Ulcer Assessment dated 02/12/2026 reflected location of area, right heel, type of ulcer, diabetic, area resolved, no, 1.40 cm x 1.40 cm x 1.96 cm. Record review of Resident #10's Active Orders as of: 02/20/2026 reflected Clean Rt heel with wound cleanser apply Promogran Prisma (collagen wound dressing), then apply Betadine (povidone iodine solution) moistened gauze and wrap with kerlix. Every other day and prn, start date 02/17/2026. Observation on 02/20/2026 at 11:00 am of the ADON performing treatment for Resident #10 revealed the ADON sanitized her hands and wore gloves when she entered the room. She removed the old kerlix and dressing, cleaned the right heel wound with wound cleanser, applied the collagen wound dressing and rewrapped the foot with kerlix without using the moistened betadine gauze which was in a cup on the clean bedside table with the other treatment supplies. During an interview on 02/20/2026 at 11:30 am, the ADON stated she did not apply the betadine moistened gauze as was ordered. She stated she did not know why she did not use the betadine moistened gauze as ordered. She stated she was trained to follow physician orders and if an order was not followed delayed healing or complications could occur to the wound. During an interview on 02/20/2026 at 08:31 am, the DON stated the ADON missed applying the betadine to Resident #10's decubitus ulcer on his right heel. She stated she was accountable for the nursing care at the facility. She stated the ADON needed to follow physician orders or the wound could have delayed healing. During an interview on 02/20/2026 at 10:45 am with the ADM, she stated the nurses needed to follow physician orders or care could be compromised. Upon request on 02/20/2026 at 11:40 am, the DON and the ADM did not provide a facility policy and procedure on quality of care of following physician orders or pressure sores before exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible; for 1 (room [ROOM NUMBER]) of 1 room on hallway with 6 residents residing on hallway reviewed for environment, in that:The facility failed to secure room [ROOM NUMBER] that was being used as storage with 2 unlocked housekeeping carts were not locked that contained potentially unsafe cleaning chemicals.This deficient practice could result in residents coming in contact with potentially unsafe cleaning chemicals.The findings included: Observation on 02/17/2026 at 11:20 a.m. revealed room [ROOM NUMBER] with no lock to the door and it was being used as storage for housekeeping floor cleaning machines along with 2 housekeeping carts in the room. The housekeeping carts had refills for the antibacterial hand foam sitting on the bottom of the carts and were not locked. Housekeeping cart #1 and cart #2 each had a 2-liter antibacterial hand foam bottle with approximately 3/4 of the bottle remaining sitting on the bottom shelf of the cart. Housekeeping cart #1 had the key in the door of the cart and was unlocked with the following chemicals in the cart: 1. Bold Power hard surface & glass cleaner 24-ounce bottle with approximately 11 ounces left warning to keep out of reach of children and may cause sensitivity or irritation to eyes, ears and lungs. 2. Biowaste Degrader 18-ounce bottle with approximately 12 ounces in the bottle warning on side of bottle may cause sensitivity or irritation to the eyes, ears and lungs. toilet bowl cleanser. Housekeeping cart #2 had no key with the door unlocked with the following chemicals in the cart: 1. Biowaste Degrader, 18-ounce bottle of cleaner disinfectant approximately 17 ounces in the spray bottle, Danger Precautionary STATEMENTS Hazards to Humans and Domestic Animals Danger keep out of reach of children. 2. Oder Neutralizer spray 18 ounces bottle warning on side of bottle may cause sensitivity or irritation to the eyes, ears and lungs. 3. Cream Cleanser 40 0unce bottle with approximately about 1/4 of bottle left. Warning notice on bottle Danger harmful if swallowed. Cause skin irritation. Causes serious eye damage. During interview and observation on 02/17/2026 at 11:46 a.m., the Housekeeping Supervisor stated housekeeping was given the room to put their stuff in, but the carts were supposed to be locked. The Housekeeping Supervisor was observed locking the carts and taking the key. The Housekeeping Supervisor stated they were refilling the soap and the antibacterial hand foam should have been locked up and removed from the carts. The Housekeeping Supervisor stated a resident could be at risk of coming into the room, and they might open it up and drink it or spray their eyes. The Housekeeping Supervisor stated a resident could get sick if they did that. The Housekeeping Supervisor stated the housekeeper and herself were responsible for making sure the carts were locked. The Housekeeping Supervisor further stated the room should have been locked. The Housekeeping Supervisor was observed taking the antibacterial hand foam and locking it in the housekeeping closet on another hall. During an interview on 02/20/2026 at 9:27 a.m., the DON stated by leaving housekeeping carts unattended and unlocked it could put residents at risk of being able to get the chemicals. The DON stated cleaning chemicals should be locked up and that the housekeepers were responsible for ensuring the carts were secure. During an interview on 02/20/2026 at 11:26 a.m., the Administrator stated housekeeping carts should have been stored locked, and all chemicals should not be left out opened on the cart and not locked up when not in view of a staff member. The Administrator stated that was so that residents could not access chemicals. The Administrator stated the potential effect to the residents could be the residents could ingest the chemicals or spill them. Review of the facility's policy, Daily Common Area Cleaning, dated 2021, read, It is the policy of this facility to maintain cleanliness in an orderly manner. The goal is to keep facilities clean and odor free, while providing the residents, their families, and staff with the safest environment possible and projecting a positive image. Housekeeping carts/chemicals must me locked when not within eyesight of a staff member.

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	675071	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yorktown Nursing and Rehabilitation Center	670 W Fourth St Yorktown, TX 78164

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences for 2 (Residents #28 and #36) of 4 residents reviewed for oxygen therapy. The facility failed to ensure oxygen therapy was delivered at the prescribed rate for Resident #28. 2. The facility failed to ensure the oxygen concentrator that delivered oxygen to Resident #36 had a clean filter. These deficient practices could place residents at risk of respiratory distress.The findings included: 2. Record review of Resident #36's electronic face sheet dated 02/18/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), acute bronchitis (inflammation of the bronchial tubes, often caused by viral infections leading to symptoms liked coughing, mucus production and chest discomfort), dysphagia (difficulty swallowing) and psychotic disorder (group of severe mental illnesses characterized by psychosis, which involves a loss of touch with reality). Record review of Resident #36's annual MDS assessment dated [DATE] reflected he could understand others and be understood by others. He scored 13 of 15 on his BIMS which indicated his cognitive status was intact. He required substantial assistance with his ADLs. He received oxygen therapy while he was a resident. Record review of Resident #36's comprehensive person-centered care plan dated 07/23/2025 reflected Focus, has chronic obstructive pulmonary disease .Interventions/Tasks, may use oxygen at 2L/min via nasal cannula every night shift. Record review of Resident #36's Active Orders as of: 02/18/2026 reflected May use oxygen at 2L/min via nasal canula every night shift related to chronic obstructive pulmonary disease, start dated 07/23/2026, clean oxygen concentrator filter weekly every Sunday, start dated 10/24/2024. Record review of Resident #36's TAR dated 02/01/2026-02/28/2026 reflected LVN A initialed on the TAR that the concentrator filter was cleaned on 02/15/2026. Observation on 02/17/2026 at 11:41 am, revealed Resident #36's oxygen concentrator's black foam was covered with a thick gray coat of dust and dirt. Observation on 02/18/2026 at 09:00 am, revealed Resident #36's oxygen concentrator's black foam filter was covered with a thick gray coat of dust and dirt. Observation on 02/19/2026 at 10:28 am, revealed Resident #36's oxygen concentrator's black foam filter was covered with a thick gray coat of dust and dirt. Observation on 02/20/2026 at 09:15 am with the DON revealed Resident #36's oxygen concentrator filter was coated with gray dust and dirt. During an interview on 02/20/2026 at 09:20 am, the DON stated oxygen concentrator filters needed to (continued on next page)

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Yorktown Nursing and Rehabilitation Center	670 W Fourth St Yorktown, TX 78164

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be cleaned and changed as needed because it could result in respiratory difficulty for the resident by not cleaning the oxygen he received. During an interview on 02/20/2026 at 10:34 am with LVN A, she stated she worked the night shift and initialed off on the oxygen tubing changes and the humidifier, but she did not remember to clean the oxygen filter. She stated it was all included, but she did not clean the oxygen filter on the concentrator. She stated she initialed off on it, but it was not done. She stated it was important for the oxygen filter to be clean otherwise respiratory compromise could happen. During an interview on 02/20/2026 at 10:45 am with the ADM, she stated the nurses needed to follow physician orders or care could be compromised. She stated it was important to follow guidelines and to clean the oxygen filters on the concentrators to prevent complications and respiratory distress. Record review of LVN A's Nurse Proficiency Audit dated 07/01/2025 reflected she satisfactorily completed Oxygen/Respiratory, administration and maintenance. Record review of the facility 5-Liter oxygen concentrator A5LC-1 Owner's Manual (undated) reflected Physical features, has an intake filter and a cabinet filter to prevent dust and particulate from entering the concentrator., cleaning the cabinet filter, remove the filter from the access door, wash the cabinet filter with water, and allow to completely dry, WARNING: DO NOT operate the concentrator without the filters installed, or if they are wet. Record review of the facility policy and procedure titled Oxygen Administration (undated) reflected The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring, responses, and safety precautions associated with it are performed by the nurse. 1. Record review of Resident #28's face sheet dated 02/18/2026, revealed Resident #28 was admitted to the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease, unspecified (a progressive, incurable, yet treatable lung disease that obstructs airflow and makes breathing difficult). Record review of Resident #28's Significant Change MDS assessment, dated 01/16/2026, revealed the residents' BIMS score was 14 indicating intact cognition. Record review of Resident #28's physician order summary dated, 02/18/2026, read, O2 via nasal cannula at 2L/min for shortness of breath/O2>89 with an order date of 01/09/2026. Record review of Resident #28's care plan, revised 02/17/2026, revealed Resident #28 had a focus of The resident has Asthma and interventions/task of Give nebulizer treatments and oxygen therapy as ordered. Observation and interview on 02/17/2026 at 11:12 a.m. revealed Resident #28 was sitting in a recliner wearing a nasal cannula attached to an oxygen concentrator set between 3 and 4 LPM. Resident #28 stated she did not know what the oxygen concentrator was supposed to be set at. Observation on 02/18/2026 at 9:12 a.m. revealed Resident #28 was lying in her bed talking on the phone and wearing an oxygen cannula with the oxygen concentrator set between 3 and 4 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 02/18/2026 at 9:25 a.m., LVN D stated as she entered Resident #28's room Resident #28 was supposed to have her oxygen concentrator set at 2 liters per minute continuously. LVN D stated she had not touched the oxygen concentrator and as she approached the concentrator LVN D stated Why is it set almost at 4 liters per minute? LVN D was then observed adjusting Resident #28's oxygen concentrator to 2 LPM. LVN D stated that the oxygen concentrator could not be set higher than 2 liters per minute without an order. LVN D stated they should follow the physician orders for oxygen settings due to it could put residents at risk of over oxygenation. LVN D further stated it could cause the residents to become disoriented. During an interview on 02/20/2026 at 9:16 a.m., the DON stated the nurse over Resident #28 was responsible for ensuring the oxygen concentrator was at the proper setting. The DON further stated Resident #28 had COPD and by the concentrator not being at the proper setting it could cause further respiratory problems. During an interview on 02/20/2026 at 11:30 a.m., the Administrator stated that the nurse was responsible for ensuring the proper setting of the concentrator. The Administrator stated the oxygen not being set at the proper setting could affect the residents in getting the oxygen needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication cart (Station II Medication Cart) reviewed.The facility failed to remove an expired tube of Medi-honey (wound gel, offers protection against invading bacteria, is effective against a wide variety of bacteria, cleans the wound, rapidly lifting dead tissue, reduces wound odor and provides a moist environment for healing) with an expiration date, of 07/01/2025 from Station II's II's medication cart.This deficient practice could result in decreased effectiveness of medications.The findings were: Observation on 02/18/2026 at 12:37 PM of Station II medication cart with LVN C revealed a small tube of Medi-honey with an expiration date of 07/01/2025. During an interview on 02/19/2026 at 12:40 pm, LVN C stated the Medi-honey was house stock and used for residents. During an interview on 02/19/2026 at 1:00 pm, LVN C stated expired substances should not be left on the medication cart and should be removed because they could be less potent after they expire. She stated nurses were responsible for checking the cart and removing expired medications. During an interview on 02/20/2026 at 10:42 am, the DON stated she checked Station I's medication cart, but did not get to Station II's. She stated the pharmacist checked the medication carts quarterly, and the nurses check the carts as needed and when they used the medication. She stated the expired Medi-honey was missed and needed to be discarded and replaced. She stated a medication could be less effective if used after the expiration date. During an interview on 02/20/2026 at 10:45 am with the ADM, she stated the nurses needed to check the carts and medication rooms for expired medications continually, because medications could be less effective after they expire. Record review of the facility's policy and procedure titled Expired Medications and Medications with Shortened Expiration Dates dated 2025 reflected Ensure all medications in the facility are rotated and/or reviewed on a consistent basis to prevent having expired medications in the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete, accurate, readily accessible and systematically organized for 2 (Residents #28 and #36) of 19 residents reviewed for clinical records. The facility failed to ensure Resident #28's MAR/TAR reflected her order for receiving oxygen at 2 LPM via nasal cannula for nurses to monitor for proper setting. 2. The facility failed to ensure LVN A accurately documented in Resident #36's TAR that his oxygen concentrator filter was not cleaned when she initialed that it was. These deficient practices could result in inaccurate clinical records and decreased continuity of care.The findings included: 2. Record review of Resident #36's electronic face sheet dated 02/18/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), acute bronchitis (inflammation of the bronchial tubes, often caused by viral infections leading to symptoms liked coughing, mucus production and chest discomfort), dysphagia (difficulty swallowing) and psychotic disorder (group of severe mental illnesses characterized by psychosis, which involves a loss of touch with reality). Record review of Resident #36's annual MDS assessment dated [DATE] reflected he could understand others and be understood by others. He scored 13 of 15 on his BIMS which indicated his cognitive status was intact. He required substantial assistance with his ADLs. He received oxygen therapy while he was a resident. Record review of Resident #36's comprehensive person-centered care plan dated 07/23/2025 reflected Focus, has chronic obstructive pulmonary disease, Interventions/Tasks, may use oxygen at 2L/min via nasal cannula every night shift. Record review of Resident #36's Active Orders as of: 02/18/2026 reflected May use oxygen at 2L/min via nasal canula every night shift related to chronic obstructive pulmonary disease, start dated 07/23/2026, clean oxygen concentrator filter weekly every Sunday, start dated 10/24/2024. Record review of Resident #36's TAR dated 02/01/2026-02/28/2026 reflected LVN A initialed on the TAR that the concentrator filter was cleaned on 02/15/2026. Observation on 02/17/2026 at 11:41 am, Resident #36's oxygen concentrator's black foam was covered with a thick gray coat of dust and dirt. Observation on 02/18/2026 at 09:00 am, Resident #36's oxygen concentrator's black foam filter was covered with a thick gray coat of dust and dirt. Observation on 02/19/2026 at 10:28 am, Resident #36's oxygen concentrator's black foam filter was covered with a thick gray coat of dust and dirt. Observation on 02/20/2026 at 09:15 am with the DON revealed Resident #36's oxygen concentrator filter was coated with gray dust and dirt. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/2026 at 10:34 am with LVN A, she stated she worked the night shift and initialed off on the oxygen tubing changes and the humidifier, but she did not remember the oxygen filter. She stated it was all included, but she did not clean the oxygen filter on the concentrator. She stated she initialed it off, but it was not done. She stated her documentation was not accurate about the filter being cleaned which misrepresented care was provided. During an interview on 02/20/2026 at 10:40 am, the DON stated LVN A should not have initialed off that Resident f#36's oxygen filter was cleaned when it was not. She stated the medical record was a legal document and the accounts needed to be accurate. During an interview on 02/20/2026 at 10:45 am with the ADM, she stated the nurses needed to follow physician orders or care could be compromised. She stated it was important for proper documentation to occur in the medical record to accurately reflect the care provided. Record review of LVN A's Nurse Proficiency Audit dated 07/01/2025 reflected she satisfactorily completed Documentation. Record review of the facility policy and procedure titled Oxygen Administration (undated) reflected The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring, responses, and safety precautions associated with it are performed by the nurse. Record review of the facility policy and procedure titled Documentation (undated) reflected The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. Record review of Resident #28's face sheet dated 02/18/2026, revealed Resident #28 was admitted to the facility on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease, unspecified (a progressive, incurable, yet treatable lung disease that obstructs airflow and makes breathing difficult). Record review of Resident #28's Significant Change MDS assessment, dated 01/16/2026, revealed the residents' BIMS score 14 for intact cognition with oxygen use not coded as being used as a resident in Section O. Record review of Resident #28's care plan, revision date of 02/17/2026, revealed Resident #28 had a focus of The resident has Asthma and interventions/task of Give nebulizer treatments and oxygen therapy as ordered. Record review of Resident #28's physician order summary dated, 02/18/2026, read, O2 via nasal cannula at 2L/min for shortness of breath/O2>89 with an order date of 01/09/2026. Record review of Resident #28's January MAR/TAR, dated 02/20/2026, revealed Resident #28's order was not present for nurses to monitor setting of the oxygen concentrator and the nasal cannula placement. Record review of Resident #28' February MAR/TAR, dated 02/20/2026, revealed Resident #28's physician order for oxygen use was added to the MAR/TAR on 02/19/2026, read, Oxygen LPM: 2L Via: Nasal cannula every shift relate to Chronic Obstructive Pulmonary disease, Unspecified Assess (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	O2 Sat. Observation and interview on 02/17/2026 at 11:12 a.m. revealed Resident #28 was sitting in recliner wearing a nasal cannula with oxygen concentrator set between 3 and 4 LPM. Resident #28 stated she did not know what the oxygen concentrator was supposed to be set at. Observation on 02/18/2026 at 9:12 a.m. revealed Resident #28 was lying in her bed talking on the phone and wearing oxygen cannula attached to oxygen concentrator set between 3 and 4 LPM. During an interview and observation on 02/18/2026 at 9:25 a.m., LVN D stated as she entered Resident #28's room that Resident #28 was supposed to have her oxygen concentrator set at 2 liters per minute continuously. LVN D stated she had not touched the oxygen concentrator and as she approached the concentrator LVN D stated Why is it set almost at 4 liters per minute? LVN D was then observed adjusting Resident #28's oxygen concentrator to 2 liters per minute. LVN D stated that the oxygen concentrator could not be set higher than 2 liters per minute without an order. LVN D stated they should follow the physician orders for oxygen settings due to it could put residents at risk of over oxygenation. LVN D further stated it could cause the residents to become disoriented. During an interview on 02/20/2026 at 1:24 p.m., the MDS Coordinator stated Resident #28's oxygen order was not on the MAR/TAR when she had completed the Significant Change MDS assessment dated [DATE]. The MDS Coordinator stated she used the MAR/TAR when coding the MDS assessments and she did not see oxygen on the MAR/TAR for Resident #28's Significant Change MDS assessment. The MDS Coordinator stated she had reviewed the MAR/TAR to see what the nurse had administered but it was not documented. The MDS Coordinator further stated that the nurses had not been checking off on the MAR. The MDS Coordinator stated usually the MAR would say check the O2 sats and the nurses would document if they had to administer oxygen or not. During an interview on 02/20/2026 at 1:29 p.m. the DON stated oxygen use should be on the TAR. The DON further stated it would trigger the nurse to make sure the oxygen concentrator setting was correct, ensure everything was in place, tubing was good and this should have been done every shift. The DON stated oxygen use should have been on the TAR when the physician order was written. The DON stated by not putting the oxygen use on the TAR it could be set at a higher level and the level would be unknown causing a potential when unchecked of making Resident #28 sicker because she had COPD. The DON stated the nurse who put in the order initially should have put on the TAR. Record review of the facility's policy titled Medication Orders, dated v3-2025, read, Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by licensed nurses or pharmacists and confirmed in writing by the prescriber within five (5) business days or per the specific States regulations if differs or is more stringent. Procedure: Elements of the medication order. 1. Documentation of the medication order. A. Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the current physician order sheet, the telephone order sheet, if it is a verbal order, and the Medication Administration Record (MAR). B. Transcribe or enter electronically newly prescribed medications on the MAR or treatment record.