STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675277	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Inn of LA Grange	457 N Main St LA Grange, TX 78945

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 13 of 64 days (first quarter of 2026) reviewed in that: The facility failed to ensure they had a RN on duty daily for 13 days of the 64 days in the first quarter from 01/2026 through 03/2026.This deficient practice placed residents at risk of missing nursing assessments, resident supervision, and skilled nursing treatment. Findings included:Review of the facility's RN staffing hours for the months of January, February, and March of 2026 revealed no RN hours for the following days: 01/11/2026 (SU); 01/24/2026 (SA); 01/25/2026 (SU); 02/01 (SU); 02/07 (SA); 02/08 (SU); 02/14 (SA); 02/15 (SU); 02/16 (MO); 02/21 (SA); 02/22 (SU); 02/28 (SA); 03/01 (SU).During an interview with the ADON on 03/05/2026 at 10:03 a.m., it was revealed she had been doing the nursing schedule. She said the policy for RN coverage was facility did not have an RN on staff all the time because the NP came in the facility frequently. She said an RN was supposed to be scheduled everyday but because of licensing the facility did not have to have an RN. She said she thought the facility had applied for a waiver. She said she was responsible for making sure there was an RN every day. She said if the facility did not have an RN every day it could only affect the resident as far as if a resident passed away. She said the RN could pronounce someone dead. She said the ADM and DON monitored to ensure there was an RN on schedule. She said there were only two RN that worked at the facility. She added she did not know why the facility had not had RN coverage. During an interview with the DON on 03/05/2026 at 10:14 a.m., it revealed she had been trained on nursing schedule requirements. She said she did not know the policy for RN scheduling requirements. She said she did not know that the facility needed to have an RN 8 hours a day every day. The ADON is responsible for doing the schedule. She said it could affect the residents if there is something that is out of scope of practice for the LVN that an RN can like pronounce a resident. She said she and the ADM monitors to ensure there is an RN on schedule 7 days a week. She said they mentioned the scheduling in the QAPI meeting. She said they monitored by having a meeting with the staff in the mornings. She said she did not know why there were no RN coverage for the 13 days. During an interview with the ADM on 03/05/2026 at 10:22 a.m., she said that she had been trained on the nursing requirements related to scheduling. She said the policy for RN hours was 8 hours a day 7 days a week. She said the ADON was responsible for ensuring that the facility had an RN 8 hours a day 7 days a week. She said if an RN was not scheduled it could delay RN care to a resident in need of an RN. She said HR and corporate monitored to ensure the facility had an RN 8 hours a day. She said HR and corporate monitored by following up to make sure the schedule was accurate. She said the facility did not have an RN for 10 days out of February due to an RN that resigned. She said the facility had two RN positions open and did not have success in hiring an RN.Record review of Staffing, Sufficient and Competent Nursing Policy dated 08/2022 revealed Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.Review of the TAC Title 26 S554.901 of this chapter (relating to Quality of Care) (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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reflected . (2) Registered nurse. (A) The facility must use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, except when waived under paragraph (5) or (6) of this subsection.

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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 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 observations, interviews, and record reviews, the facility failed to provide a private space for residents' monthly council meetings and the confidential resident group meeting during the survey for five of five residents reviewed for resident council. The facility failed to provide the Resident Council with a private meeting area to conduct their meetings. This failure could place residents at risk of not being able to voice concerns due to a lack of privacy. Findings included: A confidential group interview and observation in facility dining room were conducted on 3/04/2026 at 2:00 PM with five residents. During this confidential group interview the meeting was interrupted by facility staff three times within a thirty-minute time span. Three of the residents stated the interruptions sometimes occur during Resident Council meetings, because the meetings are held in the dining room.Interview conducted with ACTD on 3/03/2026 at 1:48 PM. The ACTD stated that the Resident Council Meeting can be held privately in the dining room. She reported that she had signs that would be posted on the doors. Interview conducted with ACTD on 3/05/2026 at 11:39 AM. The ACTD stated she has been employed at the facility for two years and is familiar with the Resident Council policy. She reported that Resident Council meetings are held in the dining room with the doors closed. When told about staff walking in and out during the meetings, the ACTD stated the dining room is the only available area to hold the meetings. When asked how staff are made aware that the meeting is private, she stated staff are informed by word of mouth and that she has told staff not to enter during the meetings. The ACTD further stated she has not previously requested another meeting location that would provide more privacy but would consider requesting one. The ACTD stated that not having a private space for meetings could prevent residents from voicing their concerns.Interview conducted with DON on 3/05/2026 at 11:59 AM. The DON stated she recently began working at the facility and has not yet had the opportunity to review the facility's Resident Council policy. The DON stated the Resident Council policy requirements are generally universal and that residents must have a private space to meet without interruptions. She stated one must be invited to attend. The DON stated that a lack of privacy during Resident Council meetings could have a negative impact on residents. She explained that residents may feel they could not speak freely if staff were present or interrupt the meeting, and they may fear retaliation. The DON stated the Resident Council meeting should be a safe place for residents to express their concerns.Interview conducted with ADM on 3/05/2026 at 12:26 PM. The ADM stated she has been at the facility since July 2025. The ADM stated the dining room has two doors that can be closed to allow the Resident Council meeting to be held privately. The ADM stated there was a lack of communication the previous day regarding the meeting. She stated that Resident Council meetings are typically held on the second Tuesday of the month unless the schedule changes. The ADM stated information about the Resident Council meeting is usually communicated during morning meetings with staff. The ADM further stated the kitchen has a separate exit that does not lead into the dining room. The ADM acknowledged that residents have the right to meet privately. She stated the potential effect of staff entering during meetings could cause residents to feel they cannot freely express their opinions and could interfere with their privacy.Review of facility policy revised February 2021, named Resident Council reflected: Policy statement The facility supports residents' rights to organize and participate in the resident council. Policy Interpretation and Implementation1. The purpose of the resident council is to provide a forum for:a. residents, families and resident representatives to have input in the operation of the facility;b. discussion of concerns and suggestions for improvement;c. consensus building and communication between residents and facility staff; andd. disseminating information and gathering feedback from interested residents.2. All residents are eligible to participate in the resident council. The facility staff encourages residents who are willing to participate. Staff, visitors, or other guests may attend resident council meetings if invited by the respective resident group.3. The resident council group is provided with space, privacy and support to conduct meetings.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received care consistent with professional standards of practice, to ensure necessary treatment and services to promote healing for two of three residents reviewed for pressure ulcers. (Resident #8 and Resident #27) A) The facility failed to ensure the ADON followed standard precautions during wound care for Resident #8's unstageable deep tissue injury (DTI) right heel pressure ulcer (is a full-thickness injury whose depth cannot be determined because the wound bed is obscured by necrotic tissue, slough, or eschar) on 03/04/2026 when she failed to clean the unstageable pressure ulcer in a manner that did not contaminate the wound. She further failed to apply the dressing to the wound as to not cause unnecessary pressure, or trap air and moisture which could hinder the healing process. B) The facility failed to ensure the ADON followed standard precautions during wound care for Resident #27's Stage III coccyx pressure ulcer (a full-thickness skin loss potentially extending into the subcutaneous tissue layer. Wounds often present with granulation tissue and epibole (rolled wound edges) and may have slough and/or eschar.) on 03/04/2026 when she failed to use a cleaning technique on the pressure ulcer that did not cross contaminate the pressure ulcer or prevent the pressure ulcer once cleaned from becoming re-contaminated. She further failed to apply the wound treatment and wound care products to the wound in a manner that ensured the product was able to work as intended to promote healing. These failures could cause severe pain, and lead to systemic infections causing harm or death for residents that have or are at risk for pressure ulcers. Findings: A) Review of Resident #8's face sheet reflected a [AGE] year old female admitted on [DATE] with the following diagnoses Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Rhabdomyolysis (a condition characterized by the breakdown of muscle fibers leading to the release of harmful substances into the blood stream) and osteoarthritis (the protective cartilage that cushions the ends of the bones wears down over time leading to pain). Review of Resident #8's Annual MDS dated [DATE] reflected that she did not have a BIMS conducted indicating she had severe cognitive impairment. Further review of her MDS reflected that she was assessed to have unhealed pressure ulcers and was assessed to have an unstageable deep tissue injury (DTI). Review of Resident #8's comprehensive care plan reflected a focus area dated 01/21/2026 The resident has a deep tissue injury to right heel. Pressure ulcer. Interventions included Administer treatment as ordered and monitor for effectiveness.Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. Review of Resident #8's consolidated physician orders dated 03/04/2026 reflected an order dated 02/25/2026 Cleanse right heel with wound cleanser, pat dry, apply xeroform and cover with a silicone bordered gauze. Observation on 03/04/2026 at 10:41 AM revealed the ADON outside of Resident #8's room to prepare the treatment supplies. After opening and shutting the treatment cart drawers' multiple times and touching various surfaces with her hands, without hand hygiene and no gloves she got out gauze and placed on a piece of wax paper, the xeroform dressing and a silicone boarded dressing. She placed an entire bottle of wound cleanser on the wax paper. The ADON entered the room with the supplies and without cleaning the overbed table placed the treatment supplies on the overbed table (she obtained the overbed table from the resident's roommates' side of the room). The ADON then without hand hygiene she donned gloves. The ADON removed the dirty dressing from Resident #8's right heel, without changing gloves or hand hygiene she sprayed wound cleanser on the gauze brought in and cleaned the unstageable DTI by swiping up and down and across the wound (which could cause any bacteria from the surrounding tissue to be brought into the wound). Without changing gloves or hand hygiene she removed the xeroform gauze from the package and gathered up into a slight ball and placed on the wound (which can cause pressure issues, trapped air and moisture which can hinder the healing process, it is recommended to apply xeroform gauze to avoid wrinkles, it is recommended to use by applying smoothly to wound bed (www.woundsource.com)). The ADON (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then applied the silicone outer dressing over the balled up xeroform. She took off her gloves and took the wound cleanser and placed it back into her cart without wiping it done. No hand hygiene was performed after the wound treatment. B) Review of Resident #27's face sheet dated 03/05/2026 reflected an [AGE] year old male admitted on [DATE] with the following diagnoses, pressure ulcer unstageable to sacral area (is a full-thickness injury whose depth cannot be determined because the wound bed is obscured by necrotic tissue, slough, or eschar), Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and CHF (congestive heart failure)(long-term condition in which your heart can't pump blood well enough to meet your body's needs.). Review of Resident #27's Quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 2 indicating severe cognitive impairment. Resident #27 was further assessed to have a Stage III pressure ulcer. Review of Resident #27's comprehensive care plan reflected a focus area dated 02/21/2026 Resident has Stage III sacral wound. Pressure ulcer. Interventions included Administer treatment as ordered and monitor for effectiveness.Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. Review of Resident #27's consolidated physician orders reflected an order dated 02/21/2026 Cleanse sacral wound with wound cleanser. Apply collagen particles and calcium alginate and cover with silicone bordered super absorbent dressing. Observation on 03/04/2026 at 2:48 PM revealed the ADON outside of Resident #27's room to gather supplies. She placed all the supplies (gauze, calcium alginate, collagen powder and boarded silicone dressing) on a piece of wax paper on her cart. The ADON then went down the hall (two doors down) and used the hand sanitizer on the wall (turning her back on her supplies). The ADON then returned to the cart, got her supplies and entered the resident's room and placed the wax paper on the resident's overbed table that she did not clean (It was observed to have two water rings and food particles on the table). The ADON then left the room stating she was going to get a gown. When she re-entered the room without hand hygiene, she donned gloves. She then shut the door with her gloved hands. She then grabbed the dirty overbed table with her gloved hands to bring it closer to her. At that point someone knocked on the resident's door and with her gloved hands she opened the door then re-shut the door. Without hand hygiene or a glove change she had the two staff members in room assisting to turn Resident #27 on his side. She removed his old dressing to reveal a Stage III pressure ulcer to his coccyx with 3 cm depth (the wound was clean with no signs of infection) she continued her treatment with the same gloves by cleaning the wound across the top of the wound from the outside across the wound. The ADON did not clean the inside of the wound, only across the open area. The ADON swiped across the wound multiple times from the outside in. After cleaning across the wound she let go of this left buttock which she was holding to have access to his wound and the extra skin of his left buttock fell over the wound while she obtained the other wound care supplies (contaminating the area) without recleaning or performing hand hygiene or changing her gloves she applied the collagen to the outside of the wound not the inside wound bed and placed a calcium alginate over the tunnelling, none placed inside with 3 cm depth of the wound. The ADON then covered the wound with the outside silicone dressing. (No glove changes or hand hygiene performed at any time during the wound care) she removed her gloves and took her supplies to the cart. No hand hygiene was performed after the treatment. In an interview on 03/04/2026 at 2:56 PM the ADON stated she did not know she needed to clean the over bed tables before putting down the wax paper. She stated she did use hand sanitizer out in the hall before she started gathering her treatment supplies. She stated she did not wash her hands or change gloves during the treatment with Resident #8 when moving from clean to dirty and stated, If I washed my hands that many times, I would not have hands. The ADON was not sure regarding the application of the xeroform whether she did it right or not and stated that it was the way she was taught. She stated on Resident #27 she used the hand sanitizer in the hall but stated she did not wash her hands or use gloves in the room. When asked about her wound cleaning techniques and application of the wound dressings for Resident #27 she stated, What was I supposed to do, have one of the aides hold it? She stated she applied the dressing to his wounds the way she was taught. In an (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 03/05/2026 at 10:00 AM the DON stated she expected the nurses to wash their hands before going into the room and when they come out. When asked about the facility policy regarding hand washing, she stated yes staff should clean hands before and during wound care when going from dirty to clean, when asked about cleaning the table she stated Yes it should be cleaned. The DON stated resident wounds should be cleaned thoroughly from the inside out and wound care products should be used as recommended to promote healing. In an interview on 03/05/2026 at 10:05 AM the RNC stated nurses should clean wounds from the center out and around not back and forth and the staff should have assistance in the room to help hold the resident in a position when effective wound care can be done. The RNC stated dressings should be applied smooth, without any wrinkles to prevent pressure or wound damage and the wound care products should be used as recommended and the entire wound should be treated. Review of the facility's policy Wound Care dated (2001) reflected The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached.2. Wash and dry your hands thoroughly. 3. Position resident. If necessary, place disposable cloth next to residents (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing.5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly (hand sanitizer can be used). 6. Put on gloves. Gown as indicated based on EBP definition. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no-touch technique. Use tongue blades and applicators to remove ointments and creams from their containers. 16. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard them into designated container. Wash and dry your hands thoroughly. Review of the facility's policy Handwashing/ hand hygiene dated (2001) reflected This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal.

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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 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 two of five residents (Resident #8 and Resident #27) reviewed for infection control practices. A) The facility failed to ensure the ADON followed standard precautions during wound care for Resident #8's unstageable right heel pressure ulcer on 03/04/2026 when she failed to perform hand hygiene during wound care, set up a clean wound dressing field without cross contamination, use enhanced barrier precautions on a chronic wound per facility policy, or use a cleaning technique on the pressure ulcer that did not cross contaminate the pressure ulcer. B) The facility failed to ensure the ADON followed standard precautions during wound care for Resident #27's Stage III coccyx pressure ulcer on 03/04/2026 when she failed to perform hand hygiene during wound care, set up a clean wound dressing field without cross contamination and failed to use a cleaning technique on the pressure ulcer that did not cross contaminate the pressure ulcer or prevent the pressure ulcer once cleaned from becoming re-contaminated. This failure placed residents at risk for developing wound infections, and at risk for healthcare associated cross-contamination and infection.Findings included: A) Review of Resident #8's face sheet reflected a [AGE] year old female admitted on [DATE] with the following diagnoses Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Rhabdomyolysis (a condition characterized by the breakdown of muscle fibers leading to the release of harmful substances into the blood stream) and osteoarthritis (the protective cartilage that cushions the ends of the bones wears down over time leading to pain). Review of Resident #8's Annual MDS dated [DATE] reflected that she did not have a BIMS score conducted indicating she had severe cognitive impairment. Further review of her MDS reflected that she was assessed to have unhealed pressure ulcers and was assessed to have an unstageable deep tissue injury (DTI). Review of Resident #8's comprehensive care plan reflected a focus area dated 01/21/2026 The resident has a deep tissue injury to right heel. Pressure ulcer. Interventions included Administer treatment as ordered and monitor for effectiveness.Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. Review of Resident #8's consolidated physician orders dated 03/04/2026 reflected an order dated 02/25/2026 Cleanse right heel with wound cleanser, pat dry, apply xeroform and cover with a silicone bordered gauze. Observation on 03/04/2026 at 10:41 AM reveled the ADON outside of Resident #8's room to prepare the treatment supplies. After opening and shutting the treatment cart drawers' multiple times and touching varies surfaces with her hands, without hand hygiene and no gloves she got out gauze and placed on a piece of wax paper, the xeroform dressing and a silicone boarded dressing. The resident did not have an EBP sign on the door and the ADON did not don PPE prior to entering the room. She placed an entire bottle of wound cleanser on the wax paper. The ADON entered the room with the supplies and without cleaning the overbed table placed the treatment supplies on the overbed table (she obtained the overbed table from the resident's roommates' side of the room). The ADON then without hand hygiene she donned gloves. The ADON removed the dirty dressing from Resident #8's right heel, without changing gloves or hand hygiene she sprayed wound cleanser on the gauze brought in and cleaned the unstageable DTI by swiping up and down and across the wound (which could cause any bacteria from the surrounding tissue to be brought into the wound). Without changing gloves or hand hygiene she removed the xeroform gauze from the package and gathered up into a slight ball and placed on the wound (which can cause pressure issues, trapped air and moisture which can hinder the healing process, it is recommended to apply xeroform gauze to avoid wrinkles, it is recommended to use by applying smoothly to wound bed (www.woundsource.com). The ADON then applied the silicone outer dressing over the balled up xeroform. She took off her gloves and took the wound cleanser and placed it back into her cart (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without wiping it done. No hand hygiene was preformed after the wound treatment. B) Review of Resident #27's face sheet dated 03/05/2026 reflected an [AGE] year old male admitted on [DATE] with the following diagnoses pressure ulcer unstageable to sacral area (is a full-thickness injury whose depth cannot be determined because the wound bed is obscured by necrotic tissue, slough, or eschar), Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) and CHF (long-term condition in which your heart can't pump blood well enough to meet your body's needs.). Review of Resident #27's Quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 2 indicating severe cognitive impairment. Resident #27 was further assessed to have a Stage III pressure ulcer. Review of Resident #27's comprehensive care plan reflected a focus area dated 02/21/2026 Resident has Stage III sacral wound. Pressure ulcer. Interventions included Administer treatment as ordered and monitor for effectiveness.Follow facility policies/ protocols for the prevention/ treatment of skin breakdown. Review of Resident #27's consolidated physician orders reflected an order dated 02/21/2026 Cleanse sacral wound with wound cleanser. Apply collagen particles and calcium alginate and cover with silicone bordered super absorbent dressing. Observation on 03/04/2026 at 2:48 PM revealed the ADON outside of Resident #27's room to gather supplies. She placed all the supplies (gauze, calcium alginate, collagen powder and boarded silicone dressing) on a piece of wax paper on her chart. The ADON then went down the hall (two doors down) and used the hand sanitizer on the wall (turning her back on her supplies) The ADON then returned to the cart got her supplies and entered the resident's room and placed the wax paper on the residents overbed table that she did not clean (It was observed to have two water rings and food particles on the table) The ADON then left the room stating she was going to get a gown. When she re-entered the room without hand hygiene she donned gloves. She then shut the door with her gloved hands. She then grabbed the dirty overbed table with her gloved hands to bring it closer to her. At that point someone knocked on the resident's door and with her gloved hands she opened the door then re-shut the door. Without hand hygiene or a glove change she had the two staff members in room assisting to turn Resident #27 on his side. She removed his old dressing to reveal a Stage III pressure ulcer to his coccyx with 3 cm depth (the wound was clean with no signs of infection) she continued her treatment with the same gloves by cleaning the wound across the top of the wound from the outside across the wound. The ADON did not clean the inside of the wound, only across the open area. The ADON swiped across the wound multiple times from the outside in. After cleaning across the wound she let go of this left buttock which she was holding to have access to his wound and the extra skin of his left buttock to fell over the wound while she obtained the other wound care supplies (contaminating the area) without recleaning or performing hand hygiene or changing her gloves she applied the collagen to the outside of the wound not the inside wound bed and placed a calcium alginate over the tunnelling, none placed inside with 3 cm depth of the wound. The ADON then covered the wound with the outside silicone dressing. (No glove changes or hand hygiene performed at any time during the wound care) she removed her gloves and took her supplies to the cart. No hand hygiene was performed after the treatment. In an interview on 03/04/2026 at 2:56 PM the ADON stated she did not know she needed to clean the over bed tables before putting down the wax paper. She stated she did use hand sanitizer out in the hall before she started gathering her treatment supplies. She stated she did not wash her hands or change gloves during the treatment with Resident #8 when moving from clean to dirty and stated, If I washed my hands that many times, I would not have hands. The ADON was not sure regarding the application of the xeroform whether she did it right or not and stated that it was the way she was taught. She stated Resident #8 was not on EBP she stated that Resident #8's wound was chronic, but she did not think the resident needed to be on EBP. She stated on Resident #27 she used the hand sanitizer in the hall but stated she did not wash her hands or use gloves in the room. When asked about her wound cleaning techniques and application of the wound dressings for Resident #27 she stated, What was I supposed to do have one of the aides hold it She stated she applied the dressing to his wounds the way she was taught. In an interview on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/05/2026 at 10:00 AM the DON stated she expected the nurses to wash their hands before going into the room and when they come out. When asked about the facility policy regarding hand washing, she stated yes staff should clean hands before and during wound care when going from dirty to clean, when asked about cleaning the table she stated Yes it should be cleaned. The DON stated resident wounds should be cleaned thoroughly from the inside out and wound care products should be used as recommended to promote healing. She further stated Resident #8's wound was chronic but was not sure if she needed to be on EBP. In an interview on 03/05/2026 at 10:05 AM the RNC stated nurses should clean wounds from the center out and around not back and forth and the staff should have assist in the room to help hold the resident in a position when effective wound care can be done. The RNC stated dressings should be applied smooth without any wrinkles prevent pressure or wound damage and the wound care products should be used as recommended and the entire wound should be treated. The RNC stated regarding Resident #8's EBP, that the wound was chronic, and the policy states she should be on EBP, and she would ensure that she is placed on EBP moving forward. Review of the facility's policy Enhanced Barrier Precautions dated (2001) reflected Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:. h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.a. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. Review of the facility's policy Wound Care dated (2001) reflected The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached.2. Wash and dry your hands thoroughly. 3. Position resident. If necessary, place disposable cloth next to residents (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing.5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly (hand sanitizer can be used). 6. Put on gloves. Gown as indicated based on EBP definition. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. 7. Use no-touch technique. Use tongue blades and applicators to remove ointments and creams from their containers. 16. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard them into designated container. Wash and dry your hands thoroughly. Review of the facility's policy Handwashing/ hand hygiene dated (2001) reflected This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e.f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program for 1 of 1 facility for 42 residents reviewed for pests.The facility failed to ensure the facility was free of pests in the dining room.This failure could place residents at risk of increased exposure to pests and vector-borne diseases and infections.Observation on 03/03/2026, at 9:21 AM this Surveyor observed 2 large size dead cockroaches in a silver pan behind the ice machine in the dining area.Observation on 03/04/2026, at 11:52 AM this Surveyor observed 2 large size dead cockroaches in a silver pan behind the ice machine in the dining area.During confidential interviews between 03/3/2026 and 03/05/2026, residents complained about roaches they observed throughout the facility (no specific dates/times provided).During an interview with HSK Dir, on 3/04/2026, at 3:17 PM, he stated the pest control company comes out every 60 days or as needed for problems that occur. Also, he stated the building is known to have a problem with water bugs AKA cockroaches, but no other problems. However, if he sees problems, he will address them, and if it happens more than once, he will call the professional pest control company to come out and handle the issue.During an interview with Dietary MNG on 03/05/2026, at 9:30 AM she revealed that she has not personally seen any roaches in the kitchen but when she took over as Dietary manager, she started her own Pest Sighting Log.During an interview with HSK D, on 03/05/2026, at 10:18 AM he stated he has seen bugs on cockroach traps in residents' rooms and usually where there is water standing. He also revealed the facility had a bug inspector out a week ago, but he was not aware of a logbook to report sightings.During an interview with ADM on 03/05/2026 at 1:09 PM she stated she has never seen signs of pests in the building but if she did, she would log this in the binder. She stated the building is checked monthly and the kitchen also has a schedule inspection in March. In the past residents have reported scratching sounds, but this has been logged and checked by maintenance.Record review of pest control log on 3/5/2026, revealed the pest control technician completed their last monthly service on 2/5/2026. It also revealed several reports of roaches at the facility. Record review on 3/5/2026 reveals a pest control invoice dated 2/5/2026, the invoice has the message attached. The hazmat closet, kitchen, nurses' station, med room, and room [ROOM NUMBER] all with reported gnats. The technician walked to the facility to treat the hallways and common area and noticed gnats down every hallway on walls. The technician reported to the Administrator and showed her months of reports regarding the lack of cleanliness in the kitchen and the information was relayed to the kitchen staff and Dietary Manger. Review of the facility's policy titled, Pest Control and Sanitization revealed: Pest ControlPolicy StatementOur facility shall maintain an effective pest control program.Policy Interpretation and Implementation1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Pest control services are provided by. Windows are screened at all times.Only approved FDA and EPA insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas.Garbage and trash are not permitted to accumulate and are removed from the facility daily.Maintenance services assist, when appropriate and necessary, in providing pest control services. SanitizationPolicy StatementThe food service area is maintained in a clean and sanitary manner.Policy Interpretation and Implementation All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure storage of medications used in the facility in accordance with currently accepted professional principles and included the appropriate expiration dates to preserve their integrity for medications stored, and to store medications properly to prevent deterioration for one of three medicaiton carts reviewed. The facility failed to ensure expired medications were removed from the 200 hall medication cart. These failures could place residents at risk of not receiving the intended therapeutic effect of the medications or contaminated medication.Findings Included: Observation on 03/04/2026 at 11:34 AM revealed the facility Unit 2 Medication cart with a bottle of Benadryl expired on 01/2026, a bottle of Meclizine expired on 01/2026, and a bottle of normal saline eye drops expired 05/2025. In an interview on 03/04/2026 at 11:36 AM MA B stated the bottle medication Benadryl, Meclizine and normal saline on the 200 hall cart were expired and should not have been on the cart. MA B stated everyone who works on the carts were responsible to look for expired medication. She stated they just got missed. In an interview on 03/04/2026 at 11:20 AM the DON stated after looking at the medication that they were expired and should not be on the medication cart. She stated it was everyone's responsibility to look for and remove expired medications. Review of the facility's Policy Medication labeling and storage dated February 2023 reflected Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide bedrooms that measured at least 80 square feet per resident in multiple resident bedrooms for 12 of 30 resident rooms (Rooms 202, 204, 207,401,403,407,501,503,504,507,509, and 510) reviewed for environment.The facility failed to ensure resident bedrooms rooms, 202, 204, 207,401,403,407,501,503,504,507,509, and 510 measured at least 80 square feet per resident.This failure could place residents at risk by limiting the amount of resident care equipment and personal belongings that could be accommodated in the resident's room. This may restrict the resident's' ability to move about the room freely and could negatively affect the residents' quality of life.The findings include: Observations conducted on 3/3/25 during the initial pool screening beginning at 8:55 AM revealed 12 resident rooms did not have the required amount of living space for each resident.Interview conducted with ADM on 3/03/2026 at 3:43 PM, she stated that she had not been successful in locating a room waiver for the facility.Observation and interview conducted 3/05/2026 at 12:11 PM. The HSK Dir measured room [ROOM NUMBER]. The area for bed A measured 75 square feet and the area for bed B measured 76 square feet. The HSK Dir stated he had assumed the director position one week prior. He stated he did not recall the required square footage for residents' rooms. The HSK Dir stated he remembered measuring the rooms approximately four years ago for a surveyor. Interview conducted with the DON on 3/05/2026 at 12:04 PM. The DON stated she was not aware of the specific square footage requirements for residents' rooms. She stated this was the first facility where she had worked in which resident rooms did not appear to meet the required room size. She stated the potential effect on the residents is that limited room space could restrict residents from having additional personal belongings, which could affect their pride.Interview conducted with ADM on 3/05/2026 at 12:21 PM. The ADM stated she has been at the facility for approximately seven months and was not aware the resident rooms did not meet regulatory room size requirements. The ADM stated she located documentation that indicated a request for a room size waiver was submitted in December 2024; however, she was unable to determine the status of that request. The ADM stated she is currently in the process of requesting a room size waiver. She stated the potential effect on residents could include decreased comfort and limited ability to arrange or maintain personal belongings within their rooms.Record review of the room roster provided by the facility on 03/03/2026 revealed 24 residents lived in Rooms 202, 204, 207,401,403,407,501,503,504,507,509, and 510 .No facility policy for regarding required resident room size or square footage was provided to survey team upon exit.