STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents right to be free from abuse and neglect for one (Resident #4) of 10 residents reviewed for abuse and neglect. The facility failed to protect Resident #4 (female resident) right to feel safe when she told the facility that she did not feel safe sharing a room with Resident #13 (male resident). Resident # 4 told the facility that she did not want to be in a room with Resident #13. Resident #4 no longer remembered her relationship with Resident #13. The facility failed to address Resident #4's concerns and allowed her to continue to reside in the same room as Resident # 4. An Immediate Jeopardy (IJ) was identified on 05/07/25. The IJ template was provided to the facility on [DATE] at 1:43 PM. While the Immediate Jeopardy was removed on 05/09/25, the facility remained out of compliance at a scope of pattern and a severity level of no harm that is not Immediate Jeopardy due to facility continuation of in-servicing and monitoring the plan of removal. This failure could place residents at risk for not having measures in place to protect them from serious harm and mental anguish. Findings included: Record review of Resident #4's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. She had the diagnoses of dementia (loss of cognition), anxiety disorder (sudden feelings of intense worry), major depressive disorder (persistent feelings of sadness or loss of interest), bi-polar disorder (periodically intense emotional states), schizophrenia (mental health condition that affects how people think, feel and behave) and a BIMS score of 8 (moderately impaired cognition). Record review of Resident #4's care plans revised 11/17/23 revealed there was no care plan area for the resident's cohabitation and relationship with Resident #13. Further review reflected she had impaired cognitive function or thought process due to dementia, interventions included cue and reorient and supervise as needed, dated initiated 02/02/25. Further review revealed she identified as a trauma survivor with trauma category of: Serious illness, childhood trauma, neglect, psychological trauma, dated initiated 7/21/21, and interventions included ask for permission to enter resident's room . be conscious of resident position when in groups, activities, dining room to promote proper communication with others and feelings of safety . behavioral health consults as needed, psychiatrist or counselor . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. He had the diagnoses of dementia (loss of cognition), anxiety disorder (sudden feelings of intense worry), bi-polar disorder (periodic intense emotional states), psychotic disorder (episodes of disrupted thoughts and perceptions), and schizophrenia (mental health condition that affects how people think, feel and behave) and a BIMS score of 11 (moderately impaired cognition). Record review of Resident #13's care plan revised 10/23/23 revealed there was no care plan area for the resident's cohabitation and relationship with Resident #4. Further review reflected he had impaired cognitive function or impaired thought process due to confusion to time and a short-term memory deficit, dated initiated 09/20/18, interventions included engage in simple, structured activities, keep his routine constant, present just one thought, idea, question, or command at a time. Further review revealed he had a behavioral problem due to anxiety and had delusions including he believed he was a prisoner of war and yelled out to relieve stress, dated revised 12/19/21, interventions included .caregivers provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by, if reasonable, discuss behavior . explain/reinforce why behavior is inappropriate . Record review of Resident #4's census report revealed she moved in room [ROOM NUMBER] on 4/28/22. Record review of Resident #13's census report revealed he moved to room [ROOM NUMBER] on 01/19/23. Record review of Resident #4's progress notes reflected: Dated 04/14/25 at 6:45 AM by LVN A: .Resident stated to night shift staff, There's a man in my room! Staff attempted to redirect and inform her that he is her roommate and boyfriend [Resident #13]. Resident responded, I don't know him! Resident would not go back to her room. Resident repeatedly asked staff, How do I get out of here? Resident then sat on the couch, waiting for her ride. Resident stayed on the couch and slept. At this time, resident continuing to sleep on couch. Dated 04/14/25 at 9 AM by LVN A: Resident woke up @ 0830 (8:30am) on the couch and came to the nurse's station asking, How do I get out of here? Nurse redirected resident to her room. Resident remembered who her boyfriend was [Resident #13]. Resident came back to the nurse's station immediately after entering her room and again asked, How do I get out of here? Nurse redirected resident for a second time. Whenever resident would enter her room, she would immediately come back up to the hall to the nurse's station asking how to leave. Nurse able to redirect resident to eat breakfast. Notified DON, ADON, and MD. Resident placed on Q(every)15 min elopement monitoring. Dated 04/15/25 at 1:30 PM by LVN A: Resident has had no attempted elopement this shift. Resident did come to staff members multiple times this shift asking, How do I get out of here? Resident redirected successfully each time. Dated 04/16/25 at 12:35 PM by LVN A: Resident has had no attempted elopement this shift. Resident did come to staff members multiple times this shift asking, How do I get out of here? Resident redirected successfully each time. Resident has had continuous bouts of confusion and has had barely any appetite since being treated for UTI. N/O UA PCR to ensure that resident's UTI has fully been treated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dated 04/16/25 at 6:28 PM by LVN A reflected the urine PCR was collected and Resident #4 did not have any signs or symptoms of distress. Dated 04/17/25 at 7:45 AM by LVN A: When delivering breakfast tray to resident, resident asked CNA, 'How far away will you be?' CNA explained that she was passing breakfast trays on the hall. Resident explained, 'That creepy man over there keeps staring at me and I just wanted to know where you will be if I need you.' Resident was referring to her boyfriend [Resident #13]. Resident has had persistent confusion past normal baseline. Pending UA PCR results for f/u on previous UTI. Resident continuing Q15 min monitoring for elopement. Dated 04/17/25 at 8:10 AM by LVN A: Resident and her boyfriend, another resident, were ambulating up the hallway and they stopped so her boyfriend could use the bathroom. When boyfriend came back, resident yelled out to nurse's station, Where did my boyfriend go? Boyfriend looked back at her and said, It's me! Resident then stated, No you're not my boyfriend! Nurse reoriented resident successfully. Dated 04/17/25 at 12:10 PM by the Director of Resident Support Services: .Resident has been experiencing increased confusion and has expressed a desire to leave the facility. Nursing staff have been consistently redirecting her during these episodes . Dated 04/17/25 at 1:27 PM by LVN A reflected Resident #4 was assessed by behavioral health services regarding increased confusion, 15 minute checks were discontinued and medications adjusted. Dated 04/23/25 at 12:09 PM by LVN A: Resident confused and does not remember her boyfriend. Resident refusing to sit with boyfriend at lunch. Dated 04/23/25 at 8:12 PM by LVN B: .Resident very confused today and could not remember boyfriend and refused to be left in the same room with him. Dated 04/23/25 at 11:23 PM by the ADON: Upon start of shift, this resident was up in dining area sitting in a chair alone. Previous shift reported that she did not want to go into the room with her boyfriend. This nurse went to speak to this resident and assisted her to her room. No issues with assisting resident to bed. This nurse spoke with resident's boyfriend/roommate and asked that he give her some time and explained that she is just confused right now. Boyfriend/roommate verbalized understanding . Dated 04/24/25 at 12:45 PM by LVN A: During lunch, resident refused to sit with her boyfriend/roommate. Resident stating he is not her boyfriend and that he is weird. Resident ate with another resident while her boyfriend/roommate ate at a different table. Resident continues to exhibit increased confusion. Resident unable to find her room or the dining room without assistance from staff. Dated 05/05/25 at 9:25 PM by LVN B: Resident was exit seeking earlier today so we implemented 15 minute checks at 9:30pm. Record review of Resident #4's Q15 elopement monitoring, start dated 04/14/25-04/17/25 reflected Resident #4 was monitored every 15 minutes. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4 lab results revealed a UTI panel, dated collected 03/21/25 and reported 03/24/25, tested positive for Escherichia coli (bacteria). Further review revealed another UTI panel, dated collected 04/16/25 and reported 04/18/25, tested negative for Escherichia coli (bacteria) and positive for Staphyloccus spp (bacteria). Record review of Resident #4's physician's orders revealed the following orders: -Ciprofloxacin 500 mg, one tablet by mouth, for 10 days for a UTI, start dated 02/25/25 and end dated 04/04/25. -urine analysis PCR for follow up of previous UTI, dated 04/16/25. -Ciprofloxacin 500 mg, one tablet by mouth, for 7 days for a UTI, start dated 04/21/25 and end dated 04/28/25. In an interview and observation on 05/05/25 at 7:17 PM with Resident #4 and Resident #13 revealed she was sitting up in bed and stated she was doing well. Resident #13 entered the room and he stated that he lived with his girlfriend (Resident #4) and they were married. He stated to Resident #4 Tell her that we are married. Resident #4 looked at Resident #13 and did not reply. In an interview on 05/05/25 at 8:36 PM with MA S, she stated Resident #4 and Resident #13 were boyfriend and girlfriend and resided in the same room for years and the family was aware and they were happy together. She stated it was not a sexual relationship and had not seen the residents in the same bed for at least a year and especially with Resident #4's incontinence. She stated Resident #4 had dementia and recently had increased confusion of her surroundings and more frequent incontinence. She stated they were monitoring her frequently. In an interview on 05/06/25 at 9:14 AM with Resident #4, she stated she had a roommate who was male and she did not like it. She stated she had girlfriends and did not want a boyfriend because it made her feel uncomfortable because sometimes boyfriends were mean. She stated there was no physical or sexual contact between them, and she denied that Resident #13 harmed her in any way. She stated he liked to sit on her bed and look out the window. She stated she didn't like him and didn't want to spend time with him but was not sure why, when he was around her she felt pretty bad. She stated she felt safe at the facility. In an interview on 05/06/25 at 9:29 AM with Resident #4's responsible party revealed she had last seen Resident #4 about 2 months ago and spoke with her over the phone on 05/05/25 and was unaware that Resident #4 voiced any discomfort with her roommate, Resident #13. She stated that she spoke with staff about 10 days ago about Resident #4's advanced directives and there was no mention Resident #4 was uncomfortable with Resident #13. She stated Resident #4 had a cognitive decline in the last few months but she found it hard to believe that Resident #4 felt uncomfortable with Resident #13. In an interview on 05/06/25 at 11:48 AM with Resident #13 revealed he and Resident #4 broke up last week and they were just companions now and it was not a sexual relationship for at least a year. He stated he planned to discharge from the facility and had just purchased a helicopter. He stated he was a prisoner of war. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/06/25 at 10:16 AM with LVN A revealed Resident #4 and Resident #13 developed a friendship that developed into a relationship, and they eventually moved into the same room with the approval of both resident representatives. She stated Resident #4 recently had a cognitive decline and had two courses of antibiotics for a UTI and was frequently incontinent. She stated there were some days Resident #4 knew who Resident #13 was; and other days she did not know who he was. She stated that Resident #4 asked her why there was a random man in her room (Resident #13). She stated that Resident #4 would sit and waited for a ride in the lobby area and she was being monitored with 15 minute checks until the behavioral health services assessed her for a secure unit placement. She stated she remembered writing the progress notes and it was discussed in a morning meeting about possibly moving Resident #4 to a different room. She stated in the meeting it was determined if they moved her to a different room then Resident #13 would have still sought her out and if Resident #4 was placed on the secure unit, they would be able to ensure they were separated; Resident #4 had also displayed more exit seeking behaviors. She stated behavioral health services determined she was not at a high enough risk to be admitted to the secured unit and it had not been discussed again. She stated she did believe Resident #4 could have felt unsafe and Resident #13 was also upset that Resident #4 did not remember who he was. In an interview on 05/06/25 at 12:30 PM with the Director of Resident Support Services revealed Resident #4 had dementia, was confused and doesn't understand why she was at the facility, her last BIMS score was a 3 (severe cognitive impairment). She stated Resident #13 also had confusion and had a low BIMS score. She stated she spoke with Resident #4 on 05/05/25 and had not heard any concerns about Resident #13. She stated a resident who did not remember their significant other or started to call them creepy, refused to go into their room or refused to sit with each other at mealtimes was a cause of concern regarding consent and abuse and could cause a resident to physically lash out at the other roommate if they invaded their space. In an interview on 05/06/25 at 12:41 PM with the DON revealed Resident #4 had a significant change in her cognition a couple of weeks ago and was more confused, was not sure where she was and stated she wanted to leave, did not recognize nursing staff or Resident #13, they placed her on 15 minute checks and tested her for a UTI- it was positive and had to go through several rounds of antibiotics and had medications adjusted. She stated that she was not aware of the progress notes that used the words creepy or weird and only remembered they discussed Resident #4's general confusion. She stated if she had known she would be concerned with resident safety and would have intervened and temporarily moved her to ensure she felt safe, informed the Executive Director, and reevaluated any causes. She stated there was not an assessment for resident consent for relationships and there was not a policy regarding resident cohabitation or relationships and did not know if it would be something to be care planned. In an interview on 05/06/25 at 1:03 PM with the ADON revealed Resident #4 and Resident #13 had been roommates for years and it had been good for a while, they typically sat together for every meal. She stated that recently Resident #4 had a UTI and was confused about where she was and who Resident #13 was and she reoriented Resident #4 to her room and to Resident #13. She stated that there were times Resident #13 came to her and was concerned because Resident #4 did not recognize who he was and was refusing to go to their room, she told Resident #13 to give Resident #4 some time and explained Resident #4 was confused. She stated that in a morning meeting LVN A brought up possibly moving Residents #4 and #13 to a separate rooms but there were concerns that Resident #13 would go into whatever room they moved Resident #4 to. Interview revealed there was a discussion about possibly admitting Resident #4 to the secured unit . The ADON could not remember why a change was not made. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/06/25 at 2:35 PM with the Executive Director revealed he started working at the facility in April of 2024 and Resident #4 and Resident #14 were already established roommates and were alright, as far as he knew it was a companionship. He stated he knew that Resident #4 had confusion and did not know the details. He stated Resident #4's progress notes would be a cause for concern for possible abuse and if he had known then he would have involved the Director of Resident Support Services and at least temporarily separated the residents or offered to separate the resident. He stated that he expected staff to report concerns to him and for the DON to inform him during morning meeting of any concerns so that they know what was going on with residents and make sure the facility addressed all their needs. He stated the facility did not have a policy for resident capacity or consent or regarding resident relationships. He stated that consent concerns would be assessed as needed, when there were concerns from family or friends, or the resident then they reassessed the situation. In an interview on 05/06/25 at 2:59 PM with LVN B revealed she started working at the facility about 3 weeks ago, and staff told her Resident #4 and Resident #13 were boyfriend and girlfriend and roommates. She stated Resident #4 did not want to go into her room with Resident #13 and she told LVN B that she did not want to be in the same room as Resident #13 and that she did not know him. LVN B stated she took Resident #4 to an empty room and suggested she sleep there. She stated Resident #4 asked LVN B why would she not want to sleep in her room and LVN B replied that Resident #4 said she felt uncomfortable with her boyfriend (Resident #13). She stated she notified the oncoming shift and continued to check on Resident #4 every 15 minutes due to her elopement risk. She stated that Resident #4's comments were concerning because it showed she felt like he was a threat to her. She stated she was not aware of the progress note where Resident #4 called Resident #13 creepy and stated she would have questioned Resident #4 more on why she used the word creepy because it sounded like she felt frightened to be alone with him. In an interview on 05/06/25 at 4:49 PM with the Director of Rehabilitation revealed Resident #4 recently had a decrease in her cognition level due to a UTI and suddenly started to dislike her roommate (Resident #13) and did not recognize him. He stated that about a week ago Resident #4's wandering, confusion, and not remembering Resident #13 was brought up during a morning meeting with the department heads. He stated he suggested they move Resident #4 to another room due to dementia and the male-female dynamic and was not sure why the residents were not moved. He stated that he could not remember if the Executive Director was present at the time. In an interview on 05/08/25 at 11:55 AM with CNA H (worked all shifts) revealed Resident #4 started to not recognize Resident #13 around January 2025 and then more consistently in the past month. CNA H stated Resident #4 said things like there's a strange or weird man in her room and she didn't know who he was. She stated she took her to LVN A who reoriented Resident #4 to Resident #13 and told her that's your boyfriend- you live with him. CNA H stated sometimes Resident #4 remembered who Resident #13 was and other times she would say no, I don't know him and went to the lobby and stayed there about an hour or so then came back and did the same thing again. CNA H stated staff redirected Resident #4 with coffee, snacks, activities, smoking breaks and eventually Resident #4 went back to her own room. She stated Resident #4 did seem afraid and confused and she saw now that it could have been a sign of abuse. Record review of the facility's freedom from abuse and neglect policy, titled Abuse, dated effective 02/01/17 and revised 0/01/23, reflected: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure. The facility administrator is the appointed Abuse Coordinator, and in his/her absence a designee will be appointed. Abuse is a willful infliction of injury or negligent, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under penal code S 21.08 (indecent exposure) or Penal code chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault. Residents will not be subjected to abuse by anyone, including, but not limited to community staff, other residents . .Reporting/Investigation: The law requires the abuse coordinator/designee, or employee of the facility who believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person to report the abuse, neglect or exploitation . Investigations will focus on determining if the abuse occurred, the extent of the abuse, and potential cause(s) . The abuse coordinator with the Director of Nursing/ designee will investigate all allegations and use the appropriate forms to document the investigation and turn it in to HHS within 5 calendar days. Upon completion of an investigation, the Director of Nursing and Administrator will analyze the occurrences, and determine what changes, if any, are needed to prevent further occurrence. All documentation of investigation must be protected and made available upon request. Protection: It is utmost important that resident(s) suspected of being abused, and all other residents must be protected during the initial identification, and investigation process. The facility will initiate immediate procedures to ensure that these residents are protected fully from any further harm or potential harm . In the event of resident-to-resident abuse, the facility will immediately protect the resident being abused and all other residents in the facility. If the initial determination is that the perpetrator is a threat to the health and safety of the residents in the facility, as determined by the attending physician/or other physician, the resident will be discharged as soon as possible. During the time that the perpetrator has not been discharged , the facility will monitor this resident one-on-one to protect all other residents. The Director of Nursing will coordinate this and set up monitoring. If a threat does not exist then an assessment will be completed, and behavior will be care planned to meet resident's needs and protect others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the inservice record dated 04/21/25 revealed the facility inserviced staff on the Long Term Care Regulation Provider Letter with emphasis on the timeliness of reporting. Review of the Long-Term Care Regulation Provider Letter, PL 2024-14 issued August 29, 2024 revealed .HHSC rules define neglect as the failure to prvide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain or mental illness. CMS defines neglect as the failure of the facility, it's employees or service providers tor provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . An Immediate Jeopardy was identified on 05/07/25. The Administrator and DON were notified on 05/07/25 at 1:43 PM of the Immediate Jeopardy. The IJ template was provided at this time and plan of removal was requested. The facility's plan of removal was accepted on 05/08/25 at 6:26 PM. The accepted plan of removal for the Immediate Jeopardy included the following: The following is a plan of?removal, which has been immediately?implemented?at [the facility], to remedy the immediate jeopardy as a result of alleged deficient practices, which?was imposed on May 7, 2025 at 1:55pm. ? On 5/7/2025 at 10am [Resident #4] was removed from the same room and placed on a separate unit away Resident #13. Resident #4 placed on enhanced supervision on 5.5.25. Resident #13 was placed on enhanced supervision 5.6.25. Resident #4 and Resident #13 assessed for signs/symptoms of abuse/neglect, physical or mental, harm by Regional Director of Clinical Services. No negative findings identified. Psych service vendor contacted by Social Services and [DON] 5.7.25 to conduct off cycle visit on 5.8.25 and/or medication review for resident #4 and resident #13 who are currently already on services with this provider per physician orders. Medical Director contacted by facility on 5.7.25 to conduct on-site assessment for Resident #4 and Resident #13 on 5.8.25. On 5.7.2025 [Executive Director], [DON], [ADON], received one to one education from Regional Director of Clinical Services on abuse/neglect/exploitation/identifying and reporting, adhering and following policy and procedures, and complying with State and Federal Guidelines. [Executive Director], [DON], and [ADON] will be in-serviced on resident to resident relationships upon the development of the policy and procedure on 5.8. 25, On 5.7.25 [the facility] contacted the legal team to assist with the development of a policy and procedure for resident to resident relationships. Completion date for the development and adoption of such policy and procedure will be 5.8.25. All staff will be staff in-serviced on Resident to Resident relationships on May 8, 2025 by [Executive Director/DON], and/or designee. In-service education included but not limited to, who to report suspected relationships to, facility obligations to serve residents participating in a resident to resident relationships, resident capacity and consent for relationships, and facility response when a potential relationship is identified. Facility will communicate changes in resident relationship statuses during routine morning meetings with the IDT team and clinical staff members. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All staff not present at time of in-service will not be permitted back to work until in-service is complete. All staff in-serviced on abuse, neglect, and exploitation on May 7, 2025 by [Executive Director] and [DON]. All staff not present at time of in-service will not be permitted back to work until in-service and competency test is complete. Completion date 5.8.25. LVN A, LVN B, ADON, DOR and DON received one to one in-service for resident to resident relationships and abuse/neglect/exploitation identifying and reporting on 5.7.25 by Regional Director of Clinical Services. All residents with the ability to communicate interviewed by [Director of Resident Support Services] and/or designee on 5/7/2025 for potential safety concerns. Nonverbal residents assessed on 5.7.25 for signs and symptoms of abuse/neglect/exploitation. The Medical Director was initially made aware May 7, 2025 of the immediate jeopardy, and has?been involved?in the development of the plan to remove during an abbreviated QA (Quality Assurance).These conversations are considered a part of the QA process. All in-servicing began 5/7/2025. No staff will be permitted to work until in-serviced. Completion date for all in-servicing will be May 8, 2025. This plan was initially implemented 5/7/2025 and will be monitored, through personal observation,?through completion byRegional [NAME] President of Operation, Regional Director of Clinical Services. Monitoring included: Record review of facility's resident relationship policy titled Consensual Intimate Relationships Between Residents, undated, reflected: Purpose: To establish guidelines and procedures regarding consensual intimate relationships between residents in the skilled nursing facility while ensuring the safety, dignity, and rights of all residents. Policy Statement: The facility recognizes and respects the personal rights of residents to engage in consensual intimate relationships with one another. This policy aims to provide a framework for supporting such relationships while maintaining a safe and respectful environment for all residents. Definitions: Consensual Intimate Relationship: A mutual relationship between residents that includes emotional, romantic, or sexual components, characterized by the voluntary agreement of both parties. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nonconsensual Intimate Relationship/Sexual Contact: If a resident appears to want the intimate relationship/sexual contact to occur, but lacks the cognitive ability to consent; or Does not want the intimate relationship/sexual contact to occur. Procedures: Residents will be informed of their rights regarding intimate relationships and the facility's policies. Both parties must be capable of providing informed consent, free from coercion or undue influence. Staff should assess the cognitive and emotional capacity of both residents to ensure they understand the nature of the relationship. Assessment of cognitive and emotional capacity will be assessed by either a licensed nurse, licensed social worker or psychiatrist/psychologist and will occur when a resident indicates a desire to engage in an intimate relationship or exhibits behaviors of engaging in an intimate relationship. Re-assessment of a resident's cognitive and emotional capacity who wish to continue in an intimate relationship will occur as needed or on certain changes of condition such as stroke, dementia, depression/psychiatric illnesses, illness, or other impacts such as medication(s), hearing/visual loss, and stress. Documentation of informed consent and assessment will be in the resident's electronic health record. Residents engaging in intimate relationships will be provided with adequate privacy. Staff will facilitate private spaces for such interactions, respecting residents' dignity and confidentiality. Staff will document any significant developments in the relationship, including any concerns raised by residents, family members, or staff and will intervene when appropriate to ensure the safety of residents. Monitoring included: Record review of an in-service, dated 05/07/25, reflected staff on all shifts were in-serviced on identifying abuse and neglect and reporting requirements, signed by nursing staff including the DON, ADON, LVN A, LVN B, occupational/speech/physical therapy staff and the DOR, Director of Resident Support Services, Director of Life Enrichment, housekeeping staff and the Director of Environmental Services. Record review of an in-service, dated 05/07/25, reflected an in-service on identifying and reporting abuse and neglect and resident to resident relationships was signed by the Executive Director, DON, ADON, DOR, LVN A and LVN B. Record review of an in-service dated 05/08/25, reflected staff on all shifts were in-serviced on the consensual intimate relationships policy was signed by nursing staff including the DON, ADON, occupational/speech/physical therapy staff, dietary staff, Director of Resident Support Services, Director of Life E[TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation for one (Resident #4) of 10 residents reviewed for abuse and neglect. 1.The facility failed to prevent Resident #4 from neglect and possible abuse when she was fearful of Resident #13 and remained in the room when she did not know who the resident was any longer. 2.The facility failed to investigate Resident #4's concerns and allegations. 3. LVN A, LVN B, the ADON and the DON failed to recognize aa possible allegation of abuse/neglect. 4. The facility failed to identify and intervene for Resident #4. 5. The facility failed to report and protect Resident #4 from additional psychosocial harm. An Immediate Jeopardy (IJ) was identified on 05/07/25. The IJ template was provided to the facility on [DATE] at 1:43 PM. While the Immediate Jeopardy was removed on 05/09/25, the facility remained out of compliance at a scope of pattern and a severity level of no harm that is not Immediate Jeopardy due to facility continuation of in-servicing and monitoring the plan of removal. These failures could place residents at risk for not having measures in place to protect them from serious harm and mental anguish. Findings included: Record review of the facility's freedom from abuse and neglect policy, titled Abuse, dated effective 02/01/17 and revised 0/01/23, reflected: .each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure. The facility administrator is the appointed Abuse Coordinator, and in his/her absence a designee will be appointed. Abuse is a willful infliction of injury or negligent, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under penal code S 21.08 (indecent exposure) or Penal code chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault. Residents will not be subjected to abuse by anyone, including, but not limited to community staff, other residents . (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	.Reporting/Investigation: The law requires the abuse coordinator/designee, or employee of the facility who believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person to report the abuse, neglect or exploitation . Investigations will focus on determining if the abuse occurred, the extent of the abuse, and potential cause(s) . The abuse coordinator with the Director of Nursing/ designee will investigate all allegations and use the appropriate forms to document the investigation and turn it in to HHS within 5 calendar days. Upon completion of an investigation, the Director of Nursing and Administrator will analyze the occurrences, and determine what changes, if any, are needed to prevent further occurrence. All documentation of investigation must be protected and made available upon request. Protection: It is utmost important that resident(s) suspected of being abused, and all other residents must be protected during the initial identification, and investigation process. The facility will initiate immediate procedures to ensure that these residents are protected fully from any further harm or potential harm . In the event of resident-to-resident abuse, the facility will immediately protect the resident being abused and all other residents in the facility. If the initial determination is that the perpetrator is a threat to the health and safety of the residents in the facility, as determined by the attending physician/or other physician, the resident will be discharged as soon as possible. During the time that the perpetrator has not been discharged , the facility will monitor this resident one-on-one to protect all other residents. The Director of Nursing will coordinate this and set up monitoring. If a threat does not exist then an assessment will be completed, and behavior will be care planned to meet resident's needs and protect others. Record review of the inservice record dated 04/21/25 revealed the facility inserviced staff on the Long Term Care Regulation Provider Letter with emphasis on the timeliness of reporting. Review of the Long-Term Care Regulation Provider Letter, PL 2024-14 issued August 29, 2024 revealed .HHSC rules define neglect as the failure to prvide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain or mental illness. CMS defines neglect as the failure of the facility, it's employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Record review of Resident #4's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. She had the diagnoses of dementia (loss of cognition), anxiety disorder (sudden feelings of intense worry), major depressive disorder (persistent feelings of sadness or loss of interest), bi-polar disorder (periodically intense emotional states), schizophrenia (mental health condition that affects how people think, feel and behave) and a BIMS score of 8 (moderately impaired cognition). (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's care plans revised 11/17/23 revealed there was no care plan area for the resident's cohabitation and relationship with Resident #13. Further review reflected she had impaired cognitive function or thought process due to dementia, interventions included cue and reorient and supervise as needed, dated initiated 02/02/25. Further review revealed she identified as a trauma survivor with trauma category of: Serious illness, childhood trauma, neglect, psychological trauma, dated initiated 7/21/21, and interventions included ask for permission to enter resident's room . be conscious of resident position when in groups, activities, dining room to promote proper communication with others and feelings of safety . behavioral health consults as needed, psychiatrist or counselor . Record review of Resident #13's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. He had the diagnoses of dementia (loss of cognition), anxiety disorder (sudden feelings of intense worry), bi-polar disorder (periodic intense emotional states), psychotic disorder (episodes of disrupted thoughts and perceptions), and schizophrenia (mental health condition that affects how people think, feel and behave) and a BIMS score of 11 (moderately impaired cognition). Record review of Resident #13's care plan revised 10/23/23 revealed there was no care plan area for the resident's cohabitation and relationship with Resident #4. Further review reflected he had impaired cognitive function or impaired thought process due to confusion to time and a short-term memory deficit, dated initiated 09/20/18, interventions included engage in simple, structured activities, keep his routine constant, present just one thought, idea, question, or command at a time. Further review revealed he had a behavioral problem due to anxiety and had delusions including he believed he was a prisoner of war and yelled out to relieve stress, dated revised 12/19/21, interventions included .caregivers provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by, if reasonable, discuss behavior . explain/reinforce why behavior is inappropriate . Record review of Resident #4's census report revealed she moved in room [ROOM NUMBER] on 4/28/22. Record review of Resident #13's census report revealed he moved to room [ROOM NUMBER] on 01/19/23. Record review of Resident #4's progress notes reflected: Dated 04/14/25 at 6:45 AM by LVN A: .Resident stated to night shift staff, There's a man in my room! Staff attempted to redirect and inform her that he is her roommate and boyfriend [Resident #13]. Resident responded, I don't know him! Resident would not go back to her room. Resident repeatedly asked staff, How do I get out of here? Resident then sat on the couch, waiting for her ride. Resident stayed on the couch and slept. At this time, resident continuing to sleep on couch. Dated 04/14/25 at 9 AM by LVN A: Resident woke up @ 0830 (8:30am) on the couch and came to the nurse's station asking, How do I get out of here? Nurse redirected resident to her room. Resident remembered who her boyfriend was [Resident #13]. Resident came back to the nurse's station immediately after entering her room and again asked, How do I get out of here? Nurse redirected resident for a second time. Whenever resident would enter her room, she would immediately come back up to the hall to the nurse's station asking how to leave. Nurse able to redirect resident to eat breakfast. Notified DON, ADON, and MD. Resident placed on Q(every)15 min elopement monitoring. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Dated 04/15/25 at 1:30 PM by LVN A: Resident has had no attempted elopement this shift. Resident did come to staff members multiple times this shift asking, How do I get out of here? Resident redirected successfully each time. Dated 04/16/25 at 12:35 PM by LVN A: Resident has had no attempted elopement this shift. Resident did come to staff members multiple times this shift asking, How do I get out of here? Resident redirected successfully each time. Resident has had continuous bouts of confusion and has had barely any appetite since being treated for UTI. N/O UA PCR to ensure that resident's UTI has fully been treated. Dated 04/16/25 at 6:28 PM by LVN A reflected the urine PCR was collected and Resident #4 did not have any signs or symptoms of distress. Dated 04/17/25 at 7:45 AM by LVN A: When delivering breakfast tray to resident, resident asked CNA, 'How far away will you be?' CNA explained that she was passing breakfast trays on the hall. Resident explained, 'That creepy man over there keeps staring at me and I just wanted to know where you will be if I need you.' Resident was referring to her boyfriend [Resident #13]. Resident has had persistent confusion past normal baseline. Pending UA PCR results for f/u on previous UTI. Resident continuing Q15 min monitoring for elopement. Dated 04/17/25 at 8:10 AM by LVN A: Resident and her boyfriend, another resident, were ambulating up the hallway and they stopped so her boyfriend could use the bathroom. When boyfriend came back, resident yelled out to nurse's station, Where did my boyfriend go? Boyfriend looked back at her and said, It's me! Resident then stated, No you're not my boyfriend! Nurse reoriented resident successfully. Dated 04/17/25 at 12:10 PM by the Director of Resident Support Services: .Resident has been experiencing increased confusion and has expressed a desire to leave the facility. Nursing staff have been consistently redirecting her during these episodes . Dated 04/17/25 at 1:27 PM by LVN A reflected Resident #4 was assessed by behavioral health services regarding increased confusion, 15 minute checks were discontinued and medications adjusted. Dated 04/23/25 at 12:09 PM by LVN A: Resident confused and does not remember her boyfriend. Resident refusing to sit with boyfriend at lunch. Dated 04/23/25 at 8:12 PM by LVN B: .Resident very confused today and could not remember boyfriend and refused to be left in the same room with him. Dated 04/23/25 at 11:23 PM by the ADON: Upon start of shift, this resident was up in dining area sitting in a chair alone. Previous shift reported that she did not want to go into the room with her boyfriend. This nurse went to speak to this resident and assisted her to her room. No issues with assisting resident to bed. This nurse spoke with resident's boyfriend/roommate and asked that he give her some time and explained that she is just confused right now. Boyfriend/roommate verbalized understanding . (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Dated 04/24/25 at 12:45 PM by LVN A: During lunch, resident refused to sit with her boyfriend/roommate. Resident stating he is not her boyfriend and that he is weird. Resident ate with another resident while her boyfriend/roommate ate at a different table. Resident continues to exhibit increased confusion. Resident unable to find her room or the dining room without assistance from staff. Dated 05/05/25 at 9:25 PM by LVN B: Resident was exit seeking earlier today so we implemented 15 minute checks at 9:30pm. Record review of Resident #4's Q15 elopement monitoring, start dated 04/14/25-04/17/25 reflected Resident #4 was monitored every 15 minutes. Record review of Resident #4 lab results revealed a UTI panel, dated collected 03/21/25 and reported 03/24/25, tested positive for Escherichia coli (bacteria). Further review revealed another UTI panel, dated collected 04/16/25 and reported 04/18/25, tested negative for Escherichia coli (bacteria) and positive for Staphyloccus spp (bacteria). Record review of Resident #4's physician's orders revealed the following orders: -Ciprofloxacin 500 mg, one tablet by mouth, for 10 days for a UTI, start dated 02/25/25 and end dated 04/04/25. -urine analysis PCR for follow up of previous UTI, dated 04/16/25. -Ciprofloxacin 500 mg, one tablet by mouth, for 7 days for a UTI, start dated 04/21/25 and end dated 04/28/25. In an interview and observation on 05/05/25 at 7:17 PM with Resident #4 and Resident #13 revealed she was sitting up in bed and stated she was doing well. Resident #13 entered the room and he stated that he lived with his girlfriend (Resident #4) and they were married. He stated to Resident #4 Tell her that we are married. Resident #4 looked at Resident #13 and did not reply. In an interview on 05/05/25 at 8:36 PM with MA S, she stated Resident #4 and Resident #13 were boyfriend and girlfriend and resided in the same room for years and the family was aware and they were happy together. She stated it was not a sexual relationship and had not seen the residents in the same bed for at least a year and especially with Resident #4's incontinence. She stated Resident #4 had dementia and recently had increased confusion of her surroundings and more frequent incontinence. She stated they were monitoring her frequently. In an interview on 05/06/25 at 9:14 AM with Resident #4, she stated she had a roommate who was male and she did not like it. She stated she had girlfriends and did not want a boyfriend because it made her feel uncomfortable because sometimes boyfriends were mean. She stated there was no physical or sexual contact between them, and she denied that Resident #13 harmed her in any way. She stated he liked to sit on her bed and look out the window. She stated she didn't like him and didn't want to spend time with him but was not sure why, when he was around her she felt pretty bad. She stated she felt safe at the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/06/25 at 9:29 AM with Resident #4's responsible party revealed she had last seen Resident #4 about 2 months ago and spoke with her over the phone on 05/05/25 and was unaware that Resident #4 voiced any discomfort with her roommate, Resident #13. She stated that she spoke with staff about 10 days ago about Resident #4's advanced directives and there was no mention Resident #4 was uncomfortable with Resident #13. She stated Resident #4 had a cognitive decline in the last few months but she found it hard to believe that Resident #4 felt uncomfortable with Resident #13. In an interview on 05/06/25 at 11:48 AM with Resident #13 revealed he and Resident #4 broke up last week and they were just companions now and it was not a sexual relationship for at least a year. He stated he planned to discharge from the facility and had just purchased a helicopter. He stated he was a prisoner of war. In an interview on 05/06/25 at 10:16 AM with LVN A revealed Resident #4 and Resident #13 developed a friendship that developed into a relationship, and they eventually moved into the same room with the approval of both resident representatives. She stated Resident #4 recently had a cognitive decline and had two courses of antibiotics for a UTI and was frequently incontinent. She stated there were some days Resident #4 knew who Resident #13 was; and other days she did not know who he was. She stated that Resident #4 asked her why there was a random man in her room (Resident #13). She stated that Resident #4 would sit and waited for a ride in the lobby area and she was being monitored with 15 minute checks until the behavioral health services assessed her for a secure unit placement. She stated she remembered writing the progress notes and it was discussed in a morning meeting about possibly moving Resident #4 to a different room. She stated in the meeting it was determined if they moved her to a different room then Resident #13 would have still sought her out and if Resident #4 was placed on the secure unit, they would be able to ensure they were separated; Resident #4 had also displayed more exit seeking behaviors. She stated behavioral health services determined she was not at a high enough risk to be admitted to the secured unit and it had not been discussed again. She stated she did believe Resident #4 could have felt unsafe and Resident #13 was also upset that Resident #4 did not remember who he was. In an interview on 05/06/25 at 12:30 PM with the Director of Resident Support Services revealed Resident #4 had dementia, was confused and doesn't understand why she was at the facility, her last BIMS score was a 3 (severe cognitive impairment). She stated Resident #13 also had confusion and had a low BIMS score. She stated she spoke with Resident #4 on 05/05/25 and had not heard any concerns about Resident #13. She stated a resident who did not remember their significant other or started to call them creepy, refused to go into their room or refused to sit with each other at mealtimes was a cause of concern regarding consent and abuse and could cause a resident to physically lash out at the other roommate if they invaded their space. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/06/25 at 12:41 PM with the DON revealed Resident #4 had a significant change in her cognition a couple of weeks ago and was more confused, was not sure where she was and stated she wanted to leave, did not recognize nursing staff or Resident #13, they placed her on 15 minute checks and tested her for a UTI- it was positive and had to go through several rounds of antibiotics and had medications adjusted. She stated that she was not aware of the progress notes that used the words creepy or weird and only remembered they discussed Resident #4's general confusion. She stated if she had known she would be concerned with resident safety and would have intervened and temporarily moved her to ensure she felt safe, informed the Executive Director, and reevaluated any causes. She stated there was not an assessment for resident consent for relationships and there was not a policy regarding resident cohabitation or relationships and did not know if it would be something to be care planned. In an interview on 05/06/25 at 1:03 PM with the ADON revealed Resident #4 and Resident #13 had been roommates for years and it had been good for a while, they typically sat together for every meal. She stated that recently Resident #4 had a UTI and was confused about where she was and who Resident #13 was and she reoriented Resident #4 to her room and to Resident #13. She stated that there were times Resident #13 came to her and was concerned because Resident #4 did not recognize who he was and was refusing to go to their room, she told Resident #13 to give Resident #4 some time and explained Resident #4 was confused. She stated that in a morning meeting LVN A brought up possibly moving Residents #4 and #13 to a separate rooms but there were concerns that Resident #13 would go into whatever room they moved Resident #4 to. Interview revealed there was a discussion about possibly admitting Resident #4 to the secured unit . The ADON could not remember why a change was not made. In an interview on 05/06/25 at 2:35 PM with the Executive Director revealed he started working at the facility in April of 2024 and Resident #4 and Resident #14 were already established roommates and were alright, as far as he knew it was a companionship. He stated he knew that Resident #4 had confusion and did not know the details. He stated Resident #4's progress notes would be a cause for concern for possible abuse and if he had known then he would have involved the Director of Resident Support Services and at least temporarily separated the residents or offered to separate the resident. He stated that he expected staff to report concerns to him and for the DON to inform him during morning meeting of any concerns so that they know what was going on with residents and make sure the facility addressed all their needs. He stated the facility did not have a policy for resident capacity or consent or regarding resident relationships. He stated that consent concerns would be assessed as needed, when there were concerns from family or friends, or the resident then they reassessed the situation. In an interview on 05/06/25 at 2:59 PM with LVN B revealed she started working at the facility about 3 weeks ago, and staff told her Resident #4 and Resident #13 were boyfriend and girlfriend and roommates. She stated Resident #4 did not want to go into her room with Resident #13 and she told LVN B that she did not want to be in the same room as Resident #13 and that she did not know him. LVN B stated she took Resident #4 to an empty room and suggested she sleep there. She stated Resident #4 asked LVN B why would she not want to sleep in her room and LVN B replied that Resident #4 said she felt uncomfortable with her boyfriend (Resident #13). She stated she notified the oncoming shift and continued to check on Resident #4 every 15 minutes due to her elopement risk. She stated that Resident #4's comments were concerning because it showed she felt like he was a threat to her. She stated she was not aware of the progress note where Resident #4 called Resident #13 creepy and stated she would have questioned Resident #4 more on why she used the word creepy because it sounded like she felt frightened to be alone with him. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/06/25 at 4:49 PM with the Director of Rehabilitation revealed Resident #4 recently had a decrease in her cognition level due to a UTI and suddenly started to dislike her roommate (Resident #13) and did not recognize him. He stated that about a week ago Resident #4's wandering, confusion, and not remembering Resident #13 was brought up during a morning meeting with the department heads. He stated he suggested they move Resident #4 to another room due to dementia and the male-female dynamic and was not sure why the residents were not moved. He stated that he could not remember if the Executive Director was present at the time. In an interview on 05/08/25 at 11:55 AM with CNA H (worked all shifts) revealed Resident #4 started to not recognize Resident #13 around January 2025 and then more consistently in the past month. CNA H stated Resident #4 said things like there's a strange or weird man in her room and she didn't know who he was. She stated she took her to LVN A who reoriented Resident #4 to Resident #13 and told her that's your boyfriend- you live with him. CNA H stated sometimes Resident #4 remembered who Resident #13 was and other times she would say no, I don't know him and went to the lobby and stayed there about an hour or so then came back and did the same thing again. CNA H stated staff redirected Resident #4 with coffee, snacks, activities, smoking breaks and eventually Resident #4 went back to her own room. She stated Resident #4 did seem afraid and confused and she saw now that it could have been a sign of abuse. An Immediate Jeopardy was identified on 05/07/25. The Administrator and DON were notified on 05/07/25 at 1:43 PM of the Immediate Jeopardy. The IJ template was provided at this time and plan of removal was requested. The facility's plan of removal was accepted on 05/08/25 at 6:26 PM. The accepted plan of removal for the Immediate Jeopardy included the following: The following is a plan of removal, which has been immediately implemented at [the facility], to remedy the immediate jeopardy as a result of alleged deficient practices, which was imposed on May 7, 2025 at 1:55pm.? On 5/7/2025 at 10am [Resident #4] was removed from the same room and placed on a separate unit away Resident #13. Resident #4 placed on enhanced supervision on 5.5.25. Resident #13 was placed on enhanced supervision 5.6.25. Resident #4 and Resident #13 assessed for signs/symptoms of abuse/neglect, physical or mental, harm by Regional Director of Clinical Services. No negative findings identified. Psych service vendor contacted by Social Services and [DON] 5.7.25 to conduct off cycle visit on 5.8.25 and/or medication review for resident #4 and resident #13 who are currently already on services with this provider per physician orders. Medical Director contacted by facility on 5.7.25 to conduct on-site assessment for Resident #4 and Resident #13 on 5.8.25. On 5.7.2025 [Executive Director], [DON], [ADON], received one to one education from Regional Director of Clinical Services on abuse/neglect/exploitation/identifying and reporting, adhering and following policy and procedures, and complying with State and Federal Guidelines. [Executive Director], [DON], and [ADON] will be in-serviced on resident to resident relationships upon the development of the policy and procedure on 5.8. 25, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5.7.25 [the facility] contacted the legal team to assist with the development of a policy and procedure for resident to resident relationships. Completion date for the development and adoption of such policy and procedure will be 5.8.25. All staff will be staff in-serviced on Resident to Resident relationships on May 8, 2025 by [Executive Director/DON], and/or designee. In-service education included but not limited to, who to report suspected relationships to, facility obligations to serve residents participating in a resident to resident relationships, resident capacity and consent for relationships, and facility response when a potential relationship is identified. Facility will communicate changes in resident relationship statuses during routine morning meetings with the IDT team and clinical staff members. All staff not present at time of in-service will not be permitted back to work until in-service is complete. All staff in-serviced on abuse, neglect, and exploitation on May 7, 2025 by [Executive Director] and [DON]. All staff not present at time of in-service will not be permitted back to work until in-service and competency test is complete. Completion date 5.8.25. LVN A, LVN B, ADON, DOR and DON received one to one in-service for resident to resident relationships and abuse/neglect/exploitation identifying and reporting on 5.7.25 by Regional Director of Clinical Services. All residents with the ability to communicate interviewed by [Director of Resident Support Services] and/or designee on 5/7/2025 for potential safety concerns. Nonverbal residents assessed on 5.7.25 for signs and symptoms of abuse/neglect/exploitation. The Medical Director was initially made aware May 7, 2025 of the immediate jeopardy, and has been involved in the development of the plan to remove during an abbreviated QA (Quality Assurance).These conversations are considered a part of the QA process. All in-servicing began 5/7/2025. No staff will be permitted to work until in-serviced. Completion date for all in-servicing will be May 8, 2025. This plan was initially implemented 5/7/2025 and will be monitored, through personal observation, through completion by Regional [NAME] President of Operation, Regional Director of Clinical Services. Monitoring included: Record review of facility's resident relationship policy titled Consensual Intimate Relationships Between Residents, undated, reflected: Purpose: To establish guidelines and procedures regarding consensual intimate relationships between residents in the skilled nursing facility while ensuring the safety, dignity, and rights of all residents. Policy Statement: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility recognizes and respects the personal rights of residents to engage in consensual intimate relationships with one another. This policy aims to provide a framework for supporting such relationships while maintaining a safe and respectful environment for all residents. Definitions: Consensual Intimate Relationship: A mutual relationship between residents that includes emotional, romantic, or sexual components, characterized by the voluntary agreement of both parties. Nonconsensual Intimate Relationship/Sexual Contact: If a resident appears to want the intimate relationship/sexual contact to occur, but lacks the cognitive ability to consent; or Does not want the intimate relationship/sexual contact to occur. Procedures: Residents will be informed of their rights regarding intimate relationships and the facility's policies. Both parties must be capable of providing informed consent, free from coercion or undue influence. Staff should assess the cognitive and emotional capacity of both residents to ensure they understand the nature of the relationship. Assessment of cognitive and emotional capacity will be assessed by either a licensed nurse, licensed social worker or psychiatrist/psychologist and will occur when a resident indicates a desire to engage in an intimate relationship or exhibits behaviors of engaging in an intimate relationship. Re-assessment of a resident's cognitive and emotional capacity who wish to continue in an intimate relationship will occur as needed or on certain changes of condition such as stroke, dementia, depression/psychiatric illnesses, illness, or other impacts such as medication(s), hearing/visual loss, and stress. Documentation of informed consent and assessment will be in the resident's electronic health record. Residents engaging in intimate relationships will be provided with adequate privacy. Staff will facilitate private spaces for such interactions, respecting residents' dignity and confidentiality. Staff will document any significant developments in the relationship, including any concerns raised by residents, family members, or staff and will intervene when appropriate to ensure the safety of residents. Monitoring included: Record review of an in-service, dated 05/07/25, reflected staff on all shifts were in-serviced on identifying abuse and neglect and reporting requirements, signed by nursing staff including the DON, ADON, LVN A, LVN B, occupational/speech/physical therapy staff and the DOR, Director of Resident Support Services, Director of Life Enrichment, housekeeping staff and the Director of Environmental Services. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an in-service, dated 05/07/25, reflected an in-service on identifying and reporting abuse and neglect and resident to resident relationships was signed by the Executive Director, DON, ADON, DOR, LVN A and LVN B. Record review of an in-service dated 05/08/25, reflected staff on all shifts were in-serviced on the consensual intimate relationships policy was signed by nursing[TRUNCATED]

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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 interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) to avoid duplicative testing and effort for one (Resident #9) of 2 residents reviewed for PASARR. The facility failed to refer Resident #12 to the state authority for potential mental illness trigger by submitting a corrected PASARR evaluation after the addition of a mental health diagnosis. This failure could affect the residents who had a documented psychiatric diagnosis by placing them at risk for not receiving needed treatment and services. Findings included: A review of Resident #12's Face Sheet dated 5/9/25 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #12 had on onset of schizoaffective disorder on 11/27/24. Review of Resident #12's MDS annual assessment dated [DATE] indicated the resident was considered by the State Level 2 PASARR process to have serious mental illness to include Schizophrenia (a chronic mental illness characterized by significant disruptions in though, perception, emotion, and behavior). Her other active diagnoses were Depression (a mood disorder characterized by persistent feelings of deadness, loss of interest and difficulty functioning in daily life) and Psychotic Disorder (a mental disorder characterized by a disconnection from reality). Review of Resident #12's PASARR Level 1 Screening, dated 3/12/24, revealed no mental illness. Review of Resident #12's medical records revealed no PASARR Level II screening or no Mental Illness Resident Review Form. Interview with the Regional MDS Coordinator on 5/8/25 at 11:57pm revealed that Resident #12 completed the first PASSAR on 3/12/24 and it was negative for mental illness. Then her PCP added schizoaffective disorder with an onset of 11/27/24. She stated the resident should have had a Level II screening or a Mental Illness Resident Review filed with the LIDDA but did not. She was unsure of why it was not completed. She stated the MDS coordinators were supposed to check for new orders on the 24-hour reports and send the appropriate referrals if necessary. She noted the order for Schizoaffective diagnosis was uploaded, but communication failed somehow. The risk to the resident for not being properly referred for PASARR would be the resident missed out on services they possibly qualified for that could help with their symptoms. Review of the facility's policy PASARR revised 11/15/23 reflected . The purpose of this policy is to ensure PASARRs are being obtained and completed timely and accurately .6. Follow Texas PASRR Policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASARR status.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for one of two (Resident #57) residents reviewed for baseline care plans. The facility failed to complete a baseline care plan for Resident #57. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services. Findings included: Review of Resident #57's 5-day MDS assessment dated [DATE], reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. She had a BIMS of 12 which indicated she was moderately cognitively impaired. She was always incontinent of bowel and bladder, required substantial to maximum assistance with ADL's and had diagnoses including chronic obstructive pulmonary disease (lung disease that blocks airflow and make if difficult to breath) and heart failure. She required continuous oxygen. Record review of Resident #52's electronic record census information reflected an admission date of 04/15/25- discharged [DATE]-Re-admit on 04/22/25-discharged on 04/23/25-re-admitted on [DATE]. Record review of Resident #57s electronic record reflected the baseline care plan had been initiated on 05/02/25, but the baseline care plan was never completed. The only section completed was for Social Services. In an observation and interview with Resident #57 on 05/05/25 at 06:40 p.m. Resident #57 was observed lying in bed with O2 via nasal canula. O2 was set to deliver 5 liters per minute. Resident #57 was noted to have a Foley catheter draining dark amber colored urine. Resident #57 stated she was on antibiotics for a urinary tract infection. She stated she used O2 continuously at 5 liters per minute. She stated she had been back at the facility for about 5 days. In an interview with RN F on 05/08/25 at 01:50 p.m. she stated she thought the DON was responsible for completing the baseline care plan. She stated she had never received any instruction on completing the baseline care plan. In an interview with LVN A on 05/08/25 at 01:53. p.m. she stated was told only an RN could complete the baseline care plan. She stated she assumed the DON or the MDS nurse completed the care plan. She stated she had never been instructed on the completion of the baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Corporate MDS Nurse on 05/08/25 at 01:55 p.m. she stated she searched Resident #57's electronic record and determined the baseline care plan had not been completed. She stated the care plan was an interdisciplinary approach, stating nursing needed to add their information, therapy, social services and dietary. She stated all parties were to sign after completion and then the care plan was to be printed and signed by the resident and or responsible party. She stated a copy was to be provided to the resident or responsible party and the signed baseline care plan was to be uploaded into the electronic record. She stated the baseline care plan was the beginning of the comprehensive care plan and provided a person-centered approach to the resident's immediate needs and wishes upon their admission to the facility. In an interview with RN G on 05/08/25 at 02:30 p.m. she stated she had no idea who was responsible for completing the baseline care plan. She stated she assumed it was the DON or the MDS nurse. She stated she had never received any instructions on the completion of the baseline care plan. In an interview with LVN E on 05/08/25 at 02:35 p.m. she stated she had no idea who was responsible for the baseline care plans. She stated she assumed it was the MDS nurse. During an interview with the DON on 05/08/25 at 03:40 p.m. she stated the admitting nurse was responsible for initiating the baseline care plan. She stated it did not have to be an RN. When asked about their policy, she stated she was unaware their policy indicated the baseline care plan had to be completed by an RN. In an interview with the Regional Director of Clinical Services on 05/08/25 at 03:45 p.m. she stated they would need to clarify their policy which required an RN was responsible for completion of the baseline care plan. She stated the baseline care was to address the resident immediate needs which the admitting nurse would be able to determine. She stated they would have to review their process and educate accordingly. Record review of the facility's policy titled, Comprehensive Care plan, dated January 2021, reflected, Every resident will have an individualized interdisciplinary plan of care in place. A baseline care plan of care to meet the resident's immediate needs shall be develop for each resident withing forty-eight (48) hours of admission .A Registered Nurse will complete the Baseline Care Plan in the RN's absence in the Clinical reimbursement role. An RN initiates all Care Plans. To assure that the resident's immediate care needs are met and maintained, the baseline care plan will be developed with forty-eight (48) of the resident's Admission. It will be utilized until the Comprehensive Care Plan is developed. Record review of the facility's policy titled, Baseline Care Plan, dated November 2019, reflected, A baseline care plan is required to be completed withing 48 hours of admission .The baseline care plan must include: Initial goals based on admission orders-Physician orders-Dietary orders-Therapy Services-Social Services-PASARR (If applicable) .The facility must provide the resident and their representative with a summary of the baseline care plan to include as a minimum- Resident's initial goals- A summary of medications and dietary instructions-Any services and treatments administered by the facility and personnel acting on behalf of the facility such as therapy or psych services-Information to properly care for the resident upon admission-Address specific health and safety concerns .

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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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet resident needs for 7 (Resident #4, #13, #22, #28, #34, #165, #12) of 27 residents reviewed for care plans. 1. The facility failed to create and implement a care plan that reflected Resident #4's relationship and cohabitation with Resident #13. 2. The facility failed to create and implement a care plan that reflected Resident #13's relationship and cohabitation with Resident #4. 3. The facility failed to create and implement a care plan that reflected Resident #22's relationship with Resident #28. 4. The facility failed to create and implement a care plan that reflected Resident #28's relationship with Resident #22. 5. The facility failed to create and implement a care plan that reflected Resident #165's relationship with Resident #34. 6. The facility failed to create and implement a care plan that reflected Resident #34's relationship with Resident #165. 7. The facility failed to create a care plan that reflected Resident #12's need for interventions to manage her left-hand contracture. These failures could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included: 1. Record review of Resident #4's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. She had the diagnoses of dementia (loss of cognition), anxiety disorder (sudden feelings of intense worry), major depressive disorder (persistent feelings of sadness or loss of interest), bi-polar disorder (periodically intense emotional states), schizophrenia (mental health condition that affects how people think, feel and behave) and a BIMS score of 8 (moderately impaired cognition). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's care plan revised 11/17/23 revealed there was no care plan area for the resident's cohabitation and relationship with Resident #13. Further review reflected she had impaired cognitive function or thought process due to dementia, interventions included cue and reorient and supervise as needed, dated initiated 02/02/25. Further review revealed she identified as a trauma survivor with trauma category of: Serious illness, childhood trauma, neglect, psychological trauma, dated initiated 7/21/21, and interventions included ask for permission to enter resident's room . be conscious of resident position when in groups, activities, dining room to promote proper communication with others and feelings of safety . behavioral health consults as needed, psychiatrist or counselor . In an interview and observation on 05/05/25 at 7:17 PM with Resident #4 and Resident #13 revealed she was sitting up in bed and stated she was doing well. Resident #13 entered the room and he stated that he lived with his girlfriend (Resident #4) and they were married. He stated to Resident #4 Tell her that we are married. Resident #4 looked at Resident #13 and did not reply. In an interview on 05/05/25 at 8:36 PM with MA S, she stated Resident #4 and Resident #13 were boyfriend and girlfriend and resided in the same room for years and the family was aware and they were happy together. She stated it was not a sexual relationship and had not seen the residents in the same bed for at least a year and especially with Resident #4's incontinence. She stated Resident #4 had dementia and recently had increased confusion of her surroundings and more frequent incontinence. She stated they were monitoring her frequently. In an interview on 05/06/25 at 9:14 AM with Resident #4, she stated she had a roommate who was male and she did not like it. She stated she had girlfriends and did not want a boyfriend because it made her feel uncomfortable because sometimes boyfriends were mean. She stated there was no physical or sexual contact between them, and she denied that Resident #13 harmed her in any way. She stated he liked to sit on her bed and look out the window. She stated she didn't like him and didn't want to spend time with him but was not sure why, when he was around her she felt pretty bad. She stated she felt safe at the facility. In an interview on 05/06/25 at 11:48 AM with Resident #13 revealed he and Resident #4 broke up last week and they were just companions now and it was not a sexual relationship for at least a year. He stated he planned to discharge from the facility and had just purchased a helicopter. He stated he was a prisoner of war. In an interview on 05/06/25 at 10:16 AM with LVN A revealed Resident #4 and Resident #13 developed a friendship that developed into a relationship, and they eventually moved into the same room with the approval of both resident representatives. In an interview on 05/06/25 at 1:03 PM with the ADON revealed Resident #4 and Resident #13 had been roommates for years and it had been good for a while, they typically sat together for every meal. In an interview on 05/06/25 at 2:35 PM with the Executive Director revealed he started working at the facility in April of 2024 and Resident #4 and Resident #14 were already established roommates and were alright, as far as he knew it was a companionship. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/06/25 at 2:59 PM with LVN B revealed she started working at the facility about 3 weeks ago, and staff told her Resident #4 and Resident #13 were boyfriend and girlfriend and roommates. 2. Record review of Resident #13's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. He had the diagnoses of dementia (loss of cognition), anxiety disorder (sudden feelings of intense worry), bi-polar disorder (periodic intense emotional states), psychotic disorder (episodes of disrupted thoughts and perceptions), and schizophrenia (mental health condition that affects how people think, feel and behave) and a BIMS score of 11 (moderately impaired cognition). Record review of Resident #13's care plan revised 10/23/23 revealed there was no care plan area for the resident's cohabitation and relationship with Resident #4. Further review reflected he had impaired cognitive function or impaired thought process due to confusion to time and a short-term memory deficit, dated initiated 09/20/18, interventions included engage in simple, structured activities, keep his routine constant, present just one thought, idea, question, or command at a time. 3. Record review of Resident #22 Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted on [DATE] with the diagnoses of dementia (loss of cognition), heart disease, and anxiety disorder (intense worry or fear). She had a BIMS of 2 (severely impaired cognition) and moderate difficulty hearing. In an interview on 05/06/25 at 3:24 PM with Resident #22 she stated she was happy in a relationship with Resident #28 and had no concerns. She stated she felt safe at the facility. Record review of Resident #22's care plan revealed there was no care plan that addressed her relationship with Resident #28. Further review revealed she had impaired cognitive function and loss of memory, times sense, and impaired decision-making abilities and was not always understood or able to understand verbal and non-verbal language, dated revised 1/21/25. Interventions included cue, reorient and supervise as needed .keep the resident's routine consistent .break tasks into one step at a time . 4. Record review of Resident #28 Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses of epilepsy (seizures), unspecified affective mood disorder (mood disorder), and nerve pain. He had a BIMS score of 8 (moderately impaired cognition). In an interview on 05/08/25 at 10:05 AM with Resident #28 revealed he and Resident #22 were in a consensual non-sexual relationship and staff were aware and he felt treated with respect and dignity. He stated that their relationship was important to him because it made him feel young and happy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's care plan revealed there was no care plan that addressed his relationship with Resident #22. Further review reflected he had impaired cognitive function and loss of memory, times sense, and impaired decision-making abilities due to dementia and was not always understood or able to understand verbal and non-verbal language, dated revised 1/23/25. Interventions included cue, reorient and supervise as needed .keep the resident's routine consistent .break tasks into one step at a time . 5. Record review of Resident #165's Comprehensive MDS, dated 04.28.25, he was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of heart failure, kidney disease, and depression (loss of feelings of sadness or loss of interest). He had a BIMS score of 15 (intact cognition). In an interview on 05/08/25 at 9:45 AM with Resident #165 he stated he had been in a consensual, non-sexual relationship with Resident #34 for about 6 months. He stated that he got Resident #34 flowers from the store yesterday. He stated that the relationship was important to him because he didn't feel alone. He stated he felt safe at the facility and his rights were respected. Record review of Resident #165 care plan revealed there was no care plan that addressed his relationship with Resident #34. Further review revealed he was at risk for a self-care deficit and ineffective coping due to the diagnosis of depression, dated initiated 12/27/24, interventions included: .administer medications as ordered .provide care in a warm and caring manner .encourage resident to be an active participant in decision making . 6. Record review of Resident #34's Quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female, admitted to the facility on 02/04/24 and readmitted on [DATE], with the diagnoses of mild dementia (loss of cognition) with anxiety (intense worry or fear), and idiopathic chronic gout (a form of arthritis). She had a BIMS score of 12 (moderately impaired cognition). In an interview on 05/08/25 at 10 AM with Resident #34 she stated she was in a consensual, non-sexual relationship with Resident #165. She stated she felt safe at the facility and that her rights were respected at the facility. Record review of Resident #34's care plan revealed there was no care plan that addressed her relationship with Resident #165. Further review revealed she had impaired cognitive function and loss of memory, times sense, and impaired decision-making abilities due to dementia and was not always understood or able to understand verbal and non-verbal language, dated intiated 02/21/24. Interventions included cue, reorient and supervise as needed .keep the resident's routine consistent .break tasks into one step at a time . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/06/25 at 12:41 PM with the DON she stated Resident #4 and Resident #13 had already established a relationship and were living in the same room when she started working at the facility in November of 2023. She stated she was aware that Residents #22, and #28, Residents #165, and #34 were in relationships. She stated Resident #22 and Resident #28 had slightly impaired cognition and the family had provided consent for the relationship, they did not reside in the same room. She stated that she saw Resident #165 with his hand around Resident #34's shoulder when they returned from a smoke break. She stated that she was not sure if a resident relationship would be something that they care planned because it was not necessarily part of their care. She stated typically the MDS nurse updated care plans and any nurse was able to update the care plan. She stated the Regional MDS Coordinator was responsible for care plans until they filled the MDS nurse position. In an interview on 05/06/25 at 2:35 PM with the Executive Director he stated that the MDS nurse was responsible for care plans and the Regional MDS Coordinator currently updated the care plans until the facility filled the MDS nurse position. He stated he was not sure if resident relationships would be care planned and was aware that Residents #4, #13, #22, and #28 were in relationships that were non-sexual. He stated care plans ensured staff knew what was going on with the resident and to ensure they addressed all their needs. In an interview on 05/09/25 at 12:53 PM with the Regional MDS Coordinator she stated it was important to care plan a resident relationship to ensure a resident's rights were respected, to guide a safety plan, and ensure the residents rights to privacy. She stated that care plans guide how they took care of residents. In an interview on 05/09/25 at 12:12 PM with the ADON revealed the MDS nurse was responsible for care plans and they were updated upon resident change of condition, during quarterly care plan meetings and the weekly standard of care meetings. She stated consensual resident relationships were important to care plan to ensure staff were aware of the relationship, the resident's consent status, and to know what level of privacy the residents were allowed. 7. Review of Resident #12's admission Minimum Data Set Assessment, dated 3/1/25, reflected she was a [AGE] year-old female with an admission date of 4/18/23. Resident #12 had no cognitive impairment, and her BIMS score was 15. She had upper and lower extremity impairment on one side and required use of a wheelchair. Resident #12 required assistance in putting shoes on, lower body dressing, bathing, toileting, and personal hygiene. Resident was also fully dependent in transfers and turning in bed. Resident had the following active diagnosis: Stroke (a medical condition that occurs when blood flow to the brain is interrupted or reduced, leading to brain cell damage) (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin), Arthritis (swelling or tenderness I one or more joints, causing joint pain or stiffness that often gets worse with age), Non-Alzheimer's Dementia (brain disorder that caused progressive cognitive decline), unspecified lack of coordination, unsteadiness on feet and muscle weakness. Review of Resident #12's Order Recap Report dated 5/8/25 reflected an order for 07/26/23 to 6/12/24 .may have brace to left hand to prevent contracture. Wear brace during day and off at night. Two times a day for Preventative . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility Contracture Management Log for December 2024 reflected Resident #12 was evaluated on 11/27/24 and a contracture was observed on left hand that required a splint. Review of facility Contracture Management Log for April 2025 reflected Resident #12 was evaluated on 02/24/25 and a contracture was observed on left hand that required a splint. Observation of Resident #12 on 05/05/25 at 7:54pm revealed possible contracture on left hand without a brace or splint. The surveyor attempted to interview the resident but there was no response. Review of Resident #12's care plan revised 1/21/25 reflected .Resident Complains of Increased Pain / Discomfort and is at Risk for Injury from Decrease in ADLs Disease process Date Initiated: 01/21/2025 Revision on: 01/21/2025 o The resident will not have an interruption in normal activities due to pain through the review date. Date Initiated: 01/21/2025 Target Date: 01/14/2025 o The resident will not have discomfort related to side effects of analgesia through the review date. Date Initiated: 01/21/2025 Target Date: 01/14/2025 o The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Date Initiated: 01/21/2025 Target Date: 01/14/2025 o Administer analgesia tylenol as per orders. Give 1/2 hour before treatments or care. Date Initiated: 01/21/2025 Revision on: 01/21/2025 LPN RN o Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Date Initiated: 01/21/2025 CNA LPN RN o Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Date Initiated: 01/21/2025 Revision on: 01/21/2025 LPN RN o Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function. Date Initiated: 01/21/2025 LPN RN Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Date Initiated: 01/21/2025 LPN RN o Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Date Initiated: 01/21/2025 LPN RN o Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Date Initiated: 01/21/2025 CNA LPN RN o Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss . Resident #12's Care Plan did not reflect interventions for her left-hand contracture or for the use of a brace on the contracted hand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Rehabilitation on 05/07/25 at 1:14pm revealed Resident #12 had PT and OT from 2/24/25 to 4/18/25 and was discharged due to plateauing in her progress. Resident #12 had a contracture to her left hand and should have had a splint as there was an order on file, as he insured it was there. He stated Resident #12 was also on the Contracture Management Logs and was followed up with every quarter, last follow-up was 04/15/25. The Director of Rehab was unable to provide the active order, and stated someone had cancelled the order without discussing it with him. He would have never recommended the order be discontinued, as Resident #12 needed the splint to help manage her contracture. There should always be an order for the splint and the splint/brace should be care planned. They needed to have an order to obtain the appropriate consents. He stated he would assess Resident #12 immediately and enter the order. Interview with CNA X on 05/07/25 at 1:24pm revealed Resident #12 had a splint on her left hand at one time but wouldn't keep it on. CNA X had not had her put it on recently and had no idea where the split was at. The only thing being done for her contracture was Resident #12 used a stress ball. Observation of Resident #12 on 05/07/25 at 1:23pm revealed the resident sitting in the common area watching TV without a splint or brace on her left hand. Interview with CNA J on 05/08/25 8:42am revealed she was not familiar with the resident, as she had just started working the resident's hall but stated Resident #12 did not have a splint yesterday or this morning. The aide stated residents with a contracture would normally have a splint or brace and access to toys that would help with the contracture. Interview with LVN A on 05/08/25 at 9:16am revealed Resident #12 had a contracture and therapy had given the resident a splint, but she was unsure if it was an active order because she had not seen Resident #12 with it on. She stated that a care plan would have had the need for a splint for a contracture. The risk of not wearing the splint if it was recommended by therapy was the risk of the contracture getting worst and causing more pain. Interview with the Regional MDS Coordinator on 05/08/25 at 11:57pm revealed it was the job of the MDS coordinators to complete the comprehensive care plan. The nurses and Administration Team would update the care plans with new orders or acute orders. A splint or brace would be something that was listed on the care plan. She was unable to provide a care plan for Resident #12 that had the splint or brace listed as an intervention for contracture. The risk to the resident of not having the splint care planned would have been that everyone would not be aware of the resident's needs related to her contracture causing more issues for the resident. Interview with the Director of Nursing on 05/08/25 at 12:09pm revealed she was unsure if Resident #12 had a contracture. She stated that contractures and splints would have had orders and were care planned. She stated every intervention used on residents needed to be care planned, the risk of not having a splint in the care plan was that the hand could become more contracted. The MDS nurse should have kept care plans updated, but all nurses had the ability to update care plans. The Regional MDS Coordinator was filling in for the MDS nurse because the position was vacant. Interview with the Executive Director on 05/08/24 at 12:45pm revealed the MDS coordinator oversaw updating care plans but the DON, ADON and social worker could also update them. Care Plans should include splints or braces if needed. Anything that has an order should be care planned. The risk of not having a splint care planned would be that the resident wouldn't receive everything they needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN G on 05/08/25 2:30pm revealed she was aware that Resident #12 had a contracture on one and that she had received therapy multiple times. She reported Resident #12 had a brace for her contracted hand at one point and believed she still had it but no longer used it. She stated that Resident #12 didn't like to use it and it was discontinued in the orders a long time ago. She stated that contractures and braces were included in care Pplans. Interview with the Director of Rehabilitation on 05/08/27 at 2:57pm revealed that he no longer had access to Resident #12's OT evaluation that had the discharge recommendation for brace or splint because it was in their old electronic system and they switched over to a new system in April. He only had the OT discharge evaluation from 4/18/25 that did not list the brace for the contracture on it. He stated that he was sure Resident #12 required a splint/brace because he had put the order in and someone had discontinued it without discussing with him. He stated he reassessed the resident yesterday and she continued to have a contracture and needed a brace. He entered in the order for the brace. He stated Resident #12 continued to be listed on his Contracture Management log. He stated he always discussed the need of a split/brace with the IDT and would teach the nurses and CNAs how to put it on safely. the length of time to wear it, what to assess for in order to take it off and how many times per day it was necessary. He stated he did this when he entered the order and discharged the resident from therapy. Record review of the facility's policy, Comprehensive Care Plan revised on 04/25/21 reflected: .The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process .5. The Interdisciplinary Team will review the healthcare practitioner's notes and orders (e.g. dietary needs, medications, routine treatment, etc) and implement a Comprehensive Care Plan to meet the residents' care needs including but not limited to: .b. Physician orders .d. Therapy services .l. Psychosocial Mood State/Adjustment to Placement/PASRR Needs as indicated .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one (Resident #12) of six residents reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #12's contracture to her left hand upon discharge from therapy services. These failures could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included: Review of Resident #12's admission MDS Assessment, dated 3/1/25, reflected she was a [AGE] year-old female with an admission date of 4/18/23. Resident #12 had minimal cognitive impairment, and her BIMS score was 15. She had upper and lower extremity impairment on one side and required use of a wheelchair. Resident #12 required assistance in putting shoes on, lower body dressing, bathing, toileting, and personal hygiene. Resident was also fully dependent in transfers and turning in bed. Resident had the following active diagnosis: Stroke (a medical condition that occurs when blood flow to the brain is interrupted or reduced, leading to brain cell damage) (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin), Arthritis (swelling or tenderness I one or more joints, causing joint pain or stiffness that often gets worse with age), Non-Alzheimer's Dementia (brain disorder that caused progressive cognitive decline), unspecified lack of coordination, unsteadiness on feet and muscle weakness. Review of Resident #12's care plan revised 1/21/25 did not reflect interventions for her left-hand contracture or for the use of a brace on the contracted hand. Review of Resident #12's Order Recap Report dated 5/8/25 reflected an order for 7/26/23 to 6/12/24 .may have brace to left hand to prevent contracture. Wear brace during day and off at night. Two times a day for Preventative . Review of Discontinued Order by ADON dated 6/12/24 reflected the order for the left-hand brace had been discontinued .Reason for Discontinue: Refusal d/t non fitting. Review of Resident #12's Order Summary Report revealed the following order on 5/7/25 .L wrist/hand brace to be worn by patient twice a day to help limit potential contracture . Review of facility's quarterly Contracture Management Log for December 2024 reflected Resident #12 was evaluated on 11/27/24 and a contracture was observed on left hand that required a splint. Review of facility's quarterly Contracture Management Log for April 2025 reflected Resident #12 was evaluated on 2/24/25 and a contracture was observed on left hand that required a splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12 OT Discharge Summary dated 4/18/25 reflected Discharge Recommendations: 24 hour care . There was no mention of a splint or contracture on the discharge summary. Observation on Resident #12 on 5/5/25 at 7:54pm revealed possible contracture on left hand without a brace or splint. Attempted to interview Resident #12 however she was unable to answer questions due to cognitive deficits. Interview with Director of Rehabilitation on 5/7/25 at 1:14pm revealed Resident #12 had PT and OT from 2/24/25 to 4/18/25 and was discharged due plateauing in her progress. Resident #12 had a contracture on left hand and should have had a splint as there was an order on file, as he insured it was there. He stated Resident #12 was also on the Contracture Management Logs and was followed up with every quarter, last follow-up was 4/15/25. Director of Rehab was unable to provide the active order, he stated someone had cancelled the order without discussing it with him. He would have never recommended the order be discontinued, as Resident #12 needed the splint to help manager her contracture. There should always be an order for the splint and the splint/brace should be care planned. They needed to have an order to obtain the appropriate consents. He stated he would assess Resident #12 immediately and enter the order. Observation of Resident #12 on 5/7/25 at 1:23pm revealed resident sitting in common area watching TV without a splint or brace on left hand. Interview with CNA X on 5/7/25 at 1:24pm revealed Resident #12 had a splint on her left hand at one time but would not keep it on. CNA X had not put it on recently and had no idea where the split was at. The only thing being done for her contracture was Resident #12 uses a stress ball. Interview with CNA J on 5/8/25 8:42am revealed she was not familiar with the resident, as she had just started working the resident's hall but stated Resident #12 had not had a splint yesterday or this morning. Residents with a contracture would normally have a splint or brace and access to toys that would help with the contracture. Interview with LVN A on 5/8/25 at 9:16am revealed Resident #12 had a contracture and therapy had given the resident a splint, but she was unsure if it was an active order because she had not seen Resident #12 with it on. The risk of not wearing the splint if it was recommended by therapy was the risk of the contracture getting worst and causing more pain. Interview with Director of Nursing on 5/8/25 at 12:09pm revealed she was unsure if Resident #12 had a contracture. She stated that contractures and splints would have had orders. She stated every intervention used on residents needed to have an order and be care planned, the risk of not having an order for a splint was that the hand could become more contracted. Interview with the Executive Director on 5/8/24 at 12:45pm revealed that a splint or brace should have a physician order and be added to the care plan. The risk of not having an order for a splint was that the resident wouldn't receive everything they needed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN G on 5/8/25 2:30pm revealed she was aware that Resident #12 had a contracture on one and that she had received therapy multiple times. She reported Resident #12 had a brace for her contracted hand at one point and believed she still had it but no longer used it. She stated that Resident #12 did not like to use it and it was discontinued in the orders a long time ago. She stated she followed the written orders when determining whether a resident needed a splint or not. Interview with the Director of Rehabilitation on 5/8/27 at 2:57pm revealed he no longer had access to Resident #12's OT evaluation that had the discharge recommendation for brace or splint because it was in their old electronic system, and they switched over to a new system in April. He only had the OT discharge evaluation from 4/18/25 that did not list the brace for the contracture on it. He stated that he was sure Resident #12 required a splint/brace because he had put the order in, and someone had discontinued it without discussing with him. He stated he reassessed the resident yesterday, 5/7/25 and she continued to have a contracture and needed a brace. He entered in the order for the brace. He stated Resident #12 continued to be listed on his Contracture Management log. He stated he always discussed the need of a split/brace with the IDT and will teach the nurses and CNAs how to put it on safely. the length of time to wear it, what to assess for to take it off and how many times per day it was necessary. He stated he typically did this when he entered the order and discharged the resident from therapy. Interview with the ADON on 5/8/25 at 3:44pm revealed that she had discontinued the order for the brace Resident #12 due to Resident's family member requesting it be discontinued. She stated she had asked Resident #12 and her family member for the brace because it was in the orders and the resident's family member stated she had not used the brace for a while, because it no longer fit her. The ADON stated she did not remember if she had spoken to the Director of Therapy or the therapist about discontinuing the order because it was a long time ago. She stated she was unsure if Resident #12 still needed a brace for her contracture. Review of Facility's policy, Restorative Nursing revised on 8/11/21 reflected .1. Restorative Nurse will be trained by therapy by each discipline, and a competency checklist is completed. Restorative nursing care consist of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e. g. physical, occupational, or speech therapies). A. therapy will develop and implement an individualized RNA program at the resident discharge from therapy within 72 hours. Therapy will provide individualized training with the Restorative Nurse prior to discharge from therapy. B. Restorative Nurse has 7-10 days to implement the Restorative Nurse Program. 2. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. A. Restorative Nurse will report any changes to Clinical Reimbursement Coordinator and Director of nursing for further interventions .

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 4 residents (Resident #115 and Resident #61) reviewed for accidents and hazards. 1. The facility failed to ensure adequate supervision and put measures in place to prevent Resident #115 who was at medium risk for eloping from the facility. On 03/24/25, Resident #115 eloped out of the facility and the facility was not aware the resident eloped. Resident #115 was found in his wheelchair at the intersection of the service road off a major highway. The noncompliance was identified as PNC. The IJ began on 03/24/24 and ended on 03/25/24. The facility had corrected the noncompliance before the survey began. 2. The facility failed to ensure adequate supervision and put measures in place to prevent Resident #61 from sustaining a hot liquid burn on 04/20/25 when she spilled hot coffee and sustained a second-degree burn (partial thickness burn, damages the outer and middle layers of skin. Characterized by blistering-typically heal in 7 to 21 days) to her chin and chest. The noncompliance was identified as PNC. The IJ began on 04/20/25 and ended on 04/29/25. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of potential accidents, injuries, harm, or death. Findings include: 1. Review of Resident #115's quarterly MDS assessment dated [DATE] reflected Resident #115 was a [AGE] year-old male with an admission date of 12/08/22 and readmission date of 12/05/24. Resident #115 had a BIMS of 9 indicating he was moderately cognitively impaired. He required moderate assistance with ADLs. He had no wandering behaviors and used a wheelchair for mobility. Active diagnoses included diabetes, cerebral vascular accident (stroke) and dementia (loss of cognitive functioning that interferes with daily life and activities). Record review of Resident #115's comprehensive care plan with an initialization date of 10/23/23 reflected, Resident has impaired cognitive loss related to impaired decision-making ability, is not always understood or able to understand verbal and non-verbal expression .The resident is a smoker .Interventions .Cue, reorient and supervise as needed .The resident requires SUPERVISION while smoking . Record review of Resident #115's quarterly elopement assessment completed by the ADON on 03/05/25 reflected resident was at medium risk for elopement. The assessment indicated the resident had no history of leaving the facility without supervision, had not expressed a desire to go home, no history of leaving the facility without informing the staff, and was not wander seeking. Interventions in place included exit and stairwell alarms, frequent monitoring, utilization of check in/out log, information in wander book and staff aware of resident's wander risk. (continued on next page)

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	675089	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #115's progress notes by RN G dated 03/24/25 at 07:22 p.m. reflected, This nurse was on her lunch break, driving on [name] Street when I spotted the resident in his wheelchair being pushed by a Hispanic man who lives on the corner. This nurse put her car in park and escorted the resident to the grassed area and contacted the CNA to help assist this nurse to escort the resident back to the facility. This nurse assessed the resident for injuries once the resident was back in the building. No injuries observed at this time. VS BP 132/72, P 72, T 97.4, R 17, o2 sat 94%. Resident unable to give details as to how he got to the stop sign. Another resident stated this resident was let out the front door by a family member of another resident. MD, DON, administrator, and family member notified of the incident. One on one monitoring of the resident started and completed every 15 min. Record Review of the PIR initiated on 03/24/25 reflected, RN G completed head to toe assessment on Resident #115 with no injuries, marks or bruises noted. All vital signs in normal limits. No change in resident's behavior noted. Resident did not miss any medications or treatments Provider response .3 day follow-up by Social Worker with no change in base line behavior noted .Resident placed on one-one supervision .Facility completed Elopement drill in-Service with staff as a precautionary measure .Signs posted at exits instructing visitors to not assist others to exit the facility .Facility reported the alleged incident to TXDHHSC .Facility completed review of resident's medical record, including medications, treatment record and care plan .Completed safe survey with no other allegations reported .Investigation summary .[Resident 116] observed another resident's family member assist Resident # 115 to exit the facility .Resident had no history of elopement or exit seeking behavior .Provider action taken Post-Investigation .Resident's Care plan was reviewed by the Director of Clinical operations and updated as required. Family member was educated not to assist residents to exit the facility. Resident #115's medication reviewed by Director of Clinical operations. Elopement assessment completed on residents. Facility completed Abuse prevention in-service . Record Review of Progress notes for Resident #115 from 03/24/25 through 04/18/25 reflected the resident remained on every 15-minute checks until his discharge to another facility with a locked unit on 04/18/25. Record review of the facility census dated 05/05/25 revealed Resident #115 was not a resident at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with RN G on 05/06/25 at 03:15 p.m. she stated she was working the evening Resident #115 eloped from the building. She stated he had been in the dining room eating supper and then he went out on smoke break with the other smokers. She stated after smoke break, he had come back and was in the lobby visiting which was his normal routine. She stated she took her lunch break around 06:00 p.m. and had left the building to get something to eat. She stated she spotted the resident about a block down the road being pushed in his wheelchair by an unknown male who was trying to assist him across the intersection of the service road off Highway 75. She stated she placed her car in the intersection to stop the traffic until she could push the resident off the road. She stated she called the facility and told the CNAs to come and assist. She stated Resident #115 stated he did not know where he was going. She stated she assessed him when she got him back to the facility and notified the MD, family and the Administrator and DON. She stated they placed him on one-on-one supervision. She stated they knew the door alarm and not gone off and later discovered it was the family member of another Resident in the building who had opened the door and asked him if he wanted to go outside. She stated she was not sure how the family member had the code, but stated the codes had all been changed and they had been in serviced on elopement, which included not giving the access code to anyone but staff. She stated Resident #115 had never been exit seeking prior to this incident. In an interview with MA S on 05/05/25 at 08:40 p.m. she stated she was working the night Resident #115 had left the building. She stated she had seen him in the dining room eating his dinner around 06:00 p.m. and he had gone to the front lobby which was his normal activity. She stated the next thing she heard was he was out of the building, and they were bringing him back to the facility. She stated she was told another Resident's family member had held the door open for him and let him out. She stated they had placed the resident on one-on-one monitoring, and they had changed the door code. She stated they were not allowed to give the door code to anyone. She stated the code had been changed several times since the incident with Resident #115. She stated she had received elopement training before this incident and again after the incident. In an observation on 05/05/25 at 6:10 p.m. revealed the front door was locked with code posted outside for entry. Sign posted next to the keypad alerting visitors not to assist residents in leaving the building. Upon entering the facility, the door alarm began to ring. Staff responded promptly and reset the code. Sign was posted above the inside keypad alerting visitors not to assist residents in leaving the building. In an interview with the Administrator on 05/05/25 at 07:50 p.m. he stated Resident #115 had no previous history of exit seeking or elopement. He stated he was mobile with a wheelchair. He stated when the incident occurred the staff immediately notified him after they had returned the resident to the facility. He stated he was able to look at the camera in the lobby area and observed another Residents' family member opening the door and letting Resident #115 out the front door. He stated this was also confirmed by another resident who had witnessed the family member letting Resident #115 out the front door. He stated they immediately changed the code on the doors and placed the resident on one-on-one supervision and started looking for placement in male locked unit. He stated he also educated the other Resident's family member about not assisting other residents out of the building. He stated he placed signs on both the outside of the front door and inside the front door alerting visitors not to let anyone out of the building unless they had come with them. He stated all staff were re-educated on elopement and re-instructed not to give out the access code to visitors or vendors. He stated they used to change the code monthly but had increased the frequency to daily changes and will continue to monitor compliance with staff for the next 30 days. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN B on 05/05/25 at 08:25 p.m. she stated she had worked here 3 weeks and was a PRN nurse. She stated she had been trained on elopement when she was hired. She stated the access codes to the front door were only to be given to staff. She stated they were responsible for letting visitors out of the building. She stated she had not had anyone exit seek or attempt elopement on her shift. She stated they did have a new admit over the weekend (05/03/25) that was moved to the locked unit because she was at risk and was making verbal comments about wanting to leave. She stated they had the resident on one-on-one supervision until they could get the necessary approvals to move her to the locked unit today (05/05/25). LVN B stated Resident #115 was discharged before she started working at the facility. In an interview on 05/05/25 at 08:30 p.m. with RN W, she stated she was a PRN nurse that had been here since December 2024. She stated she had received training on elopement upon hire and again in March 2025. She stated any exit seeking behavior they were to immediately increase the monitoring of the resident. She stated they would place the resident on one on one or q 15-minute checks until they determined if the resident needed to be placed on a secured unit. She stated she had never seen Resident #115 attempt to exit seek. She stated only staff were allowed to have the codes to the doors and were not to give the codes to the family members or vendors. She stated they were expected to round on the residents every 2 hours and CNAs round every 2 hours, so someone saw the residents at least every hour. In an interview with LVN A on 05/06/25 at 10:15 a.m. she stated Resident #115 had never exhibited exit seeking behaviors since he had been at the facility. She they do an elopement assessment on every new admission and then complete one quarterly on all the residents. She stated they had an elopement drill and in service in March. She stated anytime a door alarm goes off staff are to immediately go to the door, look outside to see if they see anyone and then come and do a head count of residents. She stated they an elopement binder at the nurse's station that has all the resident's information and contact numbers. She stated Resident #115 was let out by another resident's family member, who had the code to the front door. She stated they had since changed the codes numerous times since the incident and had informed family and vendors they were not allowed to give the code out. She stated staff were required escort family or vendors out of the front door. In an interview with the ADON on 05/06/25 at 01:15 p.m. she stated they had in serviced all the staff on the elopement protocol, which included keeping the codes to the doors confidential. She stated in the past some long term family members had to the codes to the door but stated since this incident no one was allowed the code except the staff. She stated they do elopement drills at least twice a year. She stated they had done 2 drills since the first of the month. She stated anytime a resident attempted an elopement or started asking to go home or leave the staff were to place the resident on one-on-one supervision until they determined if the resident was going to require placement in a secured unit, which was what they decided was best for Resident #115. She stated it took a few weeks to find placement for him and stated they kept him on one-on-one until he discharged . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA N on 05/06/25 at 03:00 p.m. she stated she was working the 02:00 p.m. to 10:00 p. m. shift on 03/24/25. She stated she had seen Resident #115 in the dining room at dinner time. She stated the resident was mobile with his wheelchair. She stated after dinner he would usually go to the front lobby and visit. She stated Resident #115 had never attempted to leave the facility. She stated she went, and assisted RN G bring the resident back to the facility. She stated the resident did not know where he was and just stated he was going for a stroll. She stated they had an elopement Inservice right after the incident and the codes to the door were changed. She stated they were instructed to not give the code to anyone other than staff. In an interview with the DON on 05/06/25 at 04:00 p.m. she stated they had re-assessed all of the residents for their elopement risk on 03/25/25. She stated they had in serviced the staff on the elopement protocol which included warning signs of residents seeking to leave and what to do when the door alarms and they initiate a search. She stated through their investigation they determined the resident had not been exit seeking but was allowed out the front door by another resident's family member. She stated the staff had been instructed they were never to give out the access code to anyone but other staff members. She stated they were currently changing the code daily to help ensure compliance. She stated they had done elopement education on 12/20/24, 01/29/25 and again on 03/25/25. In an observation on 05/07/25 at 03:40 p.m. a family member was observed going to the front door attempting to put in the code. Family member came to the nurse's station and asked if the code had been changed. LVN B informed the family member she would assist her and went and entered the code to allow the family member to exit. The family member was heard asking for the new code and was informed by LVN B they were not allowed to give out the codes to the doors, that a staff member would assist them anytime they were ready to leave to the facility. Record review of facility's policy Elopement dated 11/01/19 reflected To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing .3. The entire search process of the facility and grounds, from the time the patient/resident is missing, should be competed withing 30 minutes .6. When the patient/resident is located, the nurse completes a head-to-toe assessment. The social service designee assesses the patient/resident for emotional distress .If a resident is not located during a search of the facility, facility grounds, and immediate vicinity, and there are circumstance that place the resident health, safety, and/or welfare at risk, a report HHSC must be made as soon as the facility becomes aware the resident is missing and cannot be located . Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Examples of criteria that put a resident at higher risk of elopement .Cognitive impairment (example: those with dementia, Alzheimer's, brain injury) Exit-seeking behaviors (example: confused resident that thinks he/she needs to go pick their kids up from the school) New admission wanting desperately to leave .History of elopement at other communities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility's policy Elopement Risk assessment dated [DATE] reflected facility will assess all patients/residents for elopement potential in order to provide a safe and comfortable living environment. PROCEDURE 1. All patients/residents are assessed on admission by a licensed nurse for elopement risk utilizing the elopement risk assessment form. 2. All patients/residents are re-assessed for elopement potential by the licensed nurse/social service designee quarterly throughout a patient's/resident's stay and with a significant change .4. The licensed nurse or social service designee completes the elopement risk assessment form and presents to the interdisciplinary team for further intervention.6. The physician and the patient/resident or the patient's/resident's representative are notified of the patient's/resident's risk for elopement and the interventions that are recommended for prevention of elopement and patient/resident safety. 7. The patient's/resident's legal representative should be contacted, if possible, to obtain all pertinent information in relation to elopement risk .10. A licensed nurse documents in the nurse's notes and behavior monitoring flow record any exit seeking behavior on an on-going basis and interventions are adjust as needed. 11. A baseline plan of care should be completed on admission and any elopement risks should be identified. The Administrator and DON was notified and provided the IJ template on 05/07/25 at 01:43 p.m. of PNC IJ. The facility implemented the following interventions: Record Review of Resident #115's comprehensive care plan with a revision date of 03/24/25 reflected, Resident is an elopement risk/wanderer and is at risk for possible injury related to impaired safety awareness and diagnosis of dementia. 03/24/25 -exited the facility .Interventions .Place 1:1 due to safety until referrals can be made if placement is needed . Record review of Staff in-services reflected on 03/25/25-Staff in serviced on elopement education including elopement drill and limiting access to the door codes. Record Review of the Facility's Assessment Scoring report dated 05/06/25 reflected all the residents in the facility, including Resident #115, had a new elopement assessment completed on 03/25/25. Record review of staff in-service reflected the staff had been in serviced on Abuse and Neglect on 03/27/25. In interviews covering all three shifts (6 AM- 2PM, 2 PM-10 PM, and 10 PM- 6 AM), revealed they had been in-serviced on preventing and responding to elopements, participated in elopement drills, knew the alert code for an eloped resident, were aware of where to find the elopement book at the nurses' station and had been instructed not give the access code to the front door to anyone other than staff and had been in serviced on abuse and neglect and were aware of the different forms of abuse and neglect and the reporting requirements. The following interviews were conducted on the following dates: *05/06/25-10:15 a.m. to 02:05 p.m. LVN A, ADON, CNA J, CNA X, CNA H, CNA Y, and CNA P *05/07/25- 03:00 to 04:00 p.m. CNA Q and the Activity Director. *05/08/25-08:15 a.m. to 03:10 p.m. CNA L, CNA Z, RN F, LVN C, LVN E and the Treatment Nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*05/09/25 from 5:10 AM to 5:45 a.m. LVN HH, LVN II, CNA GG and CNA JJ. *05/09/25-10:14 a.m. to 10:45 a.m. - CNA K and CNA U The noncompliance was identified as PNC. The IJ began on 03/24/24 and ended on 03/25/24. The facility had corrected the noncompliance before the survey began. 2. Review of Resident #61's admission MDS assessment dated [DATE] reflected Resident #61 was a [AGE] year-old female with an admission date of 03/20/25. Resident #61 had a BIMS of 12 indicating she was moderately cognitively impaired. She required partial to moderate assistance with ADLs. Active diagnoses included osteomyelitis of right radius and ulna (Inflammation of bone caused by infection of the 2 bones located in the forearm) and dementia (loss of cognitive functioning that interferes with daily life and activities). Record review of Resident #61's Diet order and Communication sheet dated 03/20/25 reflected an order for Regular diet, Mechanical soft (makes food softer, easier to chew). Record review of Resident #61's care plan initiated on 04/07/25 reflected, [Resident #61] have an ADL self -care performance deficit related disease process. Activity intolerance, dementia, impaired balance, limited mobility .Interventions .Bed mobility: The resident requires supervision touching assistance by 1 staff to turn and reposition in bed as necessary .Eating: The resident is able to: setup clean-up assistance . Record review of Resident #61's progress notes by LVN C dated 04/20/25 at 2:24 p.m. reflected, Resident stated wanted coffee, aide went to get coffee out of machine in the dining room, upon return resident stated, Not hot enough, make it hotter. Aide went to get another cup and returned to resident. Moment's past, resident spilled coffee onto self, some slight redness. Aide and nurse called to room, treatment nurse assessed, and provider and POA notified. Record review of Resident #61's incident report dated 04/20/25, completed by LVN C reflected, Injury type-Burn to chest and face .Resident is alert and oriented to person, place, time and situation .Predisposing situation factors .Resident difficulty to grasp cup . Record review of Resident #61's Change of Condition report by the DON on 04/20/25 at 02:30 p.m. reflected, Primary Care Provider responded with the following orders .Silver Sept Silver Antimicrobial gel (ointment used to treat abrasions and burns) BID and leave open to air. Record review of Resident #61's progress note dated 04/21/25 at 08:35 a.m. by the DON reflected, LATE ENTRY Head to toe assessment completed at this time. Redness noted to R corner of bottom lip that extends down the R side of resident's chin and neck. Redness noted to Right side of upper chest measuring 10cm x 2cm. This area has two blistered areas that appear to be in healing phase. Blister 1 measures 1. 75cm X 1cm. Blister 2 measures 1cm X 0.5cm. Wound care on board. No other injuries, bruising, marks, or skin concerns noted during assessment. MD and family aware of findings. Resident has no c/o pain or discomfort at this time. All anticipated needs met. Call light within reach. Record Review of Resident #61's TAR from 04/21/2025 through 05/02/2025 reflected, Silver Sept Silver Antimicrobial Skin and Wound Gel two times a day for Wound Healing Apply to Chin, Neck, and Rt Upper Chest. Treatment was provided twice a day until wounds were healed on 05/02/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of the facility PIR (Provider Investigation Report) initiated on 04/21/25 reflected, . Investigation summary, resident requested coffee to be heated in microwave. Resident spilled coffee on herself and had red area and small blister to lower lip and chest. Staff were instructed not to heat coffee in the microwave. Facility reviewed coffee temperature logs in kitchen, all documentation revealed proper temperatures .Post-investigation- The Director of Clinical Operations assess resident on 04/21/25 .The Director of Clinical Operations reviewed resident's mediations to ensure proper medication administration . Residents care plan was reviewed by Director of Clinical operations and updated as required .Facility completed an Abuse Prevention-in-service as precautionary measure and not reheating beverages .Facility completed Inservice with CNA L on Abuse Prevention and Proper Positioning of residents for feeding and beverages .Facility ordered air pots for coffee service on halls . Record review of Resident #61's updated care plan dated 04/21/25, reflected, Resident has current skin concerns. Burn to right side of lip, chin, and neck. Right upper chest .Interventions .Perform treatments per MD orders. Silver Sept Silver Antimicrobial skin and wound gel. Apply BID for wound healing .Keep MD and RP informed of resident's progress . In an interview with CNA L on 05/08/25 at 08:15 a.m. she stated the day of the incident with Resident #61 she had answered her call light. She stated the resident had requested her coffee be reheated, stating it was not hot enough. She stated she took it to the breakroom and placed it in the microwave for about one minute and took it back to the resident. She stated the resident had lowered the head of her bed. She stated she placed the coffee on her overbed table and told the resident it was hot, and to be sure and raise her head up before she tried to drink it. She stated the resident told her okay. She stated she left the room and a few minutes later her call light was on again. She stated she went to her room and saw where she had tried to drink the coffee without raising her head up and had spilled some down her chin onto her chest. She stated she immediately called for the nurse who came and assessed her. She stated she was in serviced after the incident and told they were not to reheat any food or drink until they were skills checked off on the proper temperature. She stated she has had that Inservice and stated coffee was not to exceed 150 degrees and food was not to exceed 165 degrees. She stated she also learned a valuable lesson and stated she would raise the resident's bed up before she left any food or drink for a resident. She stated Resident #61 was able to feed herself and she just did not think about her trying to drink the coffee with her head down. She stated the resident had a lidded cup now for her drinks. In an interview with LVN C on 05/08/25 at 02:10 p.m. she stated she was working the night of the incident with Resident #61. She stated CNA L had come a got her and told her the resident had spilled hot coffee on her. She stated she assessed her noted redness on her chin, neck, and upper chest with a few small blisters. She stated she notified the DON, and they contacted the MD and obtained orders and started treatments on her. She stated they received in-services the next day telling them they were not to reheat any food or drinks for residents until they were skills checked off on the proper food temperatures for food and coffee. She stated she had been skills checked and knew coffee was not to be over 150 degrees and food was not to exceed 170 degrees. She stated they have thermometer at the nurse's station with the temperatures posted for the staff to use when reheating items. She stated Resident #61 ate independently and just required some set up assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview and observation of the breakroom on 05/05/25 at 06:20 pm. where the microwave was stored, revealed a locked door with a keypad. A sign posted indicating door was to be kept always locked. Interview with MA V stated the code had recently been changed on the breakroom door to ensure only staff had access to the microwave. In an observation and interview with Resident #61 on 05/05/25 at 07:00 p.m. the Resident was sitting up in bed eating her supper. No hot beverages were observed on the tray. She stated she remembered the incident that happened a few weeks ago and stated she got a burn on her collar bone. She stated she had asked the CNA to heat up her coffee and she spilled it on her when she went to take a drink. She stated the burn had healed up and proceeded to show the surveyor where the burn was. The area was observed to be healed with slight pink color noted at the burn site. Resident #61 was observed with a wrist splint on her right wrist. She stated she was right-handed and had to learn to use her left hand. She stated her left hand gets a little shaky at times, but stated she was able to feed herself. She stated the facility had provided her a cup with a lid and handles after the incident. In an interview with [NAME] T on 05/05/25 at 07:30 p.m. he stated they had been in- serviced on food temperatures and were to keep a log of the coffee temperature when it was placed in the air pots in the dining room. He stated the temperature was not to exceed 150 degrees. He stated they do not re-heat food or drinks for the residents. He stated once the tray leaves the kitchen it cannot come back into the kitchen area for reheating. He stated the nursing staff had always used the microwave in the break room for reheating items for the resident. In an interview with the Administrator on 05/05/25 at 07:55 p.m. He stated the incident with Resident #61 was the result of CNA L reheating the resident's coffee and not knowing how hot it was. He stated he immediately stopped all staff from reheating residents' food or coffee until they were all skills checked on safe food temps. He stated he also in serviced the kitchen staff to ensure they were keeping a temperature log for the coffee not to exceed 150 degrees Fahrenheit. He stated they replaced the coffee urn in the dining room with two air pots which will hold the temperature but will not continue to heat up. He stated the coffee was checked by kitchen staff every time and ensured it did not exceed 150 degrees before placed in the air pots. He stated they changed the lock on the breakroom because they were not able to change the code. He stated they can now change the code on the breakroom where the microwave is located. He stated the door was to be kept closed and always locked as well. He stated the Food Service Director in serviced and skills checked the nursing staff on proper temperatures for reheating residents' food and coffee and had placed a digital thermomotor at the nurse's desk with instructions on safe temperatures for food and drinks. In an observation and interview with Dietary Aide AA on 05/08/25 at 08:30 a.m. she was observed checking the temperature of the coffee from one of two air pots in the dining room. The temperature was 136.8 degrees. She stated they check the temperature every time they fill the air pots, and it was not to exceed 150 degrees Fahrenheit. She stated she had been in serviced about the temperatures and the logs for the coffee a few weeks ago. In an interview with the Director of Rehabilitation on 05/07/25 at 11:50 a.m. he stated they have had Resident #61 on service since she had admitted . He stated she had progressed well and could feed herself. He stated after the incident they did request a lidded cup for her since she still had some weakness in her grasp in her left hand. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on 05/08/25 at 03:10 p.m. she stated CNA L received on one training on ensuring a resident was sitting up in the bed at least at a 45-degree angle before serving food or drink. She stated all the staff were told to immediately stop reheating food and drinks until they had been skills checked on checking temperature and knowing the appropriate temperature for food and coffee. She stated the Food Service Manager had conducted that in-service and training with all the nursing staff. She stated they also updated the resident's care plan and therapy had requested a lidded cup for the resident to prevent

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for two of six residents (Resident #8, and Resident #28) reviewed for pharmacy services. 1. The facility failed to ensure LVN B followed the manufacturer's instructions to prime the Insulin Apart (Novolog) Insulin (Hormone) Pen prior to dialing in required amount of Insulin to be administered to Resident #8. 2. The facility failed to ensure LVN D followed the manufacturer's instructions to prime the Lyumjev Insulin (Hormone) Pen prior to dialing in required amount of Insulin to be administered to Resident #28. These failures placed residents at risk of not receiving full dosage of medication. Findings included: 1. Record review of Resident #8's, Face sheet, dated 05/09/25 reflected an [AGE] year-old female with an admission date of 11/06/21. Resident #8 had a diagnosis which included Type 2 diabetes. Record review of Resident #8's Physician Order summary dated 05/09/25 reflected, Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) .Inject as per sliding scale: if 0 - 250 = 0; 251 - 300 = 8; 301 -350 = 11; 351 - 400 = 14; 401+ = 14 Notify MD for further orders, subcutaneously before meals and at bedtime . with a start date of 03/03/25. An observation on 05/06/25 at 04:15 p.m. revealed LVN B performed hand hygiene and put on gloves and entered Resident #8's room to obtain a fingerstick blood sugar. Blood sugar reading was 299. LVN B checked the computer to determine the amount of insulin per sliding scale was 8 units of Insulin Aspart. LVN B retrieved the insulin pen from the medication cart and dialed in the amount of insulin required (8 units) without priming the pen and then administered the insulin to Resident #8. In an interview with LVN B on 05/06/25 at 04:20 p.m. She stated she was not aware the pen was supposed to be primed before each dose. She stated she had been checked off upon hire for fingerstick blood sugars and medication administration but had not been instructed about the need to [NAME] the insulin pen. She stated it made since now that she thought about because you could have air in the needle which could result in a resident not getting their amount of insulin required. 2. Record review of Resident #28's, Face sheet, dated 05/09/25 reflected a [AGE] year-old male with an admission date of 10/25/24. Resident #28 had a diagnosis which included Type 2 diabetes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's Physician Order summary dated 05/09/25 reflected, Lyumjev Kwik Pen Subcutaneous Solution Pen injector 100 UNIT/ML Inject as per sliding scale: if 180 - 200 = 3 units 3 units - IF blood sugar is less than 70, call MD; 201 - 230 = 4 units Give 4 units; 231 - 260 = 5 units; 261 - 290 = 7 units; 291 - 320 = 9 units; 321 - 350 = 13 units If blood sugar greater than 350, Call MD . with a start date 04/08/25. An observation on 05/06/25 at 04:45 p.m. revealed LVN D obtained Resident #28's fingerstick blood sugar. Blood sugar reading was 360. LVN D checked the computer to determine she would need to contact the MD for orders. LVN D reached out to the physician and received an order for 15 units of Lyumjev now and recheck blood sugar at HS. LVN D retrieved the insulin pen from the medication cart and dialed in the amount of insulin required (15 units) without priming the pen and then administered the insulin to Resident #28. In an interview with LVN D on 05/06/25 at 04:55 p.m. She stated the insulin pen was supposed to be primed before each dose. She stated she just forgot. She stated you had to prime the pen because you could have air in the needle which could result in a resident not getting their amount of insulin required. In an interview with the DON on 05/08/25 at 09:30 a.m. she stated the insulin pen was to be primed before each injection. She stated failure to do so could result in the resident not receiving the prescribed amount of insulin. She stated they did annual competency checks over the summer last year and as needed on an ongoing basis. Record review of the Facility's policy, Injectable Medication Administration, dated August 2020, reflected, . Pen Devices: Dial the dose as instructed by the pen manufacture . Review of manufacturer instructions for Novolog (Insulin Aspart) obtained from https://www.novomedlink.com/ searched on 05/14/25 reflected, .Giving the air shot before each injection .Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units .Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. A drop of Insulin should appear at the needle tip, if not .repeat the process .make sure the dose selector is set at 0. Turn the dose selector to number of units you need to inject . Review of manufacture instructions for Lyumjev Insulin pen obtained from https://insulins.lilly.com/lyumjev searched on 05/14/25 reflected, .Prime your pen .Turn the dose knob to 2 units .Hold the Pen with the needle pointing up and tap gently .Then push the dose knob until it stops and you see 0 in the dose window . Count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat the priming steps, but no more than 4 times .Select your dose .Turn the dose knob until the number of units you need to inject appears in the window .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label and secure drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for the facility's one (hall 600 cart) of four medication carts reviewed for storage. 1. The facility failed to ensure Resident # 28's Lyumjev Insulin (Hormone) Pen, that was used on [DATE], was dated when opened. 2. The facility failed to ensure a vial of TB PPD, that was opened and used, was dated. 3. The facility failed to ensure 5 unopened and 1 opened vial of multi-dose flu vaccine and 3 unopened and 1 opened vial of multi-dose TB PPD was stored in a locked medication room or medication cart. These failures could affect residents and staff resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications. The findings included: 1. An observation on [DATE] at 04:45 p.m. revealed LVN D obtained Resident #28's fingerstick blood sugar. Blood sugar reading was 360. LVN D checked the computer to determine she would need to contact the MD for orders. LVN D reached out to the physician and received an order for 15 units of Lyumjev (insulin). LVN D retrieved the insulin pen from the medication cart and dialed in the amount of insulin required (15 units). Observation of the insulin pen revealed no date on the pen indicating when it was opened. LVN D administered the insulin to Resident #28. LVN D returned to the medication cart, wiped the pen down with an alcohol wipe and placed it back in the medication cart. In an interview with LVN D on [DATE] at 04:55 p.m. She stated the insulin pen was supposed to be dated once it was placed on the medication cart and opened. She stated she was not sure who had opened the pen. She stated by not dating it they had no way to know how long the pen had been open. She stated the insulin was only good for 28 days once opened. She stated she should have checked to see when it was opened. She stated giving expired insulin could result in effective insulin coverage for a resident. In an interview with the DON on [DATE] at 09:30 a.m. she stated the insulin pen was to be dated once it was opened. She stated failure to do so could result in the resident receiving and expired medication which could result in ineffective treatments and uncontrolled blood sugars. 2. An observation on [DATE] at 11:40 a.m. of the Treatment nurse's refrigerator located in the unlocked shared office space of the ADON and the Treatment nurse, revealed an undated open vial of Tuberculin Purified protein derivative and 5 unopened vials of flu vaccine and 3 unopened vials of TB PPD. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Treatment nurse on [DATE] at 11:45a.m. she stated the TB PPD had to be dated when opened. She stated once it was open it would only be good for 30 days. She stated the risk of not dating it once opened was the potential for false positive or an inaccurate test, which could lead to a missed infection. She stated whoever opened the vial was responsible for dating it. She stated the flu vaccine and TB PPD were stored in her office when she started and thought that was where it was supposed to be stored. She stated the office door was locked when they leave for the day, but otherwise it was open to anyone who wanted to come in. In an interview with the DON on [DATE] at 11:50 a.m. she stated once a multi-use vial of medication was opened the staff were required to date it. She stated when they open of vial of TB PPD it had to be dated to prevent the risk of using an expired medication which would render it ineffective and could give a false positive reading of the PPD. The DON said she had no idea the TB PPD or Flu vaccine were stored in the refrigerator in the ADON's and Treatment nurses' office. She stated it should be stored in the medication room's refrigerator where it would be secured, and expiration dates could be checked. She stated she was moving it now. Record review of the facility's undated policy titled, Appropriate storage and handling of Insulin products, reflected, .Unopened insulin may be stored in a refrigerator . Facility staff will physically write the date the vial or pre-filled syringe was opened. Once opened, the vial or syringe may be stored in a medication cart and discarded according to the manufacturer recommendations . Record review of the facility's policy titled, Administering Medications, dated [DATE], reflected, .The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container . Record review of the facility's policy titled Storage of Medications, dated [DATE], reflected, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . The nursing staff shall be responsible for maintaining medication storage .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed Medications requiring refrigeration must be stored in a refrigerator located in the drug room .or other secured locations .Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in: 1. The facility failed to ensure food items in the facility refrigerator were dated or labeled. 2. The facility failed to ensure 2 dietary staff wore facial hair coverings while preparing and serving food dinner on 5/5/2025. 3. The facility failed to ensure the grease trap on the cooking griddle was cleaned and emptied daily. 4. The facility failed to ensure broken tiles from kitchen footboard were stored away from opened food. 5. The facility failed to ensure temperatures were taken of all cooked food before serving them to residents during lunch meal service on 05/6/25. 6. The facility failed to ensure some food items were not properly sealed. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food contamination. Findings Include: Observation of refrigerator in the kitchen and interview [NAME] T on 5/5/25 revealed the following: 6:29pm *1 opened box of 15lb Platter Sliced Bacon with an unsealed plastic bag of bacon about 1/2 full opened to the air. 6:30pm (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*1-gallon sized plastic bag with 10 large light green leaves, without a label of its contents or date opened. [NAME] T stated it was lettuce for sandwich fixings. *1-gallon sized plastic bag with about 30 various sized hollow white circular objects without a label of its contents or date opened, [NAME] T stated they were cut onion for sandwich fixings. *1- gallon sized plastic bag with 8 red 2-inch circular items without a label of its contents or date opened. [NAME] T stated it was sliced tomatoes for sandwich fixings. 6:31pm *5inch cylinder like green object wrapped in plastic wrap without label of what the item was or date received. [NAME] T stated it was a cucumber. *1 square clear plastic container with a yellowish beige pureed and chunky items about 1/8 full of the container with no label of what it was or used by date. [NAME] T stated it was Au Gratin Potatoes but did not know when the discard date was. Observation of freezer #1 in dining area and interview with [NAME] T on 5/5/25 at 6:34pm revealed the following: *1 sealed package of approximately 35 3inch long brown tubular items with no label of what it was. [NAME] T stated they were unopened hot dogs. *1-gallon plastic bag with 8 circular 3-inch pink discs with not label of what it was or discard date. [NAME] T stated they were burger patties he had just opened and put them away. He stated he forgot to label them and date them. Observation of refrigerator in dining room and interview with [NAME] T on 5/5/27 at 6:37pm revealed the following: * four 1-gallon clear plastic jugs of brown liquids without covers that had no discard date or label of what it was. [NAME] T stated it was tea, but he did not know when it was made. * three 1-gallon clear plastic jugs of clear liquids with no covers, discard date or label of contents. [NAME] T stated they were waters. Observation of freezer #2 in dining area and interview with [NAME] T on 05/05/27 revealed the following: 6:38pm *1-gallon sized plastic bag with about 8 2-inch beige balls with black spots on them with no label or discard date. [NAME] T stated it was cookie dough but did not know when it was opened. 6:39pm (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*2 approximately 3lb manufacture sealed bags of various sized disc shaped tan circles with no center, without a label of contents or date received. [NAME] T stated they were onion rings but did not know when they were received. * 2 12inch disc shaped circles with orange and white shredded stuff on top in sealed plastic wrap, without a label of what they were or date received [NAME] T stated they were cheese pizzas but did not know when they were received. * 20lb of mixed vegetables in a blue plastic bag about 1/2 full, inside a box that was not sealed or closed and was opened to the air with no discard date. Observation and interview on 5/5/27 at 6:40pm of [NAME] T and Dietary Aide DD were without facial hair coverings in the kitchen while serving food and getting items from the kitchen refrigerator. Interview with [NAME] T revealed the facility had coverings for their facial hair but the coverings do nothing and proceeded to show where the coverings were at and how they looked. He stated he had asked the Director of Food Services to buy facial coverings that covered their facial hair and was pending to hear back from her. He stated the risk to the residents of serving food without covering facial hair was hair could fall in the food and contaminate it. Observation and interview on 5/5/27 at 6:43pm revealed the following: *two red tiles from the floorboard loose and leaning on the wall in the kitchen next to the serving table. *a clear square plastic cannister with a red top on kitchen shelf above prep table with about 1/3 of contents that included beige various shaped circular disc with ridges on them without a label of contents or discard date. *An opened, unsealed bag of 3-lb potato chips about 3/4s full. [NAME] T revealed that the cannister had potato chips and the opened bag of potato chips was just opened by him that day during food service. *rectangular grease trap on the cooking skillet in the kitchen with about 1/8 inch thick of black grime all around it. [NAME] T opened the grease trap tray and revealed a nearly full tray with various yellow liquids. He stated he emptied the tray daily, but the expectation was that it should be emptied after every use. He stated the last time he emptied it was the night of 5/4/25, he could not recall when the entry hole was cleaned. He stated the grime was thick in his opinion. He emptied the tray again while being interviewed. He stated the risk to the residents of not emptying the tray or properly cleaning the grease trap was potential bacteria growth and fire hazard. Observation and interview on 5/5/25 at 6:53pm of dry food storage revealed 5 red baseboard tiles stored on a shelf under a bag of unsealed onions. [NAME] T revealed he did not know the reason the baseboard tiles were put on the same shelving unit below the bag of onions because that was nasty. He stated that the baseboard tiles had been falling off in the kitchen and a work order to fix them had been submitted but they had not fixed them yet. He stated the work order was submitted on 4/29/25. Record Review of May 2025 Meal Temperature Logs revealed temperatures of all food served on 5/4/25 and 5/5/25 were not taken. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with [NAME] T on 5/5/25 at 6:58pm revealed he had forgotten to take the food temperatures and log them before serving dinner that day. He knew all food needed to be tempted before serving as the risk was that food may be undercooked or too hot and could make the residents sick or burn them. Interview with [NAME] T on 5/5/25 at 7:45pm revealed the Director of Food Services had informed him the kitchen had been powered washed the day prior and the tiles on the shelf in the dry food storage had come off of the kitchen footboard and they had put the tiles on the shelf so the maintenance staff could find them easily. He stated they still should not have put the dirty tile near the open food. Observation of kitchen refrigerator on 5/6/25 at 8:22am revealed the plastic bags from previous day's observation of onions, lettuce and tomatoes (sandwich fixings) were not labeled or dated when to discard. Interview with [NAME] CC on 5/6/25 at 8:22am revealed everything in the freezers and refrigerators should be dated and labeled with the date received, date opened and discard date. He took the items out of the refrigerator and threw them away. He stated the risk to the resident of not labeling and dating was they could get sick from bad food. Observation of the kitchen floor revealed the red base board tiles had been removed. Observation of lunch being served on 5/6/25 at 12:18pm revealed [NAME] CC took out a new tray of meatloaf from the oven and did not temp it before serving it to the residents. Interview with [NAME] CC on 5/6/25 at 12:25pm revealed he failed to take the temperature of the 2nd tray of meatloaf when he took it out of the oven. He stated the oven was on, so he believed it was hot, however he should have taken the temperature. The risk to the resident of not taking the temperature was the food could not be fully cooked, and the residents could get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Director of Food Services on 5/6/25 at 12:56pm revealed she had trained all cooking staff on dating and labeling items. She stated the items should have potentially 3 dates date received, date opened and discard date. She expected all food in the refrigerators, freezers and dry goods to have been labelled. She stated she had not known sealed items removed from their original boxes with no manufacture label needed to be labelled what it was because it was clearly visible what they were, however, would start labeling everything. The expectation for sealing opened items was they wrap up the items in the original packaging if possible and put in a sealed plastic bag, with a date opened and date discarded. The risk to the residents of not appropriately labeling items were many things to include food borne illnesses such as Salmonella poisoning and cross contamination. She was informed the aide and cook last night had no facial coverings for their facial hair and stated the facility had facial hair covering nets and would talk to staff about the reason they were not being worn. The risk to the residents of not wearing the facial hair net covering was hair could fall in the food and contaminate it. The May 2025 Temperature Log was reviewed with the Director of Food Services noted temperatures were not taken on May 4th or May 5th. She stated the expectation was temperatures should have been taken every meal, every day before serving. If staff intended to serve food the food needed to be temped before serving. She stated she checked temperature logs daily to ensure temperatures were being taken every meal and every day, however she hadn't had a chance to check the log since the weekend. She stated she would be writing up the cooks for May 4th and May 5th, as they knew temperatures had to be taken of all food. The risk of the temperatures of the food not taken before serving was the food could be raw or could be too hot and burn residents. She stated she was made aware of the tiles that were broken last week and during the deep clean and sanitization of the kitchen. She had asked the staff who were sanitizing the kitchen to move the tiles somewhere that maintenance would have been able to find them, so they put them in the dry goods storage on the shelf. She stated they should not have put the tiles in any place food was stored and had asked [NAME] T to move them last night. She stated the risk of having the footboard tiles close to opened food was cross contamination and exposure of possible bacteria to the residents' food. She stated the grease trap on the kitchen stove should be emptied and cleaned after every use. She was shown a picture of how the grease trap looked yesterday with the gunk on it and she stated it was not acceptable and would ensure staff was doing a better job cleaning it. She stated the risk of not emptying the grease trap was it was a fire hazard. Review of the facility's policy Preparation of Foods revised 1/2023 .3. Food is prepared in a sanitary manner . 10. Temperatures will be documented and followed accordingly to food safety code. Review of the facility's policy Food Storage revised 4/11/2022 .6. Food removed from its original packaging will be labeled with the following: a. received date b. open date c. contents in the package .9. Opened package or leftover food it to be tightly wrapped or covered in airtight, clean containers. It should be labeled, dated with the opened or use by date .19. Safe food temperatures will be maintained at acceptable levels during food storage, preparation, holding, service, delivery, cooling and reheating .22. Food is cooked to at least 135 degrees F. Reheat foods to an internal temperature of at least 165 F 24. Check food temperatures prior to meal service. If the food temperatures are not within acceptable parameters, the food is reheated or child to an appropriate temperature .26. Food temperatures are taken and recorded at all meals . Review of the facility's policy Food Service Uniforms effective 11/01/2019 .1. Below are some guidelines on interpretation of professional: .facial hair is allowed only if beard guard is always worn while in the kitchen and during food production/service . (continued on next page)

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	675089	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Food and Drug Administrative Food Code, dated 2022, reflected, .Chapter 3. Food Condition 3-101.11 Safe, Unadulterated, and Honestly Presented The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 17 residents (Resident #47, Resident # 28, and Resident #46) observed for infection control. 1. The facility failed to ensure LVN D performed hand hygiene before and after performing Resident #47's fingerstick blood sugar on 05/06/25 and failed to perform hand hygiene after cleaning the soiled glucometer. 2. The facility failed to ensure LVN D performed hand hygiene before and after performing Resident #28's fingerstick blood sugar on Resident # 28 and failed to prevent cross contamination of the dining room table when she placed the soiled glucometer on the table after obtaining the fingerstick blood sugar on 05/06/25. 3. The facility failed to ensure CNA Q performed hand hygiene while providing incontinence care to Resident #46 on 05/07/25 and failed to ensure CNA Q performed hand hygiene before leaving the resident's room. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #47s face sheet dated 05/09/25 reflected a [AGE] year-old male with an admission date of 05/20/22. Diagnoses included type 2 diabetes. An observation on 05/06/25 at 04:30 p.m. revealed LVN D was at the medication cart preparing to obtain fingerstick blood sugar for Resident #47. LVN D put on gloves and removed the glucometer from the medication cart and wiped it down with a Sani-wipe (germicidal wipe). LVN D removed her gloves and re-gloved without performing hand hygiene and entered the resident's room. After obtaining the fingerstick blood sugar, LVN D returned to the cart, removed her gloves, and put on another pair of gloves without performing hand hygiene. LVN D then retrieved the bottle of Sani-Wipes and wiped down the glucometer and placed it back in the medication cart. LVN D then removed her gloves and without performing hand hygiene pushed the cart down the hallway to the next resident. 2. Record review of Resident #28's, Face sheet, dated 05/09/25 reflected a [AGE] year-old male with an admission date of 10/25/24. Resident #28 had a diagnosis which included Type 2 diabetes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 05/06/25 at 04:45 p.m. revealed LVN D pushing the medication cart to Resident #28's room. Resident was not in his room. LVN D stated he was probably in the dining room. LVN D pushed the cart to the nurse's station and opened the medication cart to obtain the glucometer, test strip, lancet and alcohol wipe. LVN D put on gloves without performing hand hygiene and entered the dining room. Resident #28 was sitting at the table with another resident. LVN D obtained Resident #28's fingerstick blood sugar and sat the glucometer down on the dining room table while waiting for the results. Resident's blood sugar reading was 360. LVN D gathered up the glucometer, lancet and test strip and returned to the medication cart where she disposed of the lancet and test strip. LVN D removed her gloves and put on clean gloves without performing hand hygiene and retrieved a Sani-cloth and wiped down the glucometer and placed it back into the medication cart. LVN D checked the computer to determine she would need to contact the MD for orders. LVN D reached out to the physician and received an order for 15 units of Lyumjev and recheck blood sugar at HS. LVN D then performed hand hygiene and put on gloves and retrieved the insulin pen from the medication cart and dialed in the amount of insulin required (15 units). LVN D returned to the dining room where she administered the insulin to Resident #28. LVN D returned to the medication cart, removed her gloves, but did not perform hand hygiene, and wiped down the insulin pen with an alcohol wipe and returned it to the medication cart. In an interview with LVN D on 05/06/25 at 04:55 p.m. She stated she was supposed to perform hand hygiene before and after performing a Fingerstick blood sugar. She stated she did not have any hand sanitizer on her cart. She stated she knew they were not supposed to check Resident's blood sugar or give insulin in the dining room but stated Resident #28 would not have left the dining room for her to get his blood sugar. She stated she should not have laid the glucometer on the dining room table. She stated not performing hand hygiene and placing the glucometer on the dining room table crated a risk of cross contamination and the spread of germs. In a follow up interview with Resident #28 on 05/06/25 at 05:10 p.m. resident stated he did not mind having his blood sugar checked or his insulin given to him in the dining room. He stated he would have gone to his room if that was what they wanted. He stated they had taken him to the nurse's station before when he was out of his room. He stated it really did not matter to him where he was when they got his blood sugar. 3. Record review of Resident #46's Face Sheet dated 05/09/25 reflected an [AGE] year-old female with an admission dated of 05/26/25. Diagnosis included Alzheimer's. In an observation on 05/07/25 at 02:55 p.m. CNA Q entered Resident #46's room to provide peri-care. CNA Q put on gloves but did not perform hand hygiene. CNA Q uncovered resident, pulled her pants down and unfastened the resident brief, revealing resident was wet. CNA Q provided peri care, changing the surface of the wipe with each stroke. CNA Q then retrieved a clean brief from the resident's chest of drawers, while wearing the soiled gloves, and placed the clean brief under the resident and rolled the resident over and closed the resident's brief. CNA Q then repositioned the resident, covered her up and lowered the bed. CNA Q removed her gloves, gathered the trash, and left the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/07/25 at 03:10 p.m. CNA Q stated she was supposed perform hand hygiene before and after care and before going to the next resident. She stated she was going to wash her hands when she dropped off the soiled linen. She stated she thought since she had gloves on her hands were clean. She stated she was not aware she had to change her gloves and perform hand hygiene between each glove change. In an interview on 05/08/25 at 09:30 a.m. with the DON she stated staff were to change their gloves and sanitize their hands when going from dirty to clean. She stated staff were always required to perform hand hygiene before care and after care. She stated staff were not to perform Fingerstick blood sugars or give insulin in the dining room. She stated it was a dignity issue as well as an infection control issue. She stated they do train on infection control during their skills checks and anytime they had any issues with infections in the building. She stated the risk of not adhering to the protocol was increased risk of infections. In a follow up interview with the DON on 05/08/25 at 03:00 p.m. she stated she was unable to locate skills check for CNA Q on peri-care and hand hygiene. She stated she checked her off today. She stated she was not sure how it was overlooked. Record review of the facility's policy titled, Hand Hygiene, dated October 2022, reflected, .Hand hygiene is used to prevent the spread of pathogens in healthcare settings .You should always perform hand hygiene . Before applying and after removing personal protective equipment (e.g. gloves, gown, mask, face shield/goggles) .Before and after providing any type of care .After contact with medical equipment or other environmental surfaces that may be contaminated .You must perform hand hygiene .after contact with bodily fluids, such as urine or blood .

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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 ensure an effective pest control program was implemented so the facility is free of pests and rodents for one of twenty-four residents (Resident #2), the facility's only kitchen, the facility's only nurses' station, and one hall (100 hall) of five halls reviewed for pest control. 1. The facility failed to effectively treat Resident #2's room for gnats. 2. The facility failed to keep an effective pest control program so that the facility was free of gnats in the Kitchen. 3. The facility failed to ensure one hallway (100 hall) of 5 hallways where residents' rooms were located, were free of gnats. 4. The facility failed to ensure the nurses station was free from gnats. These failures placed residents at risk for cross contamination, food borne illnesses, the spread of infection and disease, and a reduced quality of life. Findings included: 1. In an observation and interview on 05/05/25 at 6:52 PM revealed Resident #2 was lying in bed with a food tray on the bedside tables, food crumbs on the bed linen and the floor, with 5 gnats flying around her and landed on the bed linen and bedside table; she stated she had noticed the gnats for a while now, was not sure what was causing them and they bothered her but she learned to live with it. She stated that the facility did treat the room for the pests, was not sure when the last time it was treated, and housekeeping cleaned her room each day. In an observation of and interview on 05/06/25 at 3:21 PM with Housekeeper EE revealed she had cleaned Resident #2's room and floor; she stated and the residents linens were clean. At this time there was one gnat flying in the room. Housekeeper EE stated Resident #2's room did occasionally have gnats and thought it was due to Resident #2 eating in bed- the gnats were attracted to food. She stated when she saw the gnats she would write it on the pest control log and then inform the Director of Plant Operations (DPO) verbally and the room would be treated for pests. In an interview on 05/09/25 at 11:57 AM with the Director of Environmental Services (DES) revealed Resident #2 ate her meals in bed and frequently spilled food that attracted small black bugs to her room. She stated that they clean Resident #2's room [ROOM NUMBER] days a week and an additional evening cleaning on Tuesday and Thursday and Fridays. She stated Resident #2's room was treated on 05/08/25 with fly bait spray. She stated meal trays that were not picked up on time or food spills would attract the gnats and when housekeeping observed those things, they notified nursing. She stated there are cleaning products available to the staff when housekeepers were not onsite. She stated it was important for a resident's room to be free from gnats because it was an environmental hazard and was unclean for a resident. 2. Observations in the kitchen on 5/6/25 during lunch meal service revealed the following: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*12:15pm a gnat flying around the bread rolls. *12:18pm a gnat landed on a bread roll. *12:25pm a gnat flying around the bread rolls. Interview with the Director of Food Services on 5/6/25 at 12:56pm revealed she was aware of the issues with gnats flying around the kitchen and believed they had been coming from the drains. She stated they had been dumping bleach in the drains to help stop the gnats. She stated the facility had been fumigating monthly. The risk to the residents of the gnats flying around the food was they could land in the food and contaminate it. 3. Observation of the 100- hall on 05/7/2025 at 1:30pm revealed two gnats by the entryway of the conference room located in that hall. Interview with CNA J on 5/8/25 at 8:42am revealed she had noticed gnats in the 100- hall, by the coffee makers in the dining room and trashes this week. 4. Observation of nurses' station in the middle of the building on 5/8/25 at 9:00am revealed 3 gnats flying around the desks the nurses' desks. Review of the facility pest control service revealed Pest Management Service Agreement dated 7/2/19 .1. Services to be performed .a. perform monthly pest control service, including coordinating with Client's staff to implement an Integrated Pest Management plan, monitor and track pest issues inside and outside of the facility, addressing site issues both reported and observed .Pest control each month consists of: inspecting and treating interior pest issues including kitchen, laundry, exits, closets .e. when requested, treat a specific areas that are experiencing a particular problem . Review of facility's Pest Logs revealed reported incidents of gnats by staff on the following dates: *2/5/25 (room [ROOM NUMBER]), * 2/20/25 (nurses' station), *4/14/25 (nurses station), *4/27/25 (room [ROOM NUMBER]), *5/1/25 (building), * 5/8/25 (laundry, room [ROOM NUMBER] and room [ROOM NUMBER]), *5/8/25 (nurses station) and, * 5/9/25 (room [ROOM NUMBER]) (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility invoice from Perfect Pest Control dated 4/16/25 .General Comments: Upon arrival I located logbook finding no new entries at this time. I made my way to maintenance director's office to where I was told he would out at lunch. I visited with kitchen staff stating they have seen an occasional gnat. I applied a liquid residual to cracks and crevices throughout the kitchen added a foaming agent to drains and a poly a liquid residual to the bottom sides of the dish pit tables .Material: Alpine WSG .target pests: American Roaches, Gnats/Fruit/Crane . Review of facility invoice from Perfect Pest Control dated 3/11/25 revealed gnats were not addressed during the fumigation visit. Review of facility invoice from Perfect Pest Control dated 2/12/25 .General Comments: Met with MD (Maintenance Director) upon arrival, he stated he knew of nothing but has told staff to utilize the log book. I located the logbook finding 104, 304, 310 and 291 with gnats. I inspected each room and restroom finding no signs of gnats and applied an aerosol bait to walls in restroom .I also met with laundry attendant stating gnats are better but still see an occasional gnat. I applied an aerosol bait to walls Material: PT alpine pressurized fly bait .target pests: Gnats/Fruit/Crane Interview with Director of Plant Operations on 5/7/25 at 1:12pm revealed he was aware gnats being reported in the kitchen and other areas in the building and had pest control coming every time it was reported. He stated he scheduled pest control to come on 5/9/25 to spray again for gnats. Interview with CNA P on 5/8/25 8:57am revealed she had seen a couple of gnats in several of the hallways this week. Interview with Director of Nursing on 5/8/25 at 12:09pm revealed the facility had pest control come out routinely and pest control looked at the book showing when they had issues with gnats. She had not seen gnats until they were flying around a fast food item meal that was brought earlier in the break room. The risk of having gnats in the facility with residents present was issues with infection control and cross contamination. Interview with Executive Director on 5/8/24 at 12:45pm revealed staff writes sightings of pest in the pest log and pest control was asked to come out immediately. Additionally, pest control would come monthly to fumigate and would check the pest logs as well to ensure they were treating for any issues. The Director of Plant Operations would also call the pest control company as needed. The risk of having pest in the facility, particularly in the kitchen would be contamination of food. Interview with RN G on 5/8/25 at 2:30pm revealed she saw gnats on and off in patient rooms, particularly where patients were hoarding food in their room. She worked at the facility for 7 years and had seen gnats on and off. She had never seen them in the dining area. The facility's pest control policy was requested but not provided before the date and time of exit.