

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Galveston Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure residents had a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely for 5 (Resident #5, #7, #25, #39, and #58) of 20 Residents reviewed for safe, comfortable, homelike environment. The facility failed to ensure call light cords were within reach of Resident #5, #7, #25, #39, and #58. This failure could place residents at risk of not being able to summon help if needed which could result in diminished quality of life and potential injuries. Findings included: 1. Record review of Resident #5' quarterly MDS assessment, dated 06/08/26 reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, heart disease, and diabetes. Her BIMS score was 12, indicating she was cognitively intact. Her Functional Abilities assessment reflected she was dependent on staff for her ADLs. Record review of Resident #5's care plan, dated 06/11/26, revealed she had asthma and required oxygen, she required feeding via her gastric tube, and she had an ADL self-care deficit. Observation on 07/13/26 at 10:25 AM revealed Resident #5's adaptive call light was located out of reach on her nightstand. Observation on 07/15/26 at 10:00 AM revealed CNA-A and CNA-B entered Resident #5's room to check on her and exited the room without placing the resident's call light within reach. Interview on 07/15/26 at 10:03 AM CNA-A and CNA-B both exited Resident #5's room and stated they did not notice where Resident #5's call light was placed. CNA-A stated it important to have her call light where she could reach it in case she needed to call for help. 2. Record review of Resident #7's quarterly MDS assessment, dated 07/07/26, reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke, muscle wasting, and cognitive communication deficit. MDS revealed resident had a BIMS score of 1, indicating severe cognition. Functional ability assessment indicated he was dependent on staff with his activity of daily living skills and transferring in and out of bed. Observation on 07/15/26 at 10:12 AM revealed Resident #7 was in bed, with his call light located out of reach in his nightstand. In an interview on 07/15/26 at 10:12 AM Resident #7 stated he did not know where his call light was, and he often used it to notify staff of his wants and needs. 3. Record review of Resident #25's annual MDS assessment, dated 05/10/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included prostate cancer, weakness, diabetes, and dementia. His BIMS score was 14 indicating he was cognitively intact. His Functional Assessment indicated he required minimal assistance with his ADLs. Record review of Resident #25's care plan, dated 06/11/26, reflected he had fatigue related to anemia, bowel incontinence, and had some cognitive deficits. Observation on 07/15/26 at 10:15 AM revealed Resident #25 in bed, call light was out of reach; it was tucked under the fitted sheet under his bed. In an interview on 07/15/26 at 10:15 AM Resident #25 stated he did not know where his call light was located. He stated staff always put it where he could not reach it. 4. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #58's quarterly MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke affecting his left side, diabetes, and chronic pain syndrome. His BIMS score was 13, indicating he was cognitively intact. His Functional Ability indicated he was mostly independent with his ADLs. Record review of Resident #58's care plan, dated 07/02/26, reflected he required assistance with dressing the left side of his body, had diabetes, and was incontinent of bowel. Observation on 07/15/26 at 10:18 AM revealed Resident #58 was in bed with his call light located out of reach on the floor under his bed. In an interview on 07/15/26 at 10:18 AM Resident #58 stated staff forget to clip his call light to his bed, and it always fell off where he was unable to reach it. Resident #58 stated he used the call light to notify staff when he needed assistance. 5. Record review of Resident #39's quarterly MDS assessment, dated 05/23/26, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke, diabetes, and placement of feeding tube. Her BIMS score was not calculated due to her medical condition. Her Functional Abilities assessment indicated she was totally dependent on staff for her ADLs. Record review of Resident #39's care plan, dated 6/11/26 revealed she was dependent on staff for her ADLs, was a high risk for skin breakdown. Observation on 07/15/26 at 10:22 AM revealed Resident #39 was in bed sleeping, her call light was located between the wall and her nightstand. In an Interview on 07/15/26 at 10:30 RN-C stated it was important for the resident's call light to always be within their reach, even when they were up in a chair, so the resident could call for assistance if they needed help. He stated there was a risk of the resident being injured trying to get up unassisted. In an interview on 07/15/26 at 10:41 AM the DON stated call lights always needed to be within the reach of the resident. She stated the cord should be secured to the resident's bedding or clothes with the clip on the cord. She stated the risk to the resident if they could not call for assist could be falling trying to get up. Record review of the facility's undated policy Answering the call light, reflected: 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower, and from the floor.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to provide a private meeting space for the residents' monthly council meetings for 8 of 8 confidential residents reviewed for resident council. The facility failed to provide a private space for resident council meetings. This failure could place residents, who attended resident council meetings, at risk of not being able to voice concerns due to a lack of privacy. Findings included: During an observation and a confidential resident group interview with eight residents on 07/14/26 beginning at 10:00 AM, revealed the facility arranged for the meeting to be held in an open activity area in the hallway located near the Business Office, MDS Office and outside the Therapy Gym. There were no doors that could be closed to ensure the residents' privacy during the meeting. The Activity Director did not place any signs to indicate a resident council meeting was in progress. During the meeting, staff were observed walking through the area while the meeting was in progress and volunteers were doing a walk-through. The eight residents in attendance all reported that their monthly resident council meetings were held in the open activity area after 2PM when therapy was gone. The residents stated they knew it was a private meeting; however, no one had offered a private room before and they never thought about asking for one. The residents stated they were used to the open area in the activity area. The residents denied expressing their concern about the location. Interview on 07/14/26 at 11:24 a.m., the Activity Director stated she was responsible for coordinating resident council meetings monthly. She stated resident council meetings were conducted in the activity area. She stated resident council meetings were held at 2PM, to avoid conflicts with therapy sessions and minimize disruptions caused by residents and staff entering and exiting the therapy gym. The Activity Director stated she was aware resident council meetings needed to be in a private setting; however, the facility did not have a room big enough to allow that. The Activity Director stated she would usually post signs on the hallway stating Resident Council Meeting in session; however, she forgot to post them today (07/14/26). She stated she sent out a message to the facility staff and verbally told staff that a resident council meeting was being held. The Activity Director stated residents had the right to have a private meeting; however, there was no potential risk if the residents did not have a private area. Interview on 07/15/26 at 6:37 p.m. the Operations Director stated the Activity Director was responsible for arranging resident council meetings. She stated she was aware resident council meetings needed to be held in a private area. She stated resident council meetings had been held in the activity area; however, they had been exploring options to find a better place for resident council meetings. The Operations Director stated the potential risk of not holding resident council meetings in a private setting would be a violation of resident's privacy, a grievance might want to be reported privately. Record review of facility Resident Council revised 12/2025, reflected the following: The facility supports residents' rights to organize and participate in the resident council. 4. The resident council group is provided with space, privacy, and support to conduct meetings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen in that: 1. One container of macaroni salad with plastic wrap not properly sealed, dated 07/09/26 - 07/12/26, located in refrigerator #1. 2. One container of potato salad with plastic wrap not properly sealed, dated 07/06/26 - 07/09/26, located in refrigerator #2. 3. One container of hard-boiled eggs dated 07/06/26 - 07/09/26, hot dog [NAME] dated 07/03/26 - 07/06/26, and a container of red sauce dated 07/09/26 - 07/12/26, located in refrigerator #2 indicating these food items should have been removed prior to surveyor entrance date of 07/13/26. 4. The facility failed to maintain the stove area, countertops, and food preparation area in a clean and sanitary manner. These failures could affect all residents in the facility who eat from the kitchen, by placing them at risk of contracting food borne illnesses. Findings included: Interview and observation on 07/13/26 at 8:14 AM during the initial tour of the kitchen with [NAME] H revealed the kitchen floor was wet with water, food, and trash. Food crumbs were observed on the stove area and unclean countertops. In the dishwashing area, there were dirty dishes piled at the sink area. Further observations revealed there was a container of macaroni salad dated to be removed on 07/12/26 in refrigerator #1, container of potato salad dated 07/09/26, and hard boiled eggs dated 07/09/26, hot dog [NAME] dated 07/06/26, and a container of red sauce dated 07/12/26, located in refrigerator #2. According to [NAME] H, he did not complete a walk through this morning and tray aides were responsible for completing daily walk throughs to remove any outdated food containers. [NAME] H stated not removing outdated food items placed risk of bacteria growing, which could cause food to become contaminated and residents to become ill. During an interview and observation with the Dietary Manager on 07/14/26 at 9:30 AM, the Dietary Manager stated it was the responsibility of all kitchen staff to date and label food if they open them. The Dietary Manager stated that all food should be labeled with the date it was opened and a use by date if applicable. The Dietary Manager stated that not dating, labelling, and properly sealing food placed residents at risk of being served unsafe food. The Dietary Manager stated she completed a walk through daily and expected the staff to do the same and remove anything was outdated so it would not be served to residents. The Dietary Manager stated she was notified by [NAME] H that the kitchen was in disarray and had not been cleaned over the weekend. According to Dietary Manager, she expected staff to maintain a healthy, clean environment to store and prepare meals. In an interview on 07/14/26 at 4:27 PM, the Administrator stated she expected all staff to follow policy and procedure on keeping the cleanliness of the kitchen. According to the Administrator, when she started there was a lot of broken equipment and the kitchen was not kept very well. The Administrator stated that now there was a deep cleaning schedule and expectations to clean spills, crumbs, keep the floors swept and mopped, wearing hair nets and providing presentable food for residents. The Administrator stated that all food should be properly sealed, dated, and labeled; not doing so placed residents at risk of food borne illnesses. The Administrator stated the Dietary Manager was responsible for ensuring this was being done. Record review of the facility's current, undated Food Receiving and Storage policy reflected the following: Foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerated/Frozen Storage1. All foods in the refrigerator are covered, labeled, and dated (use by date) .7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review revealed the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that were readily accessible for Resident 4 of 6 (Resident #6, #20, #24 and #47) reviewed for clinical records. 1. The facility failed to ensure that consultant pharmacist medication regimen review was kept in residents' active clinical records for Resident #6, #24 and #47 after the facility underwent a change of partnership.2. The facility failed to ensure the medical records for Resident #20 included his code status. This failure placed residents at risk of not having access to their records or receiving thorough HHSC investigations of complaints. Findings included: 1. In an interview on [DATE] at 9:11 a.m. the Operational Manager was asked to provide Pharmacist Report/Drug Regimen Review for the last 12 months. Record review of facility Pharmacy binder revealed it only contained [DATE] through [DATE] Consultant Pharmacist's Medication Regimen Review. Further review revealed [DATE]-[DATE] were not provided, unable to review pharmacy review for Resident #6, Resident #24 and Resident #47. Interview on [DATE] at 6:08 p.m. the DON stated the only consultant pharmacist medication regimen review on file would be from [DATE]. She stated she does not have any pharmacy recommendations prior to [DATE]. She stated the previous facility team took everything before the new company took over in [DATE]. Interview on [DATE] at 6:10 p.m. the Operations Director stated the previous facility took most of the paper documents with them. She stated it happened before she was employed on [DATE]. She stated attempts were made to obtain documents but were unsuccessful. She stated she was aware files needed to be kept for a while. She stated the potential risk of not keeping documents on file would be the facility would be unable to track any concerns or changes within the residents. Interview on [DATE] at 6:46 p.m. the Administrator stated the previous company took all paper documents with them. He stated a lot of things were missing and attempts were made to obtain them but were unsuccessful. He stated files should be kept for years. He stated they had no control of what the previous company took. He stated the facility only had the residents' electronic health records but no paper documents prior to [DATE]. 2. Record review of Resident #20's discharge MDS Assessment, dated [DATE], revealed a [AGE] year-old male who admitted to the facility on [DATE] and discharge [DATE]. Resident #20 had diagnoses which included spinal stenosis, lumbar region with neurogenic claudication (narrowing of the lower spinal canal, compressing nerve roots), and Type 2 diabetes mellitus without complication (sustained high blood sugar levels). The MDS reflected that the residents' cognition was moderately impaired with a BIMS score of 12. Record review of Resident #20's care plan, revised [DATE], reflected the care plan did not address the resident's code status. Record review of Resident #20's [DATE] physician's orders, revealed no physician's order for code status, such as full code status or DNR. Interview on [DATE] at 12:02 p.m., Resident #20 stated he was doing well. Resident #20 stated he could not recall whether he was a full code or DNR. He stated it was something he would have to think about. Interview on [DATE] at 3:06 p.m., RN C stated he was the nurse assigned to Resident #20 before his discharge on [DATE]. RN C stated each resident should have a code status. He stated the admission nurse should document the resident's code status, full code or DNR, in the clinical records. RN C reviewed Resident #20's clinical records and stated Resident #20 did not have an order for a code status or was care plan for it. He stated the MDS Coordinator was responsible for updating care plans. He stated he was not aware Resident #20 did not have a code status. RN C stated the potential (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of not having a code status would be resident coding and staff would not know whether to resuscitate him or not. Interview on [DATE] at 3:25 p.m., the ADON stated each resident in the facility should have a code status. She stated the admission nurse was responsible for obtaining a code status. The ADON reviewed Resident #20's clinical record and stated Resident #20 did not have an order or care plan for it. She stated she was not aware there were no orders in place for Resident #20's code status. She stated the MDS Coordinator was responsible for updating care plans. The ADON stated if the resident did not have an out of hospital DNR they would be full code. She stated there would be no potential risk because the nurses would perform CPR if no DNR was in place. Interview on [DATE] at 5:32 p.m. the MDS Coordinator stated she was responsible for completing and updating comprehensive care plans. The MDS Coordinator stated residents' code status should be care planned. She stated care plans should reflect the residents' code status. She reviewed Resident #20's physician's order and stated the reason why Resident #20's code status was not care planned was due to the resident not having an order for it. She stated she was not aware Resident #20 did not have a code status. Interview on [DATE] at 6:06 p.m., the DON stated she was not aware Resident #20 did not have a code status. She stated it was the responsibility of the admitting nurse or the Social Worker to obtain a code status and include it the resident records. The DON stated if no code status was obtained the resident would be considered full code and might not reflect his wishes. Record review of facility Retention of Medical Record, dated 12/2006 reflected the following: Medical records shall be retained by the facility in accordance with current applicable laws. 1. Medical records of discharged residents will be retained for a period of 7 years. In case of minors, records shall be retained for not less than 10 years after the resident reaches legal age as established by this state.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all mechanical and electrical equipment in safe operating condition by failing to maintain the dishwasher in safe operating condition. The facility failed to ensure the dishwasher in the facility's only kitchen was cleaned, disinfected and reached minimum 120 degrees during wash and rinse cycles when the Dishwasher Aide was cleaning breakfast dishes on 7/13/26. These failures could place residents at risk of foodborne illness. Findings included: Record review on 07/13/26 at 9:30AM of Dish Machine Temperatures and Sanitizing Log dated July 2026 revealed dates 07/01/26 - 07/12/26 documented 120 for wash/120 rinse/200 parts per million for AM, Noon, and PM wash. Further review of the log revealed date 07/13/26 AM and PM logs were already filled out with 120 for wash/120 rinse/200 parts per million for AM and Noon. Interview and observation on 07/13/26 at 8:31 AM upon arrival to the kitchen revealed the Dishwasher Aide G placing breakfast dishes in the dishwasher. Observation of the dishwasher running at 109 degrees with white substance built up and bubbling in the water at the dispensing spout. Dishwasher Aide G expressed that she did not know what the white substance was that was gathered in the water. Dishwasher Aide G stated she was aware the dishwasher ran at a minimum of 120 degrees. When Dishwasher G was asked what was the procedure for washing dishes, she did not respond. Interview and observation on 07/13/26 at 9:24 AM, [NAME] H revealed when he returned to work on 07/13/26 at 5:30 AM he noticed the kitchen in disarray. According to [NAME] H, Dishwasher Aide G was responsible for dishes today, and to ensure the dishwasher was running properly. [NAME] H stated he could not identify the white substance bubbling in the water and building up at the dispensing spout. [NAME] H stated he was aware the dishwasher was to run at a minimum of 120 degrees consistently, and when staff would need to allow the dishwasher to run a few times to allow the temperature to set at 120 degrees. [NAME] H stated not allowing the temperature to reach 120 degrees before starting the dishes placed residents at risk of eating off dirty dishes, which could cause spread of infection. Interview and observation on 07/13/26 at 9:45 AM with the Maintenance Director revealed he has not had any issues with the dishwasher reaching up to 120 degrees, during his monthly inspections. The Maintenance Director stated today was the first day of hearing there was an issue, he would adjust the water temperature to allow hot water to flow to the dishwasher. According to the Maintenance Director it was important for the kitchen to have hot water to keep a clean kitchen. During an interview and observation with the Dietary Manager on 07/14/26 at 9:30 AM, the Dietary Manager The Dietary Manager stated she ran the dishwasher and did not have any issues getting the temperature to read at 132 degrees, however during the observation of 5 cycles observation revealed the temperature reaching up to 114 degrees. According to the Dietary Manager the Maintenance Director adjusted the water temperature on 07/13/26 and there were no issues afterwards. During the observation, the Dietary Manager stated she was going to have the dishwasher serviced, as it should not take 5 cycles to reach 120 degrees. The Dietary Manager stated she re-educated the dishwashing staff on ensuring the dishwasher temperature maintained at least 120 degrees while washing the dishes, not doing so placed residents at risk of food borne illness and contamination. In an interview on 07/14/26 at 4:27 PM, the Administrator stated she expected all staff to follow policy and procedure on keeping the cleanliness of the kitchen, not doing so placed all residents and staff at risk of food borne illness and their safety. According to the Administrator, when she started there was a lot of broken equipment and the kitchen was not kept very well. Record review of facility's undated policy titled Dishwashing Machine Use, reflected Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation. The operator will check temperatures using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or Part Per Million are adjusted. Record review of manufacturer's Machine Washing revealed the following: Load the Dish machine Properly - Avoid overlapping or overcrowding that can prevent water from reaching all surfaces. Make Sure the Machine is Functioning Properly - A malfunctioning or improperly maintained machine that fails to clean tableware adequately can increase the risk of cross-contamination the next time it comes into contact with food or beverages. To help ensure that your machine functions as it should to effectively clean dishes and destroy harmful microorganisms, perform these steps: 1. CHECK THE GAUGES and compare their readings with the minimum temperatures, chemical concentrations and pressure measurements listed on the data plate: High-temperature, or heat-sanitizing, machines will show a minimum rinse temperature of 180 F and minimum wash temperatures of 150 F, 155 F or 160 F, depending on machine type and make and model. Low-temperature, or chemical-sanitizing machines, also show minimum rinse and wash temperatures - typically 120 F for both - on the data plate. Chemical sanitizing machines also indicate a minimum active concentration of the sanitizer on the data plate. Pressure readings: Not all machines, including those that have a pumped rinse, have a pressure gauge. For those that do, ensure that pressure readings are close to the optimal 20 PSI. 2. CLEAN WASH ARMS AND RINSE JETS FREQUENTLY. Over time, wash arms and rinse jets can become blocked or clogged, either with food debris, sediment, or mineral scale buildup. Luckily, wash arms and rinse jets are EASY TO REMOVE for cleaning. Do so often. 3. DE-LIME. If left unchecked, lime buildup will bog down your dish machine. In fact, just 1/4 of lime scale can cause a heating element to use 39 percent more energy. 3 Regular de-liming can reduce your water and energy use dramatically.		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to equip privacy curtains to ensure full visual privacy for each resident in 5 rooms (Rooms 114, 301, 303, 307, and 402) of 20 rooms reviewed for privacy. The facility failed to ensure residents in Rooms 114, 301, 303, 307, and 402 had privacy curtains in place to ensure full visual privacy. This failure could place residents at risk of being exposed to people in the hallway during procedures when they are exposed. Findings included Observation and interview on 07/13/26 at 10:25 AM revealed room [ROOM NUMBER] was a double room with one resident in residence. Both beds had the track for ceiling suspended curtains to be installed, however there was no privacy curtain present. The resident did not know how long it had been like that. Observation on 07/13/26 at 10:31 AM revealed room [ROOM NUMBER] was a double room with two residents in residence. The W bed had tracks and clips for ceiling suspended curtains however there was no privacy curtain in place. Observation and interview on 07/13/26 at 10:46 AM revealed room [ROOM NUMBER] was a double room with two residents in residence. The D bed had tracks for ceiling suspended curtains, however there was no privacy curtain. The resident stated it had been that way for months. The W bed had a curtain that provided partial privacy. The resident of the W bed did not like having the end of his bed exposed. Observation on 07/14/26 at 9:35 AM revealed room [ROOM NUMBER] was a double room with one resident in residence. Both beds had tracks for ceiling suspended curtains, but no curtains were in place. Observation on 07/14/26 at 10:05 AM revealed room [ROOM NUMBER] was a double room with one resident in residence. Both beds had tracks for ceiling suspended curtains, however there was no privacy curtain in place. Observation on 07/15/26 from 12:35-12:45 PM revealed Rooms 114, 301, 303, 307, and 402 continued to not have privacy curtains in place. Interview on 07/15/26 at 1:00 PM Housekeeper-F stated she did not know who was responsible for replacing the privacy curtains. She thought it would be Maintenance. Interview on 07/15/26 at 1:32 PM the Director of Plant Operations stated he would hang any privacy curtain he was asked to, but he relied on nursing staff and housekeeping to let him know when they were needed. Interview on 07/15/26 at 1:44 PM the DON did not know for sure who was responsible for privacy curtains, she had been in her position for a short time, but she assumed nursing staff would notify housekeeping when a privacy curtain needed to be replaced because it was dirty. She thought housekeeping should notice if a curtain was simply missing, and maintenance needed to be notified when a curtain needed to be hung. Review of the facility's guidance Resident Room Privacy, undated, reflected: All resident rooms must be arranged and maintained to protect resident privacy and dignity. The facility will use cubicle curtains, screens, and/or other approved procedures to provide full visual privacy during care, treatment, dressing, and other personal activities. For rooms with more than one resident, each bed must have a privacy curtain that allows complete visual separation between residents. In private rooms, the ceiling-suspended curtain requirement does not apply, but the facility must still ensure privacy through other appropriate means.		

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NAME OF PROVIDER OR SUPPLIER Galveston Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	
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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 observations and interviews the facility failed to maintain an effective pest control program to keep the facility free of roaches for 1 (Resident #35) of 5 residents rooms reviewed for pest control. The facility failed to ensure Resident #35's room was free of roaches. This failure could affect residents by placing them at risk for the potential spread of infection, cross-contamination, food-borne illness, and decreased quality of life. Findings included: Record review of Resident #35's admission MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with a BIMS score of 04, indicating severe cognitive impairment. Resident #35's diagnosis included heart failure, high blood pressure and kidney disease. His Functional abilities assessment revealed he required setup or clean-up assistance with eating, oral and personal hygiene. Nutritional approaches included mechanically altered diet. Record review of Resident #35's care plan, undated, Resident #35 has impaired cognitive function or impaired thought processes related to difficulty making decisions. Goal: Resident will have no unmet needs. Interventions included resident needs assistance with all decision making. Record review of Pest Control Contract dated 03/13/26 revealed, We (Pest Control) agree to furnish Integrated Pest Management service for the period of 1 year; said contract to be renewed at the end of one year with agreement by both parties. Monthly General Pest Control the following pests: roaches, spiders, ants (excluding the crazy ant and carpenter ant), box elder, silverfish, wasp, pillbug, earwigs and rodents. Record review of pest control book revealed visits on: 07/01/26 target pest: snakes; 06/17/26 target pest: monthly service; 06/02/26 target pest: German roaches and Bed Bugs; 05/29/26 target pest: bed bugs; 05/19/26 target pest: ants, roaches, spiders; 04/20/26 target pest: German Roaches; 11/19/25 target pest: roach spider ants; 10/25/25 target pest: roach prevention; Interview and observation on 07/13/2026 11:20 AM with Residents #35 revealed Resident #35 lying in bed and stated he had concerns with roaches in his room as he pointed to the nightstand. Roaches were observed on the nightstand, roaches were crawling up, down and around Resident #35's personal belongings to include cups, personal hygiene products and food. Further observations revealed at least 10 roaches on the floor coming in and out from underneath the bottom of the nightstand and along the baseboards and behind Resident #35's nightstand. Interview on 07/13/26 at 2:35pm with Family Member B revealed Resident #35 had lots of roaches in his room everywhere. According to Family Member B the facility had treated Resident #35's room at least 3 times, however they had not gotten rid of the issue. Family Member B stated during visits you could notice roaches over food covered in boxes at his nightstand and bedside table. The roaches will beat you to the food they are out and about, and you can see them, especially at night. Interview on 07/14/26 at 3:43 PM CNA K reported he had never observed Resident #35 with roaches in his room and had not had any complaints from Resident #35 about roaches or pests. According to CNA K he has seen pest control in the facility and housekeeping making daily rounds to Resident #35's room. Interview and observations on 07/14/2026 at 3:45 PM revealed Resident #35 in bed, pointing at his nightstand and saying he had a lot of roaches and asked surveyor to open the drawer. Observation further revealed resident's nightstand with at least 30 roaches crawling all over the nightstand. Interview and observation on 07/14/2026 at 4:01 PM with the DON revealed at least 15 roaches at the resident's nightstand, the DON stated she heard roaches were on the hall however had never seen them. The DON stated she would alert the Maintenance Director and immediately left Resident #35's room. Interview and observation on 07/14/26 at 4:10 PM the DON stated she and Maintenance Director entered Resident #35's room, opened the drawer to find open food and roaches (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all over the place. According to the DON, the Maintenance Director stated he was going to call pest control. The DON stated she had been in the facility for 6 weeks and had only seen pest control once, she was not sure if there had been an issue with the contract or what, however not providing pest control placed residents at risk of decline in care, dignity, quality of life. The DON stated it was the responsibility of all staff to report any pests they see to the Maintenance Director and the Maintenance Director was responsible to maintain the building and eliminate pests as much as possible. Interview on 07/14/2026 at 4:17 PM the Maintenance Director stated he was not aware residents had issues with roaches, this was the first of him hearing about it. The Maintenance Director reported he called pest control and they will be here tomorrow (07/15/26) at 1:00 PM. According to the Maintenance Director when he opened the drawer, he only saw 1 roach and that was enough for him, he further stated there was a current pest control contract and pest control was last present in the facility about 3 weeks ago. The Maintenance Director stated it was the responsibility of staff to notify him if they see pests in the facility so he can ensure he notified pest control, not doing so could cause infestations. Review of the facility's guidance Pest Control, reflected 05/2008, reflected the following: Our facility shall maintain an effective pest control program.1.This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident #20) of 3 residents reviewed for discharge planning.1. The facility failed to notify Resident #20 of discharge, reasons for the move, and right to appeal in writing, in a language and manner he understands, and at least 30 days before Resident #20 was discharged from the facility on 07/13/26. 2. The facility failed to send a copy of the Resident #20's notice of discharge to the facility's Ombudsman.This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Findings includedRecord review of Resident #20's discharge MDS Assessment, dated 07/13/26, revealed a [AGE] year-old male who admitted to the facility on [DATE] and discharge 07/13/26. Resident #20 had diagnoses which included spinal stenosis, lumbar region with neurogenic claudication (narrowing of the lower spinal canal, compressing nerve roots), and Type 2 diabetes mellitus without complication (sustained high blood sugar levels). Resident #20's cognition was moderately impaired with a BIMS score of 12. The MDS assessment section A indicated resident's discharge return not anticipated, it was a planned discharge to Home/Community. Record review of Resident #20's care plan, revised 06/14/26, reflected there were no notes related to Resident #20's discharge goals and plans.Record review of Resident #20's Care Plan Conference dated 6/3/2026 Type of Conference: Other; DC Planning; IDT follow- up plan: assist resident with transition to community as per his preference. Record review of Resident #20's Care Plan Conference dated 6/26/2026 Type of Conference: Quarterly; Specify social services care plan change(s): Working on discharge plan; Additional comments: [Resident #20] wants facility to finish discharge plan. Record review of Resident #20's progress notes from 07/10/26 through 07/13/26 reflected: -A note by the Operations Director on 07/10/26 at 15:10 [3:10 PM] This writer has been working on [Resident #20] discharge planning with him. He has been added to the waitlist for two low-income apartment options in [name] City. [Resident #20] has agreed to transition to the community to a long stay hotel that the facility will cover the cost of the first two weeks as well as provide food for the week and toiletry items. [Resident #20] had no disagreement to this, the DON and Medical Records staff were present at the time as well. The monthly cost of the hotel was reviewed with [Resident #20] and is within his budget. Facility to also is sending a referral for Home health to an agency that will accept VA benefits. This writer did talk to the Ombudsman previously in the week regarding the discharge. The physician agrees to the discharge. Per physician, this writer did notify the emergency contact #1 so they are aware of the discharge. The information for the two apartments that [Resident #20] is on the waitlist for will be provided to him so he can follow up as needed. Discharge is planned for Monday, 7/13.-A note by the Operations Director on 07/10/26 at 15:58 [3:58 PM] With the BOM present, this writer confirmed that [Resident #1] is [sic] accepting of his discharge plan. Services were reviewed to ensure that he understood a home health referral was being sent for a provider that accepts his VA benefits, the facility would pay for the first two weeks and that the facility would provide groceries and personal items for his transition. [Resident #20] was very appreciative at this time. The Activity Director will provide [Resident #20] with a list of meals for wheels services in [city].-A note by the BOM on 07/10/26 at 16:05 [4:05] This writer, BOM, and administrator talked to (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident #20] regarding his discharge plan. He was more than agreeable and thankful for all our help. BOM assisted in setting up home health for the Monday discharge.-A note by the BOM on 07/13/26 at 9:41 The writer, BOM, and receptionist, went to speak with [Resident #20] regarding his discharge. He expressed concerns about financials. We assured him the motel would be covered and provided documentation with that. He was still disagreeing. We then informed him that his needs no longer fit those of a skilled nursing facility. He said he understood but was still acting hesitant. BOM then informed administrator of the conversation.-A note by the LVN on 07/13/26 at 15:05 [3:05] Resident discharged from the facility on 07/13/2026 at 1500 [3:00]. Discharge completed per physician orders. Resident departed the facility with all personal belongings, prescribed medications, and discharge instructions. Appropriate discharge paperwork was completed and provided. Resident left the facility in stable condition with no acute distress noted at the time of discharge.Record review of Resident #20's Discharge Summary/Post discharge Plan of Care dated 07/13/26 reflected: Resident was admitted to the facility on [DATE] with a primary diagnosis of spinal stenosis, lumbar region with neurogenic claudication. During his stay, the resident received skilled nursing services, prescribed medications, and physical and occupational therapy to address his diagnosis and improve his functional abilities.The resident participated in therapy as tolerated, with care focused on improving strength, mobility, balance, endurance, and activities of daily living. Medications were administered as ordered, and the resident was routinely monitored for pain control, safety, and response to treatment.During his stay, the resident also exhibited behaviors that required staff intervention, including smoking in front of the facility despite facility policies. There were also concerns regarding suspected illegal drug use, which were addressed according to facility policy, with the appropriate notifications and interventions implemented.Skilled nursing assessments were completed throughout the stay, and the resident's plan of care was updated as needed. The resident has completed his skilled stay and will continue with the recommended plan of care and follow-up services as appropriate.discharge date /time: 07/13/26 at 13:00 [1:00] Transportation: Private Vehicle Discharge to location: [blank] Interview on 07/13/26 at 12:02 p.m., Resident #20 stated he was doing well. Resident #20 stated he was being discharged from the facility today (07/13/26). He stated he was told he was being transferred because he was not following facility smoking policy. Resident #20 stated he was never provided with a discharge notice, he was only told he was going to a hotel that the facility would be paying for, for 2 weeks. He did not know where the hotel was located or how much it was. Resident #20 stated he did not care if he stayed or left, his only concern was financial. He stated he did not want to pay for a hotel if it was over his budget. Resident #20 stated he was told he was going to be discharged on Friday 07/10/26, which gave him no time to prepare. Interview on 07/14/26 at 9:02 a.m. Resident #20's Family Member A stated Resident #20 was not provided with a 30-day discharge notice or any notice of discharge. Family Member A stated on Friday 07/10/26 a phone call was received notifying them of the discharge. Family Member A stated Resident #20 was being discharged because he was not following the facility smoking policy and use of illegal substance in which the resident denied. Family Member A stated Resident #20 stated the facility was working on a discharge but no definitive decision was made. Interview on 07/14/26 at 9:45 a.m. the Ombudsman stated on 07/07/26 the Operational Manager told her, giving you a head up, we going to discharge [Resident #20]. She stated she had not receive any notification of the resident's discharge. She stated on 07/10/26 she was contacted by Resident #20 and informed her he was being discharged on 07/13/26. She stated she was informed by the facility that the resident was being discharged for not following smoking policy. She stated she assumed Resident #20 was going to get a 30-day discharge notice because of the reason of discharge. She stated she was not informed (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #20 was being discharged because he did not have medical necessity to be able to stay at the facility any longer. She stated if there was a facility initiated discharge the facility was required to provide a 30-day written notice to the resident, their family/representative, and the ombudsman. Per the conversation she had with Resident #20 on 07/10/26 the resident agreed to go but then on Monday 07/13/26 he did not want to leave. Interview on 07/14/26 at 2:43 p.m., LVN J stated she completed Resident #20's discharge paperwork. She stated she completed the discharge summary and resident was discharged to a hotel. LVN J stated she did not put the location of the hotel on the discharge summary because she did not have an address. LVN J stated she was not sure if Resident #20 received a 30-day discharge notice. LVN J stated Resident #20 did not require any assistance, he was able to do everything on his own. Interview on 07/15/26 at 12:52 p.m. the Operations Director stated on 06/03/26 a care conference was held with Resident #20 and the goal was for Resident #20 to return to the community. She stated Resident #20 agreed to the discharge because his health had improved and he no longer needed services. The Operations Director stated Resident #20 would also not follow facility smoking policy. She stated a notice was provided to Resident #20. Follow-up interview on 07/15/26 at 6:10 p.m. the Operations Director stated no 30-day discharge notice was provided to Resident #20. She stated a discharge notice was provided today (07/15/26) but the resident refused to sign. She stated no discharge notice was provided prior to today (07/15/26) because it was a planned discharge and the resident agreed to it. She stated the Ombudsman was verbally notified but no official notice was provided. Potential risk of not providing the required 30-day discharge notice would be the resident and/or their family may not be aware of the planned discharge, the reason for the discharge, or the destination following the discharge. Interview on 07/15/26 at 6:46 p.m., the Administrator stated Resident #20 did not receive any services at the facility and it was a planned discharge. He stated Resident #20 did not receive a 30-day discharge notice because they did not know they needed to provide one. The Administrator stated he moved from another state and was unaware of the regulation. He stated after reviewing the Texas Administrative Code it was indicated that a notice should have been provided to Resident #20 and the Ombudsman. The Administrator stated there was no potential risk to the resident if a 30-day discharge notice was not provided. He stated it was a clinical error. Record review of facility Resident admission Agreement undated, reflected the following: The Facility shall provide written notification to the Resident and, if known to the Facility, the Resident Representative (or, if none, to a family member or legal representative of the Resident) in writing, with a copy sent to a representative of the Office of the State Long-Term Care Ombudsman, at least thirty (30) days in advance of transfer or discharge, or, if necessary, as soon as practicable as permitted under applicable law. Leave the Nursing Home: Except in emergencies, nursing homes must give a 30-day written notice of their plan and reason to discharge or transfer you. The nursing home has to safely and orderly transfer or discharge you and give you proper notice of bed-hold and/or readmission requirements. Record review of facility Transfer or Discharge Documentation revised 12/2016, reflected the following: 4. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: . 2. That an appropriate notice was provided to the resident and/or legal representative.		

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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 interviews and record reviews the facility failed to ensure residents were screened for mental illness and coordinate with the State mental health authority the need for services for 1 of 4 residents (Resident #1) reviewed for PASARR screening. The facility failed to ensure Resident #1 was screened for services by the mental health authority once he received a diagnosis of Schizophrenia on 01/30/26.[BR31.1] This failure could result in residents with mental illness not receiving services to which they are entitled. Findings included: Record review of Resident #1's admission MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with a BIMS score left blank, indicating he could not successfully complete the interview with disorganized thinking. Resident #1's diagnosis included Anxiety Disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues affecting daily functioning and quality of life), Depression (a common and serious mood disorder by persistent feelings of sadness, loss of interest, and a range of emotional and physical problems), and Schizophrenia (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking. Resident #1 showed signs of little interest or pleasure in doing things, feeling, or appearing down, depressed, or hopeless and being short-tempered, easily annoyed nearly every day. His Functional abilities assessment revealed he had impairment on one side, supervision with eating, partial moderate assistance with oral hygiene, and was dependent on staff for toileting, shower/bathing self, lower body dressing and putting on or taking off footwear. Resident #1 required substantial assistance with upper body dressing and personal hygiene. Record review of Resident #1's care plan, undated, reflected he impaired cognitive function/dementia or impaired thought processes affecting communication related to long term alcohol abuse. Resident #1 had a history of refusing care related to schizophrenia. Goals: Resident #1 will maintain current level of cognitive functioning. Interventions included Administer medication as ordered. Monitor/document for side effects and effectiveness. Ask yes or no questions in order to determine the resident's needs. Communication: Use the resident preferred name. Identify yourself at each interaction. Face the residents when speaking and make eye contact. Reduce any distractions- turn off TV, radio, closed door. The residents understand consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty RN expressing self, difficulty understanding others, level of consciousness, mental status. Resident #1 uses antidepressant medication related to Depression. Goal: Resident #1 will be free from discomfort or adverse reactions related to antidepressant therapy. Interventions included: Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Monitor /document /report as needed adverse reactions to Antidepressant therapy; change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in activities of daily living ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes. Psychotropic review per interdisciplinary team at least quarterly and as needed. Resident #1 has mood impairment related to diagnosis of Major Depression Disorder. Goal: Resident will have improved mood state. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions included Administer medication as ordered. Monitor/document for side effects and effectiveness. Assist the resident in developing/providing the resident with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise, physical activity. Monitor/document/report as needed any risk for harm to self; suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Monitor/record/report to physician as needed acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. Monitor/record/report to physician as needed risk for harming others; increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Record review of Resident #1's PASRR Level 1 screening, dated 10/22/24, reflected he did not have a primary diagnosis of dementia, and there was no evidence of mental illness. Record review of Resident #1's clinical chart revealed no PASRR 1 Level 1 screening or Mental Illness/Dementia Resident Review (Form 1012), had been completed after new diagnosis of Schizophrenia on 01/30/26 by the psychiatrist. Interview on 07/13/2026 11:07 AM, Resident #1 denied any mental illness and stated he was able to voice his needs and concerns. Interview on 07/13/26 at 1:26 PM, MDS Coordinator A stated Resident #1 had a negative PASRR Level 1 Screening on 10/22/24 due to him not having evidence of mental illness. Interview on 07/14/26 at 11:13 AM, RN I stated Resident #1 had behavior issues when he was triggered. RN I stated she was aware of the Schizophrenia diagnosis however Resident #1 did not require a lot of interventions because he stayed in his room most of the time and could voice his needs. She stated the CNAs provided him with incontinent care, helped him dress in the mornings, and assisted him in his wheelchair if needed. RN I stated the MDS Coordinator was responsible for assessing residents for PASRR screenings, not doing so placed residents at risk of missing services and care that could add to quality of life. Interview on 07/15/2026 5:43 PM Regional MDS Coordinator B stated she was not aware Resident #1 had a new diagnosis of Schizophrenia, therefore had not been screened or referred to the local mental health authority after the new diagnosis. Regional MDS Coordinator B stated Resident #1's diagnosis came from the psychiatrist; therefore, a new screening would be required. Regional MDS Coordinator B stated she would complete the Mental Illness/Dementia Resident Review (Form 1012) for the doctor to sign off indicating that Resident #1 would remain negative because Schizophrenia would have needed to be diagnosed around the age of 21. She stated Resident #1 not being assessed after the new diagnosis placed him at risk not receiving services and care he might qualify for. She stated she and the other MDS Coordinator was responsible for performing the MDS assessments and referring residents to the local authority. She stated she did not know why Resident #1 had not been referred to for PASRR services in January 2026 when he got the new diagnosis. Record review of the facility's current, undated PASRR Completion Policy, reflected the following: The Center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. 1. Center Administrator will designate either the Admissions Director or Social Worker to make sure that the PASRR and/or Level of Care (LOC) is done on all potential residents. If the referral indicates anything which might constitute an SMI or ID, the PASRR must be completed prior to admission. If the resident is deemed hospital exempted that must be clearly documented in the transfer documents prior to admission from the acute care facility. 2. Administrator will also designate a backup in case the designated person is not available. 3. Administrator is accountable for monitoring the process of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Galveston Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3702 Cove View Blvd Galveston, TX 77554	
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completing the necessary paperwork for the admission.4.Business Office Manager (BOM) must have copies of the LOC and/or PASSRR in the Business Office resident file.		

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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 interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 8 residents (Residents #9 and #22) reviewed for baseline care plans. The facility did not develop a baseline care plan for Residents #9 and #22 within 48 hours of admission. This failure could place new residents at risk of not receiving necessary care and services or having important care needs identified. Findings included: Record review of Resident #9's admission MDS Assessment, dated 07/03/26, reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain dysfunction caused by systemic illness or organ failure), malnutrition (poor nutrition), and osteoporosis (bone disease). The MDS reflected that the resident's cognition was moderately impaired with a BIMS score of 08. Her Functional Abilities assessment reflected she was dependent on staff for her ADLs. Review of Resident #9's electronic health record revealed the resident's 48-hour baseline care plan was started on 06/27/26 but was not completed. Record review of Resident #22's admission MDS Assessment, dated 04/23/26, reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included chronic respiratory failure, hypertension (high blood pressure), hemiplegia and hemiparesis (one sided weakness/paralysis) following cerebral infarction (stroke) affecting right dominant side and tracheostomy status (surgical airway opening in the neck). The MDS reflected that the resident's cognition was cognitively intact with a BIMS score of 15. Review of Resident #22's electronic health record revealed the resident's 48-hour baseline care plan was started on 04/18/26 but not completed. Interview on 07/15/26 at 3:12 p.m., RN C stated when a resident admitted to the facility, the nurse on duty was expected to complete all assessments that made up the baseline care plan. He stated the baseline care plan should be completed within 48 hours of admission. RN C reviewed Resident #9 and Resident #22's electronic health record and stated the baseline care plans were not completed. He stated he was not aware the baseline care plans were not completed. RN C stated baseline care plans must be completed within 48 hours of admission to ensure staff were aware of the resident's immediate short-term goals and ongoing goals. Interview on 07/15/26 at 3:53 p.m., the ADON stated baseline care plans were completed by the admission nurse and the interdisciplinary team. She stated the admission nurse completed the admission portion of the baseline care plan, then the interdisciplinary team would review and sign off. She stated she was not aware Resident #9 and Resident #22's baseline care plans were not completed. She stated it might just need a signature. The ADON stated during morning meetings the interdisciplinary team reviewed all new admissions and ensure required assessments were completed timely. Interview on 07/15/26 at 6:16 p.m., the DON stated her expectation was for baseline care plans to be completed within 48 hours by the admission nurse. She stated it was the responsibility of the ADON and herself to ensure they were completed. She stated she was not aware baseline care plans were not being completed. She stated if baseline care plans were not completed timely the potential risk would be nursing staff may not be aware of the resident expected plan of care. Record review of facility Care Plans - Baseline revised 03/2022, reflected the following: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 (Resident #10 and #20) of 8 residents for care plan revisions, in that: The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #10's psychoactive medication use. The failure could place residents at risk of receiving inappropriate care. Findings included: Record review of Resident #10's quarterly MDS Assessment, dated 06/05/26, revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #10 had diagnoses which included major depressive disorder, recurrent severe without psychotic features, psychotic disorder (mental disorders that cause abnormal thinking and perceptions), and Non-Alzheimer's Dementia (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). The MDS reflected that the resident's cognition was moderately impaired with a BIMS score of 09. The MDS also revealed the resident received antipsychotic, antianxiety and antidepressant medications 7 days a week. Review of Resident #10's Care Plan revised 04/08/26 revealed there was no care plan addressing Resident #10's psychoactive medication use. Record review of Resident #10's July active physician orders revealed the following: - Quetiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate) Give 1 tablet by mouth three times a day for Major depressive disorder, recurrent, severe, with psychosis. Start date 05/01/26. - trazodone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day for Insomnia. Start date: 05/01/26. - Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Major depressive disorder, recurrent, severe, with psychosis. Start date: 05/02/26. Record review of Resident #10's July [DATE] revealed the resident was receiving the following medications as scheduled: - Quetiapine Fumarate Oral Tablet 100 mg by mouth three times a day; - trazodone HCl Oral Tablet 50 mg by mouth once a day; and - Sertraline HCl Oral Tablet 50 mg by mouth once a day. Interview on 07/15/26 at 5:32 p.m. the MDS Coordinator stated she was responsible for completing and updating comprehensive care plans. She stated residents who were receiving antipsychotic medication and were having behaviors should be care planned. The MDS Coordinator reviewed Resident #10's physician's orders and stated the resident was receiving antidepressant and antipsychotic medications. She reviewed Resident #10's care plan and stated the resident was not care planned for the use of the medications. She stated it was a mistake and it should have been care planned. She stated the potential risk of not care planning for antipsychotic medication would be staff may not know what to monitor or which interventions were in place. Interview on 07/15/26 at 6:08 p.m., the DON stated it was the responsibility of the MDS Coordinator to complete and update residents' care plans. She stated residents who were receiving antipsychotic medication should be care planned. She stated the potential risk of not care planning for antipsychotic medications would be plan of care not being followed for the use of the medication. Record review of Care Plans - Baseline policy did not address comprehensive care plan. Policy was requested but not provided prior to exit. Record review of facility Informed Consent for Psychotropic Drugs policy undated, reflected the following: For residents on psychotropics: Ensure IDT involvement in care planning, including review of indications, nonpharmacological alternatives, GDR, and monitoring for side effects. IDT Process: Review psychotropic use in care planning conferences; include assessment of condition, interventions, impacts, alternatives. Re-evaluate at least quarterly or upon significant change [BR3].		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 Resident (Residents #5, #9) of 9 residents reviewed for pressure ulcer treatment. 1. The facility failed to ensure Residents #5 and #9 had dressings covering their wounds. 2. The facility failed to ensure Resident #9 received wound care as ordered by the physician on 07/14/26. These failures could place residents at risk of developing wound infections. Findings included: 1. Record review of Resident #5's quarterly MDS assessment, dated 06/08/26 reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, heart disease, and diabetes. Her BIMS score was 12, indicating she was cognitively intact. Her Functional Abilities assessment reflected she was dependent on staff for her ADLs. Record review of Resident #5's care plan, dated 06/11/26, revealed she had asthma and required oxygen, she required feedings via her gastric tube (a medical device inserted directly through the abdominal wall into the stomach), and she had an ADL self-care deficit. Record review of Resident #5's physician's orders revealed an order dated 07/10/26 Cleanse stage 1 pressure injury (earliest sign of skin damage) on coccyx (tailbone) with WC/NS. Apply zinc oxide every shift and place mepilex dressing every shift for Wound on coccyx AND as needed for PRN Wound Care Observation on 07/15/26 at 2:18 p.m., of wound care, provided by the Wound Care Nurse, CNA-A, and CNA-B, revealed when Resident #5's brief was opened she had been incontinent of stool, and the dressing to her coccyx was not in place. Incontinence care was provided and wound care was completed. In an interview on 07/15/26 at 2:33 p.m., CNA-B stated she did not see a dressing to Resident #5' coccyx since she checked the resident around 8:00 AM and again around 12:00 PM. She stated she did not notify the resident's nurse. In an interview on 07/15/26 at 2:34 p.m., the Wound Care Nurse stated leaving the wound open and exposed to stool could cause the resident to develop an infection in the wound. She stated the bedside nurse could change or replace the dressing if it became saturated or fell off, based on the physician's order. In an interview on 07/15/26 at 2:40 p.m., RN-C stated he was not made aware of Resident #5's dressing not being in place. He stated if a dressing came off, he could replace it, or if it was their scheduled wound care day he could check with the wound nurse for guidance. He stated a wound left exposed could cause an infection. 2. Record review of Resident # 9's admission MDS Assessment, dated 07/03/26, reflected she was a (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] year-old female admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain dysfunction caused by systemic illness or organ failure), malnutrition (poor nutrition), and osteoporosis (bone disease). The MDS reflected that the resident's cognition was moderately impaired with a BIMS score of 08. Her Functional Abilities assessment reflected she was dependent on staff for her ADLs. The MDS reflected Resident #9 admitted to the facility with an unstageable pressure ulcer (a wound where the true depth and extent of the damage cannot be determined). Record review of Resident #9' care plan, dated 07/13/26, reflected Focus: [Resident #9] was admitted with a Unstageable pressure ulcer to right buttock. Goal: The resident will have no complications from Pressure Injury through the review date. Interventions: Implement wound care protocol. Review of Resident #9's physician's orders revealed an order dated 07/02/26 Cleanse unstageable pressure injury on right buttock daily and PRN for excessive drainage or dislodgement. Clean with NS/WC, apply Santyl activate with moist gauze and placed bordered foam dressing one time a day AND as needed for leakage or dislodgement. Record review of Resident #9's July 2026 TAR/WAR reflected there was no documentation showing Resident #9 received wound care on 07/14/26. Interview on 07/15/26 at 2:40 p.m., Resident #9 was observed in bed. The resident stated she was doing well. Resident #9 stated she was admitted to the facility with a wound on her bottom. Resident #9 stated she received wound care but could not recall how often. Observation on 07/15/26 at 2:58 p.m., of wound care for Resident #9, performed by the Wound Care Nurse, CNA-A, and CNA-B, revealed her dressing to her coccyx was not in place when her brief was removed and the wound was covered with stool. Incontinence care was provided and wound care proceeded. In an interview on 07/15/26 at 3:03 p.m., RN C stated he was the nurse assigned to Resident #9. He stated he was not made aware Resident #9 did not have a dressing in place. He stated it was expected for the CNAs to notify him or the Wound Care Nurse if no dressing was in place so that they could put one on. He stated Resident #9 received wound care daily. RN C reviewed Resident #9's TAR/WAR and stated based on documentation it did not appear resident received wound care yesterday (07/14/26). He stated Monday through Friday it was the responsibility of the Wound Care Nurse to provide wound care and on the weekends it would be the assigned nurse. He stated if the Wound Care Nurse was unable to provide wound care, she would notify the nurse to complete the wound care. RN C stated the potential risk of a wound not having a dressing or not providing wound care could lead to an infection. In an interview on 07/15/26 at 3:30 p.m., CNA D stated she had not noticed a dressing being in place since the beginning of her shift at 6 AM. She stated she did not notify the nurse, she knew it was her day for wound care and thought it could wait. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/15/26 at 4:11 p.m., the ADON stated her expectations were for wounds to be covered unless physician's order indicated otherwise. If the dressing came off when completing care, the aides were to notify the nurse or inquire if the wound needed to be covered. She stated the risk of not having a dressing on could affect the healing process. In an interview on 07/15/26 at 4:02 p.m., the DON stated her expectation for the CNAs, if they noticed a dressing missing or in need of change, was for them to notify the nurse. She expected the nurse to change the dressing immediately; it was not acceptable to delay dressing replacement just because it was their wound care day. Observation on 07/15/26 at 4:55 p.m. of Resident #9's pressure ulcer site conducted by the Wound Care Nurse revealed pressure ulcer had no signs of infection. In an interview on 07/15/26 at 5:00 p.m., the Wound Care Nurse stated wound care was performed on the weekends, or when she was not available, by the bedside nurse. She stated the nurse would know the dressing was due to be changed because it would populate on their treatment record, plus there was a physician's order they could read to guide them on how to change the dressing. The Wound Care Nurse reviewed Resident #9's WAR and stated she failed to provide wound care yesterday (07/14/26) and failed to notify the nurse. She stated she did not complete wound care because she was occupied and did not have time to complete it. She stated not providing wound care, leaving a wound open and exposed to stool could easily cause infections and/or sepsis (life-threatening reaction to an infection). Follow up interview on 07/15/26 at 6:06 p.m., the DON stated her expectation was for wound care to be completed daily by the Wound Care Nurse. Physician's orders must be followed. She stated she was not aware Resident #9's wound care was not completed on 07/14/26. She stated if the wound care was not completed by the Wound Care Nurse, she must notify the nurse. She stated the potential risk of not providing wound care could lead to an infection. Record review of facility policy Skin Management, dated 06/2022 reflected the following: Residents receive care to aid in the prevention or worsening of wound and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed and provided treatment to promote healing, prevent infection, and prevent new pressure injuries from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 5 residents (Resident #10) reviewed for adequate monitoring of unnecessary medication. The facility did not monitor Resident #10 for side-effects related to the use of the anti-depressant medications Sertraline, Trazodone and the anti-psychotic medication Quetiapine Fumarate. This failure could place the residents at risk for adverse consequences of medication. Findings included Record review of Resident #10's quarterly MDS Assessment, dated 06/05/26, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #10 had diagnoses which included major depressive disorder, recurrent severe without psychotic features, psychotic disorder (mental disorders that cause abnormal thinking and perceptions), and Non-Alzheimer's Dementia (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). The MDS reflected that the resident's cognition was moderately impaired with a BIMS score of 09. The MDS also revealed the resident received antipsychotic, antianxiety and antidepressant medications 7 days a week. Review of Resident #10's Care Plan revised 04/08/26 revealed Focus: [Resident #10] has a behaviors including paranoia, delusions, medications hyper fixation, r/t to recurrent severe, Major Depressive Disorder w/psychotic features. Goal: The resident will have fewer episodes of hyper-fixation on medications and health conditions by review date. Interventions: administer medications as ordered. Monitor/document for side effects and effectiveness. [sic] There was no care plan addressing Resident #10's psychoactive medication use. Record review of Resident #10's July 2026 Active physician orders revealed orders for the following medications: -Quetiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate) Give 1 tablet by mouth three times a day for Major depressive disorder, recurrent, severe, with psychosis. Start date 5/1/2026. -trazodone HCl [VT1.1] Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth one time a day for Insomnia. Start date 5/1/26. -Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Major depressive disorder, recurrent, severe, with psychosis. Start date 05/02/26. The orders did not include any orders to monitor for side-effects related to the use of the Quetiapine, Trazodone, and Sertraline. Record review of Resident #10's Consultant Pharmacist Medication Regimen Review dated 06/30/26, reflected Please monitor specific behavior seen and any side effects with use of psychoactive medications given. Observation on 07/13/26 at 10:28 a.m. Resident #10 was in her room sleeping, there was no response to verbal communication. No distressed or discomfort noted. Interview on 07/15/26 at 4:00 p.m. ADON stated residents receiving antipsychotic medications should have monitoring orders in place as part of their ongoing medication review. ADON reviewed Resident #10's physician orders and stated there were no monitoring orders in place. She stated the DON was responsible for reviewing pharmacy recommendations for the month of June 2026. She stated for residents receiving antipsychotic medication the expectation was for monitoring orders to be obtained. She stated it was the nurses' responsibility to obtain the orders. She stated potential risks of not monitoring antipsychotic medication would be not knowing the therapeutic effectiveness of the medication or adverse effects. Interview on 07/15/26 at 6:08 p.m. the DON stated certain medications should be monitored for side effects. The DON stated she was not aware Resident #10 had no orders for monitoring side effects for the use of psychotropic medication. She stated for residents receiving psychotropic medication the expectation was for monitoring orders to be obtained and it was the responsibility of the nurses. She stated it was the responsibility of ADON and herself to ensure orders (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were put in place. The DON stated the potential risk if staff were not monitoring the side effects of medications could lead unwanted side effects. Record review of facility Orders, Receiving and Transcribing police revised 02/24, was provided; however, it does not address monitor for behavioral or side effects. Record review of the facility's current, undated Informed Consent for Psychotropic Drugs policy reflected the following: For residents on psychotropics: Ensure IDT involvement in care planning, including review of indications, nonpharmacological alternatives, GDR, and monitoring for side effects.		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 residents (Residents #33, #56, and #65) of 8 residents reviewed for infection control. Medication Aide-E failed to sanitize the reuseable blood pressure cuff between uses on Residents #33, #56, and #65. This failure could place residents at risk from infection from another resident. Findings included: Observation on 07/14/26 at 7:58 AM MA-E checked Resident #33's blood pressure prior to administering her morning medications. Upon returning to his cart after administering her medications, he failed to sanitize the blood pressure cuff prior to moving on to Resident #56. Observation on 07/14/26 at 8:21 AM MA-E did not sanitize his blood pressure cuff prior to checking Resident #56's blood pressure. Upon returning to his cart, MA-E failed to sanitize his blood pressure cuff before moving on to Resident #65. Observation on 07/14/26 at 8:29 AM MA-E did not sanitize his blood pressure cuff prior to checking Resident #65's blood pressure. Upon returning to his cart, MA-E did not sanitize his blood pressure cuff. Interview on 07/14/26 at 8:40 AM MA-E stated he was not aware he did not sanitize the blood pressure cuff between residents. He stated he knew to do that, but just forgot to do so today. He stated it was necessary to sanitize between uses to prevent spreading an infection. In an interview on 07/14/26 at 9:44 AM the DON stated her expectation was for any re-useable medical equipment to be properly sanitized before it was used on another resident. She stated proper sanitization helped prevent spreading any infection from one resident to another. Review of the facility's guidance, reflected: All staff are reminded that any equipment used on a resident MUST be clean and disinfected immediately after each use. This includes, but is not limited to: gait belts, lift slings, blood pressure cuffs.		