STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675390	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunflower Park Health Care	1803 Highway 243 East Kaufman, TX 75142

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 3 residents (Resident #44 and Resident #47) reviewed for resident rights. The facility failed to ensure Resident #44 and Resident #47 were treated respectfully by CNA E. This failure could place residents at risk of decreased self-worth, loss of dignity, and a diminished quality of life.Findings included: 1. Record review of a face sheet dated 01/06/2026 indicated Resident #47 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (paralysis and weakness of the left side due to affected blood flow and vessels in the brain) and major depressive disorder recurrent severe without psychotic features (recurrent mood disorder characterized by intense depression or loss of interest or pleasure that lasts weeks). Record review of Resident #47's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. Resident #47's BIMS score was a 15, which indicated his cognition was intact. The MDS assessment indicated Resident # 47 required setup or clean-up assistance with eating, substantial/maximal assistance with personal hygiene, and dependent on staff for toileting and showering/bathing self. Record review of Resident #47's care plan reviewed 12/16/2025 indicated he had an ADL self-care performance deficit and required assistance from staff for his ADLs. During an interview on 01/04/2026 at 2:45 PM, Resident #47 said CNA E was the rudest aide, and he did not like the way she talked to him. Resident #47 said for example yesterday (01/03/2026), his roommate (Resident #44) spilled coffee, and today (01/04/2026) CNA E refused to give his roommate coffee because he spilled it yesterday. Resident #47 said he reported to RN C that CNA E was rude to him. 2. Record review of a face sheet dated 01/07/2026 indicated Resident #44 was a [AGE] year-old-male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system) and generalized anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear). Record review of Resident #44's Comprehensive MDS assessment dated [DATE] indicated he understood and was understood by others. Resident #44 had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #44 required supervision or touching assistance with eating, partial to moderate assistance with personal hygiene and substantial/maximal assistance with showering/bathing self. Record review of Resident #44's care plan reviewed 12/23/2025 indicated he had an ADL self-care deficit related to activity intolerance and shortness of breath. Resident #44's care plan indicated he required supervision as needed for eating. During an interview on 01/04/2026 at 2:55 PM, Resident #44 said yesterday, he accidentally dropped his cup of coffee, and this morning CNA E told him she was not going to give him any coffee because he spilled it yesterday. Resident #44 said he told RN C, CNA E was rude and would not give him his coffee, and RN C gave him coffee. Resident #44 said CNA E was rude to him. Resident #44 said it was the way CNA E spoke to him. During an interview on 01/04/2026 at 3:23 PM, RN C said in the morning (01/04/2026), CNA E called her down to Resident #44's room because he was upset and had knocked over his tray and an old cup of coffee. When she went to Resident #44's room, Resident #44 was upset because he did not get his coffee. RN C said she did not ask CNA E why she would not give Resident #44 his coffee. RN C said she just went and got him coffee. Resident #44 and Resident #47 had previously reported to her that CNA E was rude to them. RN C said she reported it to the ADON and DON, and they said they would talk to her. RN C said they should do what the resident requests because they were there to provide customer service to them. RN C said not doing what the resident requested could make them angry or change their behaviors. During an interview on 01/04/2026 at 4:16 PM, CNA E said she had not been rude to Resident #44 or Resident #47. CNA E said Resident #44 was shaking as if he could not hold a cup of coffee, so she told him she was going to get him up in his chair and then give him coffee. CNA E said Resident #44 became upset and started cussing and threw the tray on the floor. CNA E said Resident #44 had never behaved in this manner. CNA E said she did not tell Resident #44 he could not have any coffee because he spilled it yesterday. CNA E said they should meet the requests of the residents because it was their right. During an interview on 01/05/2026 at 5:30 PM, CNA G said Resident #44 and Resident #47 reported to her that CNA E was rude to them. CNA G said management was aware of the residents reporting that CNA E

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of treatment and treatment alternatives for 1 of 5 residents (Resident #3) reviewed for psychoactive medications. The facility failed to ensure written consent on HHSC Form 3713 was obtained from Resident #3 prior to the administration of Invega Sustenna, an antipsychotic medication, used to treat schizophrenia. This failure could place residents at risk for receiving medications they had not consented to, experiencing potential adverse reactions, and a potential decline in physical and mental health status.Findings included: Record review of a face sheet dated 01/07/2026 indicated Resident #3 was a [AGE] year-old female initially admitted on [DATE] and re-admitted [DATE] with diagnoses which included paranoid schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). Record review of Resident #3's Quarterly MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #3's BIMS score was an 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #3 received an antipsychotic medication. Record review of Resident #3's Order Summary Report dated 01/06/2026 indicated she had an order for Invega Sustenna prefilled syringe 234 mg/1.5 ml inject 1.5 ml intramuscularly (shot in the muscle) one time a day on the 17th every month with a start date of 10/17/2025. Record review of Resident #3's care plan reviewed 12/02/2025 indicated she required an antipsychotic medication to administer medications as ordered and educate the resident/family/caregivers about risks, benefits, and side effects. Record review of Resident #3's Treatment Administration Records for October 2025, November 2025, and December 2025 indicated she received the Invega Sustenna. Record review of Resident #3's electronic health record on 01/06/2026 did not indicate a consent for Invega Sustenna. Resident #3's electronic health record did not indicate a Form 3713 for Invega Sustenna. During an interview on 01/06/2026 at 4:22 PM, the Regional Compliance Nurse said they did not have a consent for Resident #3's Invega Sustenna. During an interview on 01/06/2025 at 5:39 PM, the ADON said the DON and she were ensuring consents were obtained for medications. The ADON said she was not aware Resident #3 did not have a consent for her Invega Sustenna. The ADON said she thought Resident #3 was not receiving the medication due to insurance issues. The ADON said it was important for the residents to have consents completed for their medications because they had to agree to the medication and the medication had to be explained to them. During an interview on 01/07/2026 at 9:29 AM, Resident #3 said she signed her consents, and she had not been asked to sign for the administration of Invega Sustenna. Resident #3 said she believed it was for schizophrenia. Resident #3 said she did not know what schizophrenia was, and the staff did not provide information regarding the risks and benefits of the medication. During an interview on 01/07/2026 at 12:45 PM, the Administrator said he expected consents for medications to be obtained. The Administrator said the nursing department was responsible for ensuring the proper consents were obtained. The Administrator said not obtaining consents for medications placed the resident at risk of receiving medications that were inappropriate. During an interview on 01/07/2026 at 1:19 PM, RN C said she administered Resident #3's Invega Sustenna last month (December 2025). RN C said she was not aware Resident #3 did not have a consent for the Invega Sustenna. RN C said when a nurse received an order for a new medication that required a consent the nurse should have the consent completed. RN C said consent should be obtained to explain to the residents the risks and benefits of the medication and the risks of not getting the medication and to get their permission. During an interview on 01/07/2026 at 2:17 PM, the DON said when there was a new order for a medication that required a consent the nurse should get the consent and the DON and ADON double checked to ensure it was obtained. The DON said the nurses were supposed to get Form 3713 signed and then give it to the DON or ADON for them to take it to medical records. The DON said she was not aware Resident #3 did not have a consent or a Form 3713 for Invega Sustenna. The DON said it was important to obtain consents for medications because of the type of medications they were and to ensure the patient was consenting. Record review of the facility's policy titled, Psychotropic Medication, revised 02/12/2025, indicated, Residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative will be informed of the benefits, risks, and alternatives for the medication

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 of 8 resident rooms (Rooms 24a and 30B) whose environments were reviewed, in that: 1.The privacy curtain rod in room [ROOM NUMBER] was not secure to the ceiling.2. An electrical extension cord was in use in room [ROOM NUMBER]a. These deficient practices could place residents at-risk for injury and poor quality of life.The findings were: 1.Observation of room [ROOM NUMBER]B on 01/04/2026 at 9:33 a.m. revealed the privacy curtain and rod on the B side of the room was hanging from the ceiling with approximately 15 not secured to the ceiling. During an interview on 01/04/2026 at 9:33 a.m., Resident #7 stated that she had not reported the loose privacy curtain rod, but that her roommate had reported it, lots of times. During an interview on 01/04/2026 at 10:35 a.m., Resident #41 stated she had told many staff members about the curtain rod but was unable to recall the staff members' names or when she had reported the concern. During an interview on 01/05/2026 at 2:20 p.m., the Maintenance Director stated that he had not been informed of the hanging privacy curtain rod and stated that he would repair it right away. During an interview on 01/07/2026 at 8:24 a.m. LVN B stated she was not aware that the privacy curtain rod was loose in room [ROOM NUMBER]. LVN B stated she would notify maintenance of work order. LVN B stated that if the privacy curtain fell down, it could injure the resident. During an interview on 01/07/2026 at 8:35 a.m., MA D stated that she was not aware the privacy curtain rod in room [ROOM NUMBER] was not secured. MA D stated that if the curtain rod were to fall down it could cause injury to Resident #7 and possibly her roommate, Resident #41. During an interview on 01/07/2026 at 10:25 a.m., the Administrator stated he was not aware that the privacy curtain in room [ROOM NUMBER] was not secured to the ceiling and that the Champion Rounds log did not reflect this. The Administrator stated he would notify maintenance immediately to ensure the rod was secured. The Administrator stated that he expects all staff members to be diligent in their rounds and identify concerns that could affect residents' safety. The Administrator stated he was ultimately responsible for monitoring the upkeep of the facility. During an interview on 01/07/2026 at 2:30 p.m., the DON stated that she was not aware the privacy curtain rod in room [ROOM NUMBER] was not securely attached. The DON stated that the Administrator monitors the room rounds that are completed daily by administrative staff, and she believed the Maintenance Director completes separate rounds. The DON stated that failure to provide a safe environment could result in harm or injury to the residents. 2. Observation of room [ROOM NUMBER]A on 01/04/2025 at 10:35 a.m. revealed a brown extension cord attached to Resident #48's phone charger. During an interview on 01/04/2025 at 10:35 a.m., Resident #48 stated the extension cord was hers because she needed it to charge her phone. Resident #48 stated no one had told her she could not have the extension cord. During an interview on 01/07/2026 at 8:24 a.m. LVN B stated she was not aware that there was an extension cord in room [ROOM NUMBER]a. LVN B stated that to her knowledge, extension cords were not allowed, and she would notify the Administrator. During an interview on 01/07/2026 at 8:35 a.m., MA D stated she was not aware that resident #48 had an extension cord. MA D stated an extension cord could be a fire hazard. During an interview on 01/07/2026 at 10:25 a.m., the Administrator stated that residents were not allowed to have extension cords unless they were checked and URL approved. The Administrator stated he was not aware of any residents who have an extension cord and upon being made aware that Resident #48 had an extension cord for her cell phone charger, stated he would purchase a longer phone charger cord to get rid of the extension cord. The Administrator stated that inappropriate or unapproved electrical items could result in an electrical fire and pose a hazardous risk of harm and injury to the residents and the facility. During an interview on 01/07/2026 at 2:30 p.m., the DON stated that she was not aware Resident #48 in room [ROOM NUMBER]a had an extension cord. The DON stated this should have been identified during Champion Rounds and stated that the Administrator monitors the room rounds that were completed daily by administrative staff, and she believed the Maintenance Director completed separate rounds. The DON stated that failure to provide a safe environment could result in harm or injury to the residents and in this case an electrical fire. Record review of the facility admission Packet, p. 24 titled Items Not Allowed in Resident Room revealed, Extension Cords and multiple plugs - not allowed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 3 of 5 residents (Resident #3, Resident #8, and Resident #12) reviewed for unnecessary psychotropic drugs. 1. The facility failed to ensure Resident #12's GDR dated 10/08/25 for citalopram (antidepressant) was completed after being approved by the physician on 11/26/25. 2. The facility failed to ensure Resident #3's duloxetine (psychotropic medication used for depression) was decreased after the PMHNP-BC agreed to the pharmacy recommendation to reduce the duloxetine to 40 mg on 11/26/2025. 3. The facility failed to ensure documentation of attempted gradual dose reductions were made for Resident #8's Invega Sustenna and Olanzapine (antipsychotic medications used to treat schizophrenia and bipolar disorder). These failures could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications.Findings included: 1. Record review of Resident #12's face sheet dated 01/07/26 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses dementia (condition characterized by progressive loss of intellectual functioning and memory impairment), high blood pressure, diabetes mellitus (disease where the body is unable to make insulin causing high blood sugars), and major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and life impairment). Record review of Resident #12's admission MDS assessment dated [DATE] indicated he understood others and made himself understood. The MDS also indicated he had a BIMS score of 13 which meant he was cognitively intact. Record review of Resident #12's care plan undated indicated he required an antidepressant with interventions to give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. (Antidepressant side effects: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations). Record review of Resident #12's medication regimen review indicated a gradual dose reduction request for medication: Citalopram 30mg tab daily signed by the physician to decrease the Citalopram to 20mg daily on 11/26/25. Record review of Resident #12's order summary report dated as of 01/07/26 after surveyor intervention indicated he had an order for: Citalopram Hydrobromide Oral Tablet 20 MG (Citalopram Hydrobromide) Give 1 tablet by mouth one time a day related to major depressive disorder, recurrent, mild with a start date of 01/06/26 and no end date. Record review of Resident #12's medication administration record dated 12/01/25-12/31/25 indicated he received Citalopram Hydrobromide Oral (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Capsule 30 MG (Citalopram Hydrobromide) Give 1 capsule by mouth one time a day for Depression for the entire month of December 2025. (with some refusals documented) Record review of Resident #12's medication record dated 1/01/26-1/07/26 indicated he received Citalopram Hydrobromide Oral Capsule 30 MG (Citalopram Hydrobromide) Give 1 capsule by mouth one time a day for Depression on 1/01/26-1/06/26. (with some refusals documented) Record review of Resident #12's medication record dated 1/01/26-1/07/26 indicated he received Citalopram Hydrobromide Oral Capsule 20 MG (Citalopram Hydrobromide) Give 1 capsule by mouth one time a day for Depression on 01/07/26 after surveyor intervention. 2. Record review of a face sheet dated 01/07/2026 indicated Resident #3 was initially admitted on [DATE] and re-admitted [DATE] with diagnoses which included paranoid schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior) and depression. Record review of Resident #3's Quarterly assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #3's BIMS score was an 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #3 received an antidepressant medication. Record review of Resident #3's Medication Regimen Review dated 10/07/2025 indicated Gradual Dose Reduction Request, Medication: Duloxetine 60 mg QHS. The PMHNP-BC signed they agreed to reduce medication to 40 mg signed 11/26/2025. Record review of Resident #3's Order Summary Report dated 01/06/2026 indicated she had an order for duloxetine 60 mg give 1 capsule by mouth at bedtime with a start date of 04/11/2025. Record review of Resident #3's care plan reviewed 12/02/2025 indicated she required antidepressant medication to give antidepressant medications ordered by the physician. Record review of Resident #3's MAR for November 2025, December 2025, and January 2026 indicated duloxetine 60 mg give 1 capsule by mouth at bedtime was administered. There was no indication that the duloxetine was decreased to 40 mg. 3. Record review of Resident #8's face sheet dated 01/07/2026 indicated she was an [AGE] year-old-female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included bipolar disorder (a disorder associated with episodes of mood swings ranging from depression lows to manic highs) and schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). Record review of Resident #8's Quarterly MDS assessment dated [DATE] indicated she understood others and was understood by others. The MDS assessment indicated Resident #8 had a BIMS score of 8, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #8 received antipsychotics, and the physician documented a GDR was clinically contraindicated on 09/05/2024. Record review of the pharmacy recommendations dated 12/04/2025 indicated for Resident #8 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Invega Sustenna 78 mg/0.5 ml inject 1 application intramuscularly one time a day every 28th day, date ordered, 04/28/2025, last GDR requested 06/07/2025. Olanzapine 10 mg give 1 tablet by mouth at bedtime, date ordered 02/07/2024, last GDR requested 06/07/2025. Record review of the pharmacy recommendations for June 2025 did not indicate documentation a GDR was attempted for Invega Sustenna and Olanzapine. Record review of Resident #8's Order Summary Report dated 01/07/2025 indicated the following orders: Invega Sustenna Intramuscular Suspension prefilled syringe 78 mg/0.5 ml inject 1 application intramuscularly one time a day every 28th day with a start date of 04/28/2025. Olanzapine 10 mg give 1 tablet by mouth at bedtime with a start date of 02/07/2024. Record review of Resident #8's care plan reviewed 10/14/2025 indicated Resident #8 required antipsychotic medications to administer medications as ordered and consult with pharmacy and doctor to consider dosage reduction when clinically appropriate. Record review of Resident #8's TARs indicated she received Invega Sustenna 78 mg/0.5 ml November 2025 and January 2025. Resident #8 refused the Invega Sustenna in October 2025 and December 2025. Record review of Resident #8's MARs for October 2025, November 2025, December 2025, and January 2026 indicated she received olanzapine 10 mg (some refusals were documented each month). During an interview on 01/06/2026 at 5:45 PM, the ADON said the DON and she were completing the pharmacy recommendations. The ADON said she did not know why Resident #12's citalopram was not decreased to 20 mg. The ADON said she did not know why Resident #3's duloxetine was not decreased. The ADON said she did not know if Resident #8's had a GDR attempt for her olanzapine and Invega Sustenna. The ADON said if a medication was supposed to be decreased and it was not the resident could possibly overdose. During an interview on 01/07/2026 at 8:15 AM, the Regional Compliance Nurse said per the pharmacy recommendations Resident #8's GDRs for olanzapine and Invega Sustenna were attempted in June 2025, but she was not able to find documentation for it. During an interview on 01/07/2026 at 12:49 PM, the Administrator said he expected reductions of medications recommended by the pharmacy to be completed. The Administrator said the nursing department was responsible for providing oversight to ensure reductions to medications were in place. The Administrator said not implementing the pharmacy's recommendations could affect the condition of the resident and the care the resident received. The Administrator said not attempting GDRs affected the quality of care and the outcome of the care for the residents. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/07/2026 at 2:19 PM, the DON said the ADON and she were responsible for the pharmacy recommendations. The DON said she was not aware the pharmacy recommended Resident #12's citalopram be decreased to 20 mg. The DON said she was not aware the pharmacy recommended for Resident #3's duloxetine to be decreased to 40 mg. The DON said when they receive the pharmacy recommendations, they go through them and put them in the providers folder for them to sign, and once it is signed off, they put the order in. The DON said she did not know if GDRs were done for Resident #8's olanzapine and Invega Sustenna. The DON said the ADON and she kept track of the GDRs with the pharmacy recommendation binder. The DON said GDRs should be attempted because of the side effects associated with the medications. Record review of the facility's policy titled, Psychotropic Medication, revised 02/12/2025, indicated, The facility will ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Residents should only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Also, residents will only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Anti-psychotic; Anti-depressant; Anti-anxiety; and Hypnotic. b. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, to discontinue these drugs. Residents who use psychotropic drugs will receive gradual dose reductions (GDRs), unless clinically contraindicated, to discontinue these drugs. For any resident who is receiving a psychotropic medication, the facility will show evidence that a GDR has been attempted unless clinically contraindicated. Medical record documentation should reflect the date of the GDR attempt, the outcome of the dose reduction attempt, and the plan regarding future GDR attempts. Physician documentation should contain the rationale for why GDR attempts are clinically contraindicated for the resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 2 of 27 residents (Resident #6 and Resident #44) reviewed for MDS assessment accuracy. The facility did not ensure Resident #6's Comprehensive MDS assessment dated [DATE] was accurately coded to reflect her level II PASRR status. The facility did not ensure Resident #44's Quarterly MDS assessment dated [DATE] accurately reflected he received hospice services. These failures could place residents at risk of not receiving care and services to meet their needs.Findings included: 1. Record review of Resident #6's face sheet dated 01/06/2026 indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #6 was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Record review of Resident #6's care plan reviewed 12/23/2025, indicated she had an intellectual disability and was PASRR positive. Record review of Resident #6's PASRR Evaluation dated 01/05/2023 indicated she had a developmental disability other than an intellectual disability that manifested before the age of 22. 2. Record review of a face sheet dated 01/07/2026 indicated Resident #44 was a [AGE] year-old-male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system) and generalized anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear). Record review of Resident #44's Quarterly MDS assessment dated [DATE] did not indicate he received hospice services. Record review of Resident #44's Order Summary dated 01/05/2026 indicated he had an order to admit to hospice for diagnosis of chronic obstructive pulmonary disease with a start date of 10/03/2025. Record review of Resident #44's care plan reviewed 12/23/2025 indicated he required hospice as evidenced by a terminal illness of chronic obstructive pulmonary disease and cancer. Record review of Resident #44's hospice documents indicated an admission date of 09/05/2025. During an interview on 01/07/2026 at 11:56 AM, the MDS Coordinator said she completed Resident #6's and Resident #44's MDS assessments. The MDS Coordinator said Resident #44 went on hospice in September 2025, so his MDS should have reflected he was on hospice. The MDS Coordinator said it was not coded accurately because it was a data entry error. The MDS Coordinator said Resident #6's MDS assessment should have reflected she was PASRR positive. The MDS Coordinator said she was aware Resident #6 was PASRR positive, and it was an oversight that she coded her MDS assessment incorrectly. The MDS Coordinator said regional provided oversight by doing spot checks, but not every MDS assessment was reviewed. The MDS Coordinator said it was important for PASRR status to be coded accurately to ensure the residents received the needed services. The MDS Coordinator said the hospice not coded accurately would affect the residents' care plan. During an interview on 01/07/2026 at 12:36 PM, the Administrator said he expected the MDS assessments to be completed accurately. The Administrator said the MDS Coordinator was responsible and the corporate MDS nurse completed audits to ensure she completed them accurately. The Administrator said not coding the MDS assessments correctly could affect the residents' function and diagnoses. During an interview on 01/07/2026 at 2:31 PM, the Regional Compliance Nurse said they did not have a policy for MDS accuracy that they followed the RAI. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.18.11 dated October 2023 indicated, .Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services.

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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. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to refer all Level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II resident review upon a significant change in status assessment for 1 of 8 residents (Resident #38) reviewed for PASRR services. Resident #38 had a diagnosis of bipolar disorder but did not have a Level II evaluation. This deficient practice could place residents at risk of not receiving appropriate services to meet their individual needs.The findings were: Record review of Resident #38's face sheet, dated 01/06/2026, revealed the resident was a [AGE] year old female and was admitted to the facility on [DATE] and re-admitted [DATE] from another skilled nursing facility with diagnoses that included chronic kidney disease, Parkinson's Disease (a progressive brain disorder that affects movement), Bipolar disorder (a serious mental illness causing mood swings), anxiety disorder (a serious mental illness causing persistent, excessive fear and worry that interferes with daily life)r, major depressive disorder (a mood disorder causing persistent sadness and loss of interest that impacts daily life), dysphagia (difficulty swallowing), dementia (a general term for significant cognitive decline), hypertension (high blood pressure), and heart failure (a chronic disease that occurs when the heart cannot pump enough blood to meet the body's needs). Record review of Resident #38's EHR diagnoses list revealed the resident's diagnoses of bipolar disorder and dementia were present at time of admission.Record review of Resident #38's comprehensive MDS assessment dated [DATE] revealed under section A1500 PASRR that Resident #38 did not have a serious mental illness and a level 2 evaluation was not completed. A1510 Level 2 PASRR conditions, serious mental illness was blank. Section I6000 indicated resident did have a bipolar disorder diagnosis. Further review of Resident #38's comprehensive assessment revealed a BIMS Score of 11 indicating moderate cognitive impairment. Record review of Resident #38's care plan revealed a focus initiated on 12/19/2025 that resident had a mood problem related to bipolar disorder and impaired cognitive function/dementia or impaired thought processes. Record review of Resident #38's PASRR (Preadmission Screening and Resident Review) Level 1 screening completed by the referring entity, a nursing facility, and dated 12/04/2025 did not reflect Resident #38 had a diagnosis of bipolar disorder or an indicator that Resident #38 had a mental illness. Record review of Resident #38's PASRR Level 1 screening completed on 5/22/23 did not reflect Resident #38 had a diagnosis of Psychosis or an indicator that Resident #38 had a mental illness.Record review of Resident #38's EHR on 01/05/2026 revealed a corrected Level 1 screening was not completed and no Level 2 PASRR evaluation was completed. Observation and interview of Resident #38 on 01/04/2025 at 10:51 a.m. revealed resident presented alert, oriented to person, general place. Presented clean, odor free, appropriately dressed. Responded appropriately to direct questions, limited responses to short phrase answers. Resident #38 did not feel she was missing any services but was unsure what was available to her under PASRR services.In an interview on 01/05/2026 at 5:22 p.m. with the MDS Nurse revealed that she was responsible for PASRR screenings and had been in this position since August 2025. The MDS Nurse stated that Level 1 on admission for Resident #38 did not indicate a positive PASRR, a PASRR Evaluation (PE2) was never completed. The MDS Nurse stated that once the qualifying diagnosis of bipolar disorder was identified, a PASRR Evaluation should have been completed and submitted to the Local Intellectual and Developmental Disability Authority (LIDDA) to determine if the resident was eligible for specialized services. The MDS Nurse stated that she was not aware the PASRR Level 1 Evaluation was incorrect, and because of this finding, and based on this finding, she would initiate a sweep of all PASRR's to ensure accurate coding and complete a PASRR Evaluation (PE2) or Form 1012 indicating dementia as primary diagnosis as indicated. In an interview with the Administrator on 01/07/2026 at 10:25 a.m., the Administrator stated that he expects nursing staff to properly identify and code resident status to ensure they receive the appropriate services under the PASRR program. Failure to provide these services could cause the resident to decline. The Administrator stated the nursing team was responsible for ensuring accurate coding for PASRR residents and he, as the Administrator, was ultimately responsible for ensuring the staff are competent in their job duties. During an interview on 01/07/2026 at 2:30 p.m., the DON stated she has a general understanding of PASRR services, but the MDS Nurse is responsible for reviewing the PASRR Level 1's on admission and submitting the PASRR Evaluations to determine eligibility. The DON stated that failure to ensure PASRR Evaluations were submitted could cause the eligible resident not to receive the care they may need and the care services they

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 8 residents (Resident #48) reviewed for PASRR Level I screenings and services.The facility failed to ensure the residents who were identified as PASRR positive on admission were assessed for appropriate services and care coordination in that Resident #48 was never evaluated for PASRR services that she was eligible for.This failure could place residents who had a mental illness at risk of not receiving individualized care, or specialized services to meet their needs. Findings included:Record review of Resident #48's face sheet dated 01/07/2026 revealed a [AGE] year-old female admitted [DATE] with diagnoses to included schizophrenia (a brain disorder causing distorted perceptions, thoughts, and emotions), pulmonary fibrosis (a lung disease where lung tissue becomes scarred, making it hard for oxygen to get into the blood stream) , hypertension (high blood pressure), mood affective disorder (a mental health condition characterized by significant disruptions in emotional stated), rheumatoid arthritis (a chronic autoimmune disease where the immune system causing painful inflammation, swelling, warmth and stiffness), depression (a mood disorder causing persistent sadness and loss of interest), and osteoporosis (a bone disease causing bones to become thin, brittle, and weak from loss of bone mass and density). Record review of Resident #48's comprehensive MDS dated [DATE] revealed a BIMS Score of 12 indicating moderate cognitive impairment. Further review of the comprehensive MDS revealed Resident #48 had upper and lower extremity range of motion impairment, utilized a wheelchair or walker for mobility, required set-up assistance in eating, supervision with bathing, upper/lower body dressing, bed mobility and moderate assistance in transfers. Record review of consolidated physician's orders dated 01/07/2026 revealed Resident #48 received Seroquel 50mg one time a day & Risperdal 1mg two times a day for schizophrenia. Record review of Resident #48's care plan identified focus initiated 10/22/2024 revealed resident required anti-psychotic medications related to schizophrenia. Record review of a PASRR Level 1 Screening dated 06/28/2024 Section C0100 indicated Yes for Mental Illness. Record review of EMR revealed no PASRR Level 2 was completed. During an interview on 01/06/2025 at 12;21 p.m., the MDS Nurse confirmed that Resident #48 did not have a PASRR Level 2 completed. The MDS Nurse stated that she has worked at this facility since August 2025 and she was responsible for reviewing the new admissions PASRR Level 1 for accuracy and completing a correction if necessary. The MDS Nurse stated that she would complete a corrected PASRR Level 1 and submit it to the Local Intellectual & Developmental Disability Authority (LIDDA) for determination of PASRR eligibility and complete an audit of all PASRR Level 1's.During an interview on 01/07/2026 at 10:25 a.m., the Administrator stated he expected the nursing department to properly identify and code resident status to ensure they receive the appropriate services under the PASRR program. The Administrator stated failure to provide these services could cause a resident to miss out on services he/she may be eligible for. The Administrator stated the MDS Nurse was responsible for reviewing the PASRR Level 1's on admission and submitting for PASRR Evaluation. The Administrator stated that he is ultimately responsible for ensuring the staff are competent in their work. During an interview on 01/07/2026 at 2:30 p.m., the DON stated she has a general understanding of PASRR services, but the MDS Nurse was responsible for reviewing the PASRR Level 1's on admission and submitting the PASRR Evaluation to determine eligibility. The DON stated that failure to ensure PASRR Evaluation was submitted could cause the eligible resident not to receive the care they may need and the care services they are eligible for. The DON stated that she was responsible for the accuracy of the PASRR program in the facility. Record review of PASRR Person Centered Service Plan / Interdisciplinary Team Policy and Procedure revealed 2. Contact the LA (Local Authority) within 2 calendar days after the individual's admission.to discuss specialized services. Record review of PASRR Policy & Procedures dated 03/16/2019 revealed 3. The Facility will review the PASRR Level 1 Screening form for completion and correctness prior to admission and submit the PASRR level 1 form per regulations.

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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 interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care within 48 hours of a resident's admission, including initial goals based on admission orders, physician orders, dietary orders, and social services for 2 of 16 (Resident #5, Resident #59) reviewed for baseline care plans.The facility failed to ensure a baseline care plan was completed within 48 hours from admission for Resident #5 and Resident #59.These failures could place residents at risk of not receiving care and services to meet their needs.The findings were: 1.Record review of Resident #5's face sheet, dated 01/06/2026, revealed Resident #5 was admitted on [DATE], with diagnoses which included: cerebral infarction (a stroke that occurs when blood flow to part of the brain is blocked, causing brain cells to die), anxiety disorder (mental illnesses causing persistent worry or fear about everyday situations), polyneuropathy (damage to multiple peripheral nerves causing numbness, tingling, weakness and pain), peripheral vascular disease (a circulation disorder leading to narrowed, blocked or weakened arteries and veins) and chronic obstructive pulmonary disease (a progressive lung condition that makes breathing difficult). Record review of Resident #5's admission MDS assessment, dated 10/13/2025, revealed a BIMS score of 15 indicating Resident #5 was cognitively intact. Further review revealed Resident #5 had lower extremity range of motion impairment, required use of a wheelchair for mobility, moderate assistance in toileting, transfers, bathing and lower body dressing and supervision in upper body dressing, and bed mobility. Record review of Resident #5's electronic medical record revealed Resident #5 did not have a baseline care plan. During an interview on 01/06/2026 at 2:45 p.m., the MDS Nurse stated the Admitting Nurse initiates the baseline care plan and completes the Baseline Care Plan acknowledgement form. The MDS Nurse stated the baseline care plan should be completed at the time of admission. The MDS Nurse stated that if the admitting nurse was not an RN, the DON usually opens the care plan for new admissions or another RN in the facility if needed. The MDS Nurse stated this facility utilized the comprehensive care plans as the Baseline Care Plan and could not say why the comprehensive care plan for Resident #5 was not initiated until 10/07/2025, 4 days after admission. During an interview on 01/06/2026 at 3:29 p.m., RN C stated that the baseline care plan was initially opened by the DON or another facility registered nurse as needed and the admitting nurse had access to add focus areas on admission. RN C stated that the MDS Nurse was responsible for the comprehensive care plan. During an interview on 01/07/2026 at 8:24 a.m., LVN B stated that she does not usually do anything about a baseline care plan and thought it was completed by the administrative nurses. LVN B stated she knew the care plan was important to understand the needs of the residents. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/2026 at 10:25 a.m., the Administrator stated that the nursing department was ultimately responsible for ensuring baseline care plans and all care plans were implemented according to state guidelines. The ADMIN stated he was ultimately responsible for ensuring the appropriate staff were competent in their job duties to ensure the care was provided appropriately. The Administrator stated he has not been at the facility very long and was still getting to know the staff and review their capabilities. During an interview on 01/07/2026 at 2:30 p.m., the DON stated that the MDS Nurse was responsible for initiating the baseline care plan and that she was responsible for monitoring that the baseline care plan was completed. The DON stated adverse effects of not completing the baseline care plan would be that no one would know how to care for the resident. 2.Record review of Resident #59's face sheet dated 01/06/26 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (disease in which the body is unable to produce insulin to control the blood sugars), high blood pressure, heart failure (disease in which the body cannot pump blood as needed), and depression (serious mood disorder that causes persistent sadness). Record review of Resident #59's admission MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. The MDS also indicated she required maximal assistance from staff for toileting, transfers, bathing, and bed mobility, and set up assistance for eating. Record review of Resident #59's electronic medical record on 01/06/26 indicated she did not have a base line care plan completed. During an interview on 01/07/26 at 12:33 PM the ADON said the MDS Nurse was responsible for completing the baseline care plan when residents were admitted to the facility. The ADON said the DON was responsible for providing the baseline care plan to the family of residents. The ADON said the failure of the baseline care plan not being completed placed Resident #59 at risk for staff not knowing Resident #59's limitations or any other care Resident #59 needed. During an interview on 01/07/26 at 1:24 PM the Administrator said the baseline care plan should have been completed within 72 hours of Resident #59's admission date. The Administrator said the nursing department was responsible. The Administrator said the failure of the baseline care plan not being completed placed a risk of staff not providing the care that Resident #59 needed. During an interview on 01/07/26 at 2:35 PM the DON said the charge nurse was responsible for the baseline care plan when the resident admits to the facility. The DON said she was not aware that the baseline care plan for Resident #59 was not completed. The DON said she thought she completed her comprehensive care plan, but it was only started. The DON said all of Resident #59's information should have been included in the care plan and not just the surgical wound and medication monitoring. The DON said the failure of the baseline care plan not being completed placed a risk for no staff knowing how to care for the Resident #59. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled Baseline Care Plan, undated, read This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. and The baseline care plan will be developed within 48 hours of a resident's admission.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 of 8 residents (Residents #7 and #59) reviewed for activities, in that:1. Resident #7 was not taken to activities after she expressed an interest in them or provided in-room activities.2. Resident #38 was not provided with 1-on-1 activities.This deficient practice could affect residents who received in-room and out-of-room activities, and place them at-risk for lack of stimulation, boredom, and depression.The findings were:1. Record review of Resident #7's face sheet revealed an [AGE] year-old female admitted [DATE] and readmitted [DATE] with diagnoses that included: chronic kidney disease (a long term condition where the kidneys lose their function over time), osteoarthritis (a degenerative joint disease leading to pain and stiffness in the affected joints), diabetes mellitus type II (a chronic condition characterized by high blood sugar levels due to lack of insulin), chronic obstructive pulmonary disease (a group of lung disease that make it hard to breathe), hypertension (high blood pressure), major depressive disorder (a mental health condition characterized by persistent sadness and loss of interest) and reduced mobility and hand contractures. Record review of Resident #7's comprehensive MDS dated [DATE] revealed a BIMS score of 14 indicating Resident #7 was cognitively intact, had upper and lower extremity range of motion limitations, required use of a wheelchair for mobility, was dependent with toileting, bathing, lower body dressing, transfers and bed mobility, required maximum assistance in transfers and upper body dressing.Record review of Resident #7's care plan, revised 11/11/2025, revealed the care plan did not address an activity focus area. Record review of the Activity Director's 1:1 room visit log revealed no documentation available for this resident. Record review of all activity progress notes in the electronic medical record revealed two entries for Resident #7 on 06/12/2023 and 06/07/2023 reflecting that Resident #7 came to the dining room to play bingo. Record review of the Activity assessment dated [DATE] revealed that it was very important to Resident #7 to do her favorite activities and that she needed assistance to and from activities and that it was important to her to have books or magazines. Record review of all activity assessments since admission [DATE], 02/06/2023, 05/11/2023, 08/14/2023, 08/16/2023, 11/11/2023, 04/12/2024, 07/05/2024, 10/05/2024 revealed no assessment identified resident's preference of activities or indicated attendance in group events or indicated individual activities provided to include in room visits. Record review of nurse aid assignments 01/06/2025 revealed tasks to include 1. Assist the resident in developing / Provide the resident with a program of activities that is meaningful and of interest to the resident. Encourage and provide opportunities for exercise, physical activity. 2. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. 3. Invite the resident to activities that promote additional fluid intake. Offer drinks during one-to-one visits. 4. The resident needs activities that minimize the potential for falls while providing diversion and distraction. Observation and interview on 01/04/2026 at 9:33 a.m. revealed Resident #7 lying in bed, awake. Resident #7 stated that the Activity Director does personal shopping for her on Tuesdays. Resident #7 stated that she does not go to activities very often anymore, noting that she was sad about that because she really loved Bingo but cannot work the markers anymore. During an interview on 01/05/2026 at 5:44 p.m., the Activity Director stated that she has only worked at the facility for a few weeks and so far, had not identified a resident who required in -room visits. The Activity Director stated that she would identify residents who could not come out of the room for medical reasons or personal reasons as eligible for in-room visits.During an interview on 01/05/2026 at 5:50 p.m., the Human Resources Director (former Activity Director at this facility) stated that she did not have any documentation for in-room visits or activity attendance for Resident #7. She stated she last worked as Activity Director on 11/30/2025.During an interview on 01/07/2026 at 8;35 a.m. MA D stated that Resident #7 only came out of the room for dialysis and does not go to other activities that she was aware of. MA D stated that she visits with Resident #7 when she passes her medications but does not stay with her long. MA D stated that not going to activities could increase depression. During an interview on 01/07/2026 at 9:15 a.m., CNA H stated that Resident #7 misses a lot of activities because of dialysis three times per week. CNA H stated that Resident #7 has told her that she misses playing Bingo.2. Record review of Resident #38's face sheet, dated 01/06/2026, revealed a [AGE] year old female who was admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses

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Sunflower Park Health Care	1803 Highway 243 East Kaufman, TX 75142

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 (Resident #1) residents reviewed for quality of care. 1. The facility failed to ensure the Treatment Nurse documented accurate skin assessments for Resident #1.2. The facility failed to ensure Resident #1 had was provided treatment for his wound to his great right toe. This failure could place residents at risk for not receiving appropriate care and treatment, a decreased quality of life, and pressure ulcers.Findings included: Record review of Resident #1's face sheet dated 01/06/26 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of dementia (condition characterized by progressive loss of intellectual functioning and memory impairment), major depression (a serious mood disorder causing persistent sadness, loss of interest, and life impairment), chronic heart failure(long term condition in which the heart does not pump blood effectively), chronic kidney disease(loss of kidney function where kidneys cannot filter waste from blood), and high blood pressure. Record review of Resident #1's admission MDS assessment dated [DATE] indicated he was understood by others and made himself understood. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. The MDS also indicated he required maximal assistance from staff for bathing, transfers, bed mobility, and toileting, and setup assistance with eating. The MDS also indicated Resident #1 had no pressure ulcers or other skin conditions. Record review of Resident #1's undated care plan indicated he had actual impairment to skin integrity related to a non-pressure area to right great toe and stage 2 intact blister to the top of his right foot with interventions in place to provide treatment per orders, to follow facility policies/protocols for the prevention/treatment of skin breakdown. Record review of Resident #1's order summary report as of 01/05/26, with discontinued orders included, indicated he had an order for:1) skin prep to blister on right foot. one time a day with a start date of 01/05/262) Cleanse with Normal saline, apply anasept gel, and apply boarded dressing every day shift for eruption of [NAME] with a start date of 12/07/2025 and discontinued on an unknown date.The order summary did not indicate an order for the non-pressure area of the right toe. Record review of Resident #1's skin assessment 1/05/26 at 10:48 AM completed by the Treatment Nurse indicated his skin was intact. Record review of Resident #1's skin assessment 1/05/26 at 6:25 PM completed by the MDS Nurse indicated his skin had a blister to top of his right foot, right big toe scabbed area right 2nd and 3rd toes scabbed areas. Record review of Resident #1's wound evaluation dated 1/01/26 indicated he had a wound of the lower back, full thickness that measured 0.3 centimeters X 0.3 centimeters X 0.6 depth with a treatment of anasept daily. The wound evaluation also indicated Resident #1 had a non-pressure wound to his right great toe that measured 2.3 centimeters X 2.8 centimeters and no depth with a treatment of mupirocin 2% daily and as needed if saturated, soiled, or dislodged for 30 days and xeroform gauze apply once daily and cover with gauze island and as needed if saturated, soiled, or dislodged for 30 days. During an observation and interview 01/05/26 at 4:40 PM the Treatment Nurse and the DON entered Resident #1's room with no gown on but donned gloves. The Treatment Nurse and DON agreed Resident #1 had a wound to his right great toe that was open and abrasions to the top of his second, third, and fourth toes. The area noted to his mid back was not open. The DON assisted the Treatment Nurse in measuring the right great toe. The Treatment Nurse said she completed a skin assessment on 01/05/26 after being told on 01/04/26 that Resident #1 had a blister on his right foot. The Treatment Nurse said when she completed the skin assessment on 01/05/26, she completed the skin assessment as no areas because the blister was already found, and she did not look at or notice Resident #1's right great toe re-opening. The Treatment Nurse said she should have completed the assessment of the entire body, input orders for all areas noted, and updated Resident #1's care plan as well. The Treatment Nurse said the failure could have caused worsening of wounds. During an interview 01/05/226 at 4:53 PM The the DON said in the past an unknown department head had been instructing the staff to only input new skin areas in the weekly skin assessment, and she had been trying to instruct the nurses on completing a full assessment and adding all skin issues. The DON said a wound doctor came in on a weekly basis and completed rounds. The DON said she and the Treatment Nurse reviewed the notes on Fridays and then input any orders or changes. The DON said the wound doctor saw Resident #1 on 1/01/26 and the facility decided he did not need the wound care doctor since Resident #1 had no pressure wounds. The DON said when the Treatment Nurse re-assessed Resident #1, the Treatment Nurse should

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Resident environment remained as free of accident hazards as is possible for 2 of 16 residents (Resident #16, Resident #41) reviewed for accidents and hazards, in that: Resident #16 had an unsecured oxygen cylinder in his room. Resident #41 was utilizing a wheelchair with an unsecured seat backrest resulting in a fall. These deficient practices placed residents at risk for injuries.The findings included: 1. Record review of Resident #16's face sheet dated 01/06/26 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of fracture of left femur, high blood pressure, diabetes mellitus (disease where the body is unable to make insulin causing high blood sugars), and atrial fibrillation (most common type of irregular heartbeats). Record review of Resident #16's admission MDS assessment dated [DATE] indicated she was able to understand others, and she was able to make herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderate cognitive loss. Record review of Resident #16's care plan dated 11/09/25 did not indicate Resident #16 used oxygen. Record review of Resident #16's order summary report as of 01/06/26 did not indicate Resident #16 had an order for oxygen. During an observation on 01/04/26 at 9:55 AM Resident #16 had an oxygen cylinder laying in the corner of her room against the wall. Resident #16 said she did not use oxygen, but the oxygen cylinder had been laying there against her wall since she had been admitted in the facility on 11/09/25. During an observation on 01/05/26 at 8:46 AM the oxygen cylinder in Resident #16's room continued to be in the corner laying against the wall. During an observation and interview on 01/06/2025 at 10:48 AM RN L said the oxygen cylinder should not have been in the resident's room. She said oxygen cylinders was were supposed to be stored on the hall in the storage room in a rack. She said the failure placed a risk for the cylinder falling or getting knocked over and possibly exploding. During an interview on 01/07/26 at 12:36 PM the ADON said the closet for oxygen is was where the oxygen cylinder should have been stored. The ADON said the oxygen cylinder should not be left in the residents' rooms propped against the wall. The ADON said the failure placed a risk for the oxygen cylinder being knocked over and could have exploded or the resident getting injured from the oxygen cylinder falling on her or it could have caused Resident #16 to trip over it. During an interview on 01/07/26 at 1:27 PM the Administrator said the oxygen cylinder should have been stored upright in the proper oxygen storage room. The Administrator said the failure placed a risk for the cylinder falling over in Resident #16's room and it was dangerous. The Administrator said the oxygen cylinder could have exploded. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/26 at 2:45 PM the DON said the oxygen cylinder should not have been lying against the wall in Resident #16's room. The DON said if Resident #16 was using the oxygen cylinder it should have been in a bag and on the back of her chair or the oxygen cylinder should have been stored in the oxygen room in the proper storage rack. The DON said the failure placed a risk to the oxygen cylinder exploding if it fell or was knocked over. Record review of the facility Compressed Gases, Safe Handling Of policy dated 12/10/25 indicated: 1. Only qualified and trained personnel may handle gas cylinders located within the facility.9. Never drop cylinders or permit them to strike against each other or against other surfaces violently.11. When tanks are stored, all tanks and cylinders should be stored in a cylinder cart or securely chained in a secure storage area. Never leave cylinders free-standing. All cylinders must be individually secured. 2. Record review of Resident #41's admission record, dated 01/06/2026, revealed an [AGE] year-old admitted on [DATE] and readmitted on [DATE] with diagnoses that included atherosclerotic heart disease (the buildup of fats and other substances in and on the artery walls), diabetes mellitus (a chronic condition where the body does not produce enough insulin leading to high blood sugar levels), dementia (severe cognitive decline beyond normal aging), osteoporosis (a bone disease where bones become thin, weak, and brittle due to decreased bone mass and density), dysphagia (difficulty swallowing), major depressive disorder (a mood disorder causing persistent sadness and loss if interest), hypertension (high blood pressure), and gout (a painful inflammatory arthritis from uric acid crystals in joints). Record review of Resident #41's comprehensive MDS dated [DATE] revealed a BIMS Score of 10 indicating resident had moderate cognitive impairment, required a wheelchair for mobility, moderate assistance in toileting, bathing, lower body dressing and transfers, supervision in bed mobility and upper body dressing. Record review of Resident #41's care plan, revised 11/11/2025, revealed resident had a history of falls and remained at risk for falls with interventions to replace wheelchair, review information on past falls and attempt to determine cause of falls. Record review of maintenance work order logs 06/01/2025-01/05/2026 revealed no work order request was completed identifying a loose bolt on Resident #41's wheelchair back rest prior to bolt loosening and falling out resulting in Resident #41 falling as per facility self-report #1045709. During an interview on 01/05/2026 at 2:01 P.M., Resident #41 stated that she never noticed that the bolt on the back of her wheelchair back rest was loose. Resident #41 stated she has received a refurbished wheelchair and was told a new wheelchair has been ordered. Resident #41 stated she has no residual effects related to the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/05/2025 at 2:20 p.m., the Maintenance Director stated that he did not have a wheelchair safety check system in place prior to the time the back rest on Resident #41 came loose causing her to fall backwards. The Maintenance Director stated that all staff members notify him of maintenance concerns utilizing an on-line referral system that he receives immediately at time of submission. The Maintenance Director stated that after this incident with Resident $41's wheelchair back rest coming loose, he and the Director of Rehab completed a safety check on all facility wheelchairs. During an interview on 01/07/2026 at 8:24 a.m., LVN B stated that she vaguely remembered that Resident #41 had a fall related to her wheelchair breaking but could not remember the details. LVN B stated she notifies maintenance personally because she was not very knowledgeable with the computer and does not like to use the online maintenance workload referral system. LVN B stated that to her knowledge, there are no outstanding work orders for C Hall (hallway where Resident #41 resides). During an interview on 01/07/2025 at 8:35 a.m., MA D stated that she submits any maintenance concerns thru the online program whenever she sees something. MA D stated she did not notice the bolt was loose on Resident #41's wheelchair backrest. During an interview on 01/07/2025 at 9:15 a.m., CNA H stated that she does utilize the scan code for maintenance work order requests, and the last one she submitted what a while back. CNA H stated she was not aware that Resident #41 had a fall related to wheelchair malfunction. During an interview on 01/07/2025 at 8:52 a.m., the Director of Rehabilitation Services (DOR) stated that all wheelchairs were checked at the time of the incident with Resident #41 and that his team completes monthly wheelchair safety audit on all residents who go to the therapy gym. The DOR stated that approximately 80% of the residents are on therapy caseload so chairs are seen regularly. The DOR was unable to provide documentation that wheelchair safety checks were on-going and stated that he tends to repair as concerns arise and if it is outside of his capability, he will notify maintenance or the specialty wheelchair company. During an interview on 01/07/2026 at 10:25 a.m., the Administrator stated the facility had a system in place called Champion Rounds to help monitor the rooms and equipment for maintenance repairs. The Administrator stated he follows up with the maintenance director to ensure the work orders are completed timely. The Administrator stated he expected the Department Heads assigned to participate in Champion Rounds to complete a thorough review of the room and medical equipment to include wheelchairs and walkers to ensure proper functioning. The Administrator stated he was not employed at the facility at the time the self-report regarding Resident #41's wheelchair malfunction and that he would review with the DOR and the Maintenance Director to ensure monthly wheelchair safety rounds are completed and logged. The Administrator stated he received the weekday Champion Round logs and monitors daily to ensure repairs are completed. During an interview on 07/07/2026 at 2:30 p.m., the DON stated that all staff were responsible for reporting maintenance concerns for resident's' rooms and equipment. The DON stated that each room has a Department Head assigned to monitor equipment repair needs and she expected the person assigned to report concerns timely. The DON stated that failure to identify equipment repair needs could result in harm or injury to the resident as in this incident with Resident #41. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested facility policy for wheelchair maintenance on 01/05/2026 at 2:20 p.m. The ADMIN and Maintenance Director stated they did not have a policy regarding equipment repair and maintenance.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 1 of 3 residents reviewed for respiratory care (Residents #26). The facility failed to ensure Resident #26's suction machine yankauer was bagged. The facility failed to ensure Resident #26 had a physician order for the use of the suction machine. The facility failed to ensure Resident #26 had the use of the suction machine included on her care plan. This failure could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory disease. Findings Included: Record review of Resident #26's face sheet dated 01/06/26 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses of chronic kidney disease (gradual loss of kidney function to where kidneys cannot filter waste effectively), high blood pressure, and bipolar disorder (disease that causes extreme mood swings from high manic to depressive lows). Record review of Resident #26's admission MDS assessment dated [DATE] indicated she understood others and usually made herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderate cognitive impairment. The MDS also indicated she was dependent on staff for toileting, bathing, and transfers, and required setup assistance from staff for eating. Record review of Resident #26's physician's order summary report as of 01/06/26 did not indicate an order for the suction machine in Resident #26's room. Record review of Resident #26's care plan dated 09/16/25 did not indicate resident required the use of the suction machine. During an observation and interview on 01/04/26 at 9:45 AM Resident #26 was lying in her bed and had a suction machine on the dresser that was bagged but had a used yankauer (tool used to suction a resident's mouth) connected to the suction machine lying outside of the bag hanging on the side of the suction machine. During an observation on 01/05/26 at 8:35 AM Resident #26 was lying in her bed and the unbagged yankauer continued to hang on the outside of the bagged suction machine on the dresser. Resident #26 said she used the suction machine on occasions. Resident #26 said she would not want to use the suction machine if the yankauer was hanging out and not clean. During an observation and interview on 01/07/26 at 10:45 AM RN L was shown the suction machine and yankauer outside of the bag hanging in Resident #26's room and she said the yankauer in Resident #26's room should have been bagged or removed after use. RN L said she had never had to use the suction machine for Resident #26 but there should have been an order in place, and the suction machine and use of it should have been included in Resident #26's care plan. RN L said the failure placed a risk for infection. During an interview on 01/07/26 at 12:37 PM the ADON said the yankauer should have been bagged while in the resident's room. The risk is was for infection from germs being in the room. The ADON said there should have been an order for the suction machine and the suction machine should have been care planned. the The ADON said it was important to have an order and care plan os for any care provided by staff. The ADON said the facility had to have a physician's order and the facility needed a care plan is to ensure the staff could provide the care and know how. During an interview on 01/07/26 at 1:28 PM the Administrator said Resident #26 should have had an order to use the suction machine and without the order in place the machine should not have been in her room. The Administrator said he expected the suction machine to be on Resident #26's care plan as well for care. The Administrator said the failure placed a risk for infection control with the yankauer not being stored properly. During an interview on 01/07/26 at 2:47 PM the DON said the suction machine should have had an order for use and a care plan. The yankauer should have been in a clean bag and not attached to the machine. The DON said providing care without and order paced a risk for practicing medicine; failure of the care plan is no one knows what is going on or why the suction machine was there. The DON said the risk of the yankauer being unbagged is was bacteria and unsanitary conditions and could cause infection or sickness. Record review of the undated facility policy Airway Suctioning indicated:Suctioning is performed to ensure a patent airway by removing secretions from the nose, pharynx, and trachea. Assemble the sectioning materials with clean container, tubing, and the kit or individually wrapped supplies for the procedure. Dispose of all supplies according to Universal Precautions. Perform hand washing. Document care.

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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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications. An unnecessary medication is any medication used: In excessive doses; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued for 1 of 8 residents (Resident #41) reviewed for unnecessary medication. The facility failed to ensure Resident #41's protein pump inhibitor (PPI) Omeprazole had been decreased according to pharmacy recommendations and physician's approval. This failure could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medication) and providing medication without physician's knowledge. The findings included: Record review of Resident #41's admission record, dated 01/06/2026, revealed an [AGE] year-old admitted on [DATE] and readmitted on [DATE] with diagnoses that included atherosclerotic heart disease (the buildup of fats and other substances in and on the artery walls), diabetes mellitus (a chronic condition where the body does not produce enough insulin leading to high blood sugar levels), dementia (severe cognitive decline beyond normal aging), osteoporosis (a bone disease where bones become thin, weak, and brittle due to decreased bone mass and density), dysphagia (difficulty swallowing), major depressive disorder (a mood disorder causing persistent sadness and loss if interest), hypertension (high blood pressure), and gout (a painful inflammatory arthritis from uric acid crystals in joints). Record review of Resident #41's comprehensive MDS dated [DATE] revealed BIMS Score 10 indicating resident had moderate cognitive impairment, required a wheelchair for mobility, moderate assistance in toileting, bathing, lower body dressing and transfers, supervision in bed mobility and upper body dressing. Record review of Resident #41's care plan, revised 11/11/2025, does not address use of PPI for acid indigestion. Record review of pharmacy recommendations dated 12/04/2025 revealed Resident #41 had been receiving Omeprazole PPI since 01/13/2024 and long-term use has been associated with increased risk of C.diff (stool infection), bone loss, and fractures. Pharmacy recommendation was to decrease Omeprazole to 20mg daily. Physician Response dated 12/10/2025 indicated he agreed with this recommendation.Record review of Resident #41's medication administration record dated 12/01/2025-01/06/2026 revealed resident received Omeprazole Capsule Delayed Release 40 mg by mouth one time a day with order start date 01/13/2024 indicating that the physician approved pharmacy recommendation was not followed.During an interview on 01/06/2026 at 3:29 p.m., RN C stated that the pharmacy recommendations were completed by the administrative nurses, and the floor nurses were advised once the updated order was in the electronic medical record. During an interview on 01/06/2026 at 5:40 p.m., the ADON stated that the pharmacy recommendations were the responsibility of the DON & ADON and that she was unable to say why the pharmacy recommendation agreed to by the physician on 12/10/2025 was not followed for Resident #41. ADON stated that failure to follow the recommendations once approved by the physician could result in the resident not receiving the appropriate / prescribed medication. ADON stated that she and the DON write the new orders once the physician signs the denial or agreement of the recommendation.During an interview on 01/07/2026 at 8:24 a.m., LVN B stated that the ADON or DON make changes based on the pharmacy recommendations once they are signed by the physicians and tell the nurse when completed to put on the 24-hour report. LVN B stated that the charge nurse does not see the actual recommendations or contact the physician for approval or denial. During an interview on 01/07/2026 at 10:25 a.m., the Administrator stated that the nursing staff and ultimately the DON were responsible for ensuring that the pharmacy recommendations once completed by the physician are put in place and that he expected the nursing administration to monitor and manage this system. The Administrator stated he was ultimately responsible to ensure the job tasks were being performed. Adverse effects to the residents could be harmful if the physician believes a medication change had occurred and it did not. During an interview on 01/07/2026 at 2:30 p.m., the DON stated that she and the ADON were responsible for reviewing and processing the pharmacy recommendations to include notifying the physician and adjusting orders as indicated. The DON was unable to state why this pharmacy recommendation was not completed. The DON stated it was important that the recommended changes were completed to ensure physicians' orders were followed. Adverse effect of not following physician's orders could cause harm or injury to the resident. Facility policy on Unnecessary Medications or Pharmacy Recommendations was requested on 01/06/2026 and 01/17/2026 but was not

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 27 residents (Resident #26) observed for medication storage. 1. The facility failed to ensure Resident #26 did not have a bottle of normal saline, a bottle of wound cleanser spray, a tube of zinc oxide protectant, and 2 tubes of zinc oxide silicone cream (medications used for wound care and barrier cream used for wound prevention) in a mauve basin on top of her personal refrigerator in her room. These failures could place residents at risk for obtaining injury or harm from misuse.Findings include: Record review of Resident #26's face sheet dated [DATE] indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses of chronic kidney disease (gradual loss of kidney function to where kidneys cannot filter waste effectively), high blood pressure, and bipolar disorder (disease that causes extreme mood swings from high manic to depressive lows). Record review of Resident #26's admission MDS assessment dated [DATE] indicated she understood others and usually made herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderate cognitive impairment. The MDS also indicated she was dependent on staff for toileting, bathing, and transfers, and required setup assistance from staff for eating. Record review of Resident #26's care plan dated [DATE] indicated she had impaired vision and impaired cognitive function with interventions in place to provide medications as ordered. Record review of Resident #26's order summary report dated as of [DATE] indicated she had orders for:Clean wound with wound cleanser or normal saline and cover with abdominal pad or gauze. Change/clean daily and when soiled as needed for wound care with a start date of [DATE] and no end date.May apply barrier cream to Bilateral buttocks as needed every shift with a start date of [DATE] and no end date. During an observation on [DATE] at 9:45 AM Resident #26 had a bottle of normal saline, a bottle of wound cleanser spray, a tube of zinc oxide protectant, and 2 tubes of silicone cream in the mauve basin on top of Resident #26's personal refrigerator in her room. During an observation on [DATE] at 8:35 AM Resident #26 continued to have a bottle of normal saline, a bottle of wound cleanser spray, a tube of zinc oxide protectant, and 2 tubes of silicone cream in the mauve basin on top of fridge in her room. During an interview on [DATE] at 1:18 PM RN C said none of the medications should have been left in Resident #26's room. RN C said all staff were responsible for ensuring no medications were in residents' rooms. RN C said the failure placed a risk for Resident #26, family, or other residents getting the medication and misusing or harming themselves. During an interview on [DATE] at 1:33 PM the Administrator said all medications should be stored in medication carts. The Administrator said the failure of leaving the medications in the room placed a risk for Resident #26 using and not knowing how to use the medications correctly and the failure also placed a risk for wandering residents getting the medications and misusing them. During an interview on [DATE] at 2:50 PM the DON said none of the medications should have been left in Resident #26's room. The DON said the wound care medications should have been kept in the medication cart with Resident #26's name and date they were opened on them. The DON said the failure placed a risk for Resident #26 or any other residents getting the medications and using, or the medications could have expired, and no one would have known. Record review of the facility policy Medication storage in the facility dated 3-2025 indicated: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 meal (lunch meal) reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that had an appetizing temperature on 01/04/2026. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview on 01/04/2026 at 10:24 AM, Resident #4 said the food was cold when she received it. During an interview on 01/04/2026 at 10:55 AM, Resident #30 said sometimes the food was cold when he received it. During an observation and interview on 01/04/2026 at 12:53 PM, the lunch tray was sampled by the Dietary Manager and three surveyors. The lunch tray sampled consisted of chicken fried chicken, corn, and mashed potatoes. The chicken fried chicken was lukewarm, and the mashed potatoes and corn were cold. The Dietary Manager said some people may have wanted the chicken fried chicken to be hotter. The Dietary Manager said the corn needed to be a little warmer because it was not hot. The Dietary Manager said the mashed potatoes needed to be warmer, as they had cooled down a little bit. During an interview on 01/04/2026 at 2:38 PM, Resident #23 said sometimes when she received her food it was cold. During an interview on 01/04/2026 at 3:46 PM, Resident #13 said the food was cold because it took so long to pass out the food to the halls from the time the food was in the kitchen. During an interview on 01/05/2026 at 6:02 PM, [NAME] A said she had not received any complaints from the residents about the food being cold. [NAME] A said the residents were supposed to be served a hot meal. [NAME] A said she was not sure how the residents receiving a cold meal could affect them. During an interview on 01/07/2025 at 11:30 AM, the Dietary Manager said she received cold food complaints from the residents. The Dietary Manager said the food was hot when it left the kitchen, but sometimes the food was not passed out in a timely manner by the staff. The Dietary Manager said she had reported the cold food complaints and the food not being passed out in a timely manner to the Administrator, DON, and previous Administrators. The Dietary Manager said she had suggested closed carts to keep the meals warmer but did not receive any resolution. The Dietary Manager said the food being cold could make the residents sick or the residents would not eat it. During an interview on 01/07/2025 at 12:30 PM, the Administrator said he expected the food to be served hot to the residents. The Administrator said the Dietary Manager was responsible for ensuring this happened. When asked if the Dietary Manager had told him about the cold food complaints and the trays not being passed out in a timely manner, the Administrator said when the food came out of the kitchen, the nursing department needed to be involved to make sure the food was taken to the residents in a timely manner, so the residents could receive their meals at the appropriate temperatures. The Administrator said if the food was cold, it was not going to taste good. Record review of the facility's policy titled, Preparation of Foods, from the Dietary Services Policy & Procedure Manual 2012, indicated, We will establish safe and nutritional preparation of food. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value.2. All food will be prepared by methods that preserve nutritive value, flavor, and appearance with a variety of color, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure regular texture corn, pureed corn, and pureed chicken strips were held at the proper temperature on 01/04/2025. This failure could place residents at risk for foodborne illness. Findings included: During an observation on 01/04/2026 at 11:53 AM, temperatures were taken of the food on the steam table by [NAME] A. The regular texture corn was 130 F, the pureed corn was 130 F, the pureed chicken strips were 132 F. During an interview on 01/05/2026 at 6:02 PM, [NAME] A said food should be held at least at 140 F. [NAME] A said if the food was not at 140 F, the food should be reheated. [NAME] A said she did not think about reheating the food before serving it because she was just trying to start serving the trays. [NAME] A said not holding food at the correct temperatures could cause the food to be bad. During an interview on 01/07/2026 at 11:35 AM, the Dietary Manager said food should be held at or above 140 F. The Dietary Manager said she liked for it to be at 165 F. The Dietary Manager said if the food temperature was not correct the food should be pulled off, and it should have been reheated to ensure it reached the appropriate temperature. The Dietary Manager said she had not observed the food temperatures to be incorrect. The Dietary Manager said the food not being held at the proper temperature could make the residents sick. During an interview on 01/07/2026 at 12:33 PM, the Administrator said he expected the food to be held above the recommended level. The Administrator said the Dietary Manager and the dietary staff should ensure they were holding the food at the proper temperatures. The Administrator said the food not held at the proper temperature could affect the quality of the food the residents received. Record review of the facility's policy titled, Daily Food Temperature Control, revised 04/09/2025 indicated, We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the Temperature Log. This is done to help ensure that food is safe and is served within acceptable ranges.4. All hot foods shall be cooked and held for service at temperatures of 140 degrees F or above. 5. Any hot or cold food which does not meet the minimum acceptable temperature shall be heated to a temperature of 165 degrees F and held at least 15 seconds.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 3 (Resident #11, Resident #29, Resident #52) of 8 residents reviewed, in that: The facility failed to ensure the thermometers inside Resident #11's, Resident #29's and Resident #52's personal refrigerators were present and functioning properly and the staff recorded the accurate temperatures of the refrigerator for two months. This failure could place residents at risk of foodborne illness due to consuming foods which might be spoiled. The findings included: Record review of Resident #11's face sheet, dated 01/05/2026, revealed an [AGE] year-old admitted [DATE] and readmitted [DATE] with diagnoses that included heart failure (a condition that occurs when the heart cannot pump enough blood for the body's needs), dementia (general term for severe cognitive decline), hypothyroidism (a condition that occurs when the thyroid gland doesn't make enough thyroid hormones to meet the body's needs), hypertension (high blood pressure), atrial fibrillation (an irregular heart rhythm that increases risk for stroke due to blood pooling and clotting) and major depressive disorder (a mood disorder causing persistent sadness, and loss of interest). Record review of Resident #11's comprehensive MDS, dated [DATE], revealed a BIMS score of 6 indicting Resident #11 had severe cognitive impairment. Resident #11 had lower extremity range of motion impairment, required a wheelchair for mobility, supervision in toileting, upper body dressing, moderate assistance in bathing, lower body dressing, bed mobility and transfers. During an observation and interview on 01/04/2026 at 10:15 a.m., Resident #11 allowed surveyor to observe personal refrigerator. Observation revealed refrigerator was packed full of undated food and drink items and no thermometer was visible. Resident #11 stated that the Activity Director does personal shopping for him and that to his knowledge, no one checks the refrigerator temperature, and he takes care of the refrigerator items himself. Resident #11 stated he thinks there used to be a thermometer in the refrigerator. Record review of Resident #29's face sheet, dated 01/07/2026, revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses that included peripheral vascular disease (a circulation disorder affecting blood vessels outside of the heart), chronic obstructive pulmonary disease (a progressive lung condition that makes breathing difficult), chronic kidney disease (a gradual loss of kidney function), chronic lymphocytic leukemia (a slow-growing blood cancer), diabetes mellitus type II (a chronic condition leading to high blood sugar levels), hypertension (high blood pressure), atrial fibrillation (an irregular heartbeat) Record review of Resident #29's comprehensive MDS dated [DATE] revealed a BIMS score 11 that indicated moderate cognitive impairment, had lower extremity impairment and required a wheelchair for mobility, maximum assistance in bathing, lower body dressing, moderate assistance in upper body dressing, and was totally dependent in toileting, bed mobility and transfers. During an observation and interview on 01/04/2026 at 10:25 a.m., Resident #29 allowed surveyor to observe personal refrigerator. Observation revealed refrigerator contained undated food items and no thermometer was visible. Resident #29 stated his family and the Activity Director assist with personal needs and shopping as needed. Resident #29 stated he did not know who checked the temperature of the refrigerator and could not recall the last time he saw a thermometer in the refrigerator. Record review of Resident #52's face sheet, dated 01/07/2026, revealed an [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses that included chronic kidney disease (a condition that occurs when the kidneys cannot filter blood well, leading to waste buildup), macular degeneration (an eye disease that damages central vision), hypertension (high blood pressure), chronic obstructive pulmonary disease (a progressive lung condition that blocks airflow causing breathing difficulties), osteoporosis (a condition that weakens bones, making them thin, brittle and prone to fracture), and dorsalgia (medical term for pain in the back and neck). Record review of Resident #52's quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating resident #52 was cognitively intact, had lower extremity range of motion impairment, utilized no mobility devices, was dependent in toileting, bathing, lower body dressing, and bed mobility, required maximum assistance in upper body dressing and transfers. During an observation and interview on 01/04/2026 at 10:30 a.m., Resident #52 allowed surveyor to observe personal refrigerator. Observation revealed refrigerator contained undated food items and no thermometer was visible. Resident #52 stated the Activity Director assists with personal needs shopping. Resident #52 stated he does not know who checks the refrigerator temperature and could not recall the last time he saw a thermometer. Record review of

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 4 residents (Resident #44) reviewed for hospice services. The facility failed to obtain Resident #44's most current Form 3071 Texas Medicaid Hospice Program Individual Election/Cancellation/Update, Form 3074, Physician Certification of Terminal Illness, Hospice Nurses' Notes, and Hospice Physician Orders. This deficient practice could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of a face sheet dated [DATE] indicated Resident #44 was a [AGE] year-old-male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). Record review of Resident #44's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #44 had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated he required supervision or touching assistance for eating, toileting hygiene, partial/moderate assistance for personal hygiene, and substantial/maximal assistance for showering/bathing himself. The MDS assessment did not indicate he received hospice services. Record review of Resident #44's Order Summary dated [DATE] indicated he had an order to admit to hospice for diagnosis of chronic obstructive pulmonary disease with a start date of [DATE]. Record review of Resident #44's care plan reviewed [DATE] indicated he required hospice as evidenced by a terminal illness of chronic obstructive pulmonary disease and cancer. Record review of Resident #44's hospice binder did not indicate:Form 3071 Texas Medicaid Hospice Program Individual Election/Cancellation/UpdateForm 3074, Physician Certification of Terminal IllnessHospice Nurses' NotesHospice Physician Orders. During an interview on [DATE] at 5:02 PM, the Hospice Case Manager said Resident #44 was on hospice services. She said the Hospice Marketer or herself took required hospice documents to the facility. The Hospice Case Manager said she usually did not take the nurses' notes to the facility. She said Resident #44 went on hospice services in September of 2025 and then re-admitted to services on [DATE] or [DATE] due to a discharge because he went to the hospital. The Hospice Case Manager said she thought she had taken all the required hospice documents for Resident #44 to the facility. She said it was important for the facility to have the required hospice documents to ensure they were all in line with the plan of care. During an interview on [DATE] at 5:39 PM, the ADON said the DON was the one making sure the hospice brought the required documents to the facility. The ADON said it was important to have hospice documents in the facility to be prepared for what the residents might need when they expired. During an interview on [DATE] at 12:38 PM, the Administrator said he expected all hospice documents to be in the facility to be able to provide appropriate care to the residents. The Administrator said the DON and the nursing department was responsible for ensuring the hospice documents were in the facility and hospice collaboration occurred. The Administrator said it was important so they knew what they had to do and what they should do for the residents' care plans. During an interview on [DATE] at 2:11 PM, the DON said the ADON and she were responsible for ensuring the required hospice documents were in the facility. The DON said she had not checked the hospice binders to see if the required hospice documents were in the hospice binders. The DON said it was important to have the required hospice documents, so they knew what was going on with the residents. Record review of the facility's undated policy titled, Hospice Service, indicated: .The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation will include:The current and past Texas Medicaid Hospice Recipient Election/Cancellation Form (#3071)Texas Medicaid Hospice-Nursing Facility Assessment Form (#3073)Physician Certification of Terminal Illness (#3074)Medicare Election Statement (if dual eligible)Verification that the recipient does not have Medicare Part AHospice Plan of CareCurrent interdisciplinary notes to include nurses notes/summaries, physician orders and progress notes, and medications and treatment sheets during the hospice certification period.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #1, Resident #6, and Resident #26) reviewed for infection control. 1. The facility failed to ensure CNA K performed proper glove changes while providing incontinent care to Resident #6 on 01/05/2026. 2.The facility failed to ensure the Treatment nurse and the DON used PPE while providing wound care for Resident #1 on 01/05/26. 3.The facility failed to ensure Resident #1 and Resident #26 had enhanced barrier precaution signage and PPE available in a cart for the staff to be aware of EBP (enhanced barrier precautions). 4. The facility failed to ensure Resident #1 had an order in place for enhanced barrier precautions. These failures could place residents at risk for cross contamination and the spread of infection.Findings included: 1. Record review of Resident #6's face sheet dated 01/06/2026 indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination). Record review of Resident #6's Quarterly MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #6 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #6 required substantial/maximal assistance with toileting hygiene. The MDS assessment indicated Resident #6 was frequently incontinent of urine and bowel. Record review of Resident #6's care plan reviewed 12/23/2025 indicated she had frequent bladder incontinence to provide incontinent care at least every 2 hours and apply moisture barrier after each episode. During an observation and interview on 01/05/2026 at 8:32 AM, CNA K provided incontinent care to Resident #6. CNA K put on gloves wiped Resident #6's front, then turned her on her side and cleaned her buttocks. CNA K grabbed the clean brief and put it on Resident #6. CNA K did not change her gloves prior to applying the clean brief. CNA K proceeded to dress Resident #6 still using the dirty gloves. After assisting Resident #6 with dressing herself CNA K grabbed Resident #6's wheelchair and walker with the dirty gloves. CNA K assisted Resident #6 into her wheelchair, and then CNA K looked in Resident #6's drawers for her comb. CNA K touched the drawers with the dirty gloves. CNA K found the comb and continued to brush Resident #6's hair, still using the same dirty gloves she used to provide the incontinent care. CNA K gathered the trash and dirty linen, placed Resident #6's overbed table in front of her. CNA K removed her gloves, disposed of the trash/linen outside of Resident #6's room, and then performed hand hygiene in the hallway. CNA K said when providing incontinent care gloves should be changed after wiping the resident and before the clean items were touched. CNA K said gloves should be changed and hand hygiene performed at the end of the incontinent care prior to dressing and assisting the resident with care. CNA K said she did not perform hand hygiene properly or change gloves appropriately because she was nervous. CNA K said not changing gloves during incontinent care could result in infections, and touching the residents' personal items with dirty gloves could result in germs traveling. (continued on next page)

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	675390	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunflower Park Health Care	1803 Highway 243 East Kaufman, TX 75142

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 - Some	During an interview on 01/07/2026 at 12:10 PM, the ADON said the DON and she completed proficiency checks when the CNAs started their first shift. The ADON said they completed the proficiency checks on the CNAs recently and there was no other oversight provided. The ADON said during incontinent care gloves should be changed and hand hygiene performed after cleaning the front area and when going to different areas of the body or if the gloves were visibly soiled. The ADON said gloves should be changed and hand hygiene performed prior to applying the clean brief. The ADON said gloves should be changed and hand hygiene performed before helping the residents with their personal care. The ADON said when she observed CNA K for her proficiency check there were no issues, and if there were, they were corrected at that moment. The ADON said not changing gloves properly, not performing hand hygiene during incontinent care could result in infections and cross contamination. The ADON said touching clean items with dirty gloves could result in the spread of infection. During an interview on 01/07/2025 at 12:41 PM, the Administrator said he expected all the staff to know what they had to do when providing incontinent care. The Administrator said he expected them to change gloves when required. The Administrator said nurse management should ensure they were making rounds and monitoring what the CNAs were doing by occasional pop ins. Nurse Management should make sure the CNAs were doing incontinent care the correct way, and if they noticed incontinent care was completed incorrectly, they should fix it right away. The Administrator said not changing gloves properly was an infection control issue, and the staff should make sure they were hand washing to prevent the spread of infection. During an interview on 01/07/2025 at 2:13 PM, the DON said gloves should be changed and hand hygiene performed after wiping the residents, when touching anything clean, and when they were finished putting on the clean brief. The DON said CNA K should have changed gloves prior to touching the residents' personal items. The DON said gloves were not required to comb the resident's hair, so CNA K should have removed her gloves. The DON said the ADON and she conducted random audits to ensure incontinent care was provided correctly. The DON said she had not noticed any issues with incontinent care. The DON said not changing gloves properly during incontinent care and touching the residents' personal items with dirty gloves could transfer bacteria. 2. Record review of Resident #1's face sheet dated 01/06/26 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of dementia (condition characterized by progressive loss of intellectual functioning and memory impairment), major depression (a serious mood disorder causing persistent sadness, loss of interest, and life impairment), chronic heart failure(long term condition in which the heart does not pump blood effectively), chronic kidney disease(loss of kidney function where kidneys cannot filter waste from blood), and high blood pressure. Record review of Resident #1's admission MDS assessment dated [DATE] indicated he was understood by others and made himself understood. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. The MDS also indicated he required maximal assistance from staff for bathing, transfers, bed mobility, and toileting, and setup assistance with eating. Record review of Resident #1's undated care plan indicated he had actual impairment to skin integrity related to a non-pressure area to right great toe and stage 2 intact blister to the top of his right foot with interventions in place to provide treatment per orders, to follow facility policies/protocols for the prevention/treatment of skin breakdown, but the care plan did not include enhanced barrier precautions. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's order summary report as of 01/06/26 indicated he had an order for: 1)skin prep to blister on right foot. one time a day with a start date of 01/05/26 The order summary did not indicate an order for enhanced barrier precautions nor the non-pressure area of the right toe. During an observation and interview 01/05/2026 at 4:40 PM the Treatment Nurse and the DON entered Resident #1's room with no gown on but donned gloves. Resident # 1 did not have an enhanced barrier precaution sign on his door, nor did he have a PPE cart outside of her room. The Treatment Nurse and DON agreed Resident #1 had a wound to his right great toe that was open and abrasi0ons to the top of his second third and fourth toes. The DON assisted the Treatment Nurse in measuring the right great toe. 3. Record review of Resident #26's face sheet dated 01/06/26 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses of chronic kidney disease (gradual loss of kidney function to where kidneys cannot filter waste effectively), high blood pressure, and bipolar disorder (disease that causes extreme mood swings from high manic to depressive lows). Record review of Resident #26's admission MDS assessment dated [DATE] indicated she understood others and usually made herself understood. The MDS also indicated she had a BIMS score of 11 which meant she had moderate cognitive impairment. The MDS also indicated she was dependent on staff for toileting, bathing, and transfers, and required setup assistance from staff for eating. Record review of Resident #26's care plan dated 09/16/25 indicated she had impaired vision and impaired cognitive function with interventions in place to provide medications as ordered. Record review of Resident #26's order summary report dated as of 01/06/26 indicated she had orders for: Clean wound with wound cleanser or normal saline and cover with abdominal pad or gauze. Change/clean daily and when soiled as needed for wound care with a start date of 12/31/25 and no end date. May apply barrier cream to Bilateral buttocks as needed every shift with a start date of 08/26/25 and no end date. During an observation on 01/04/26 at 9:45 AM Resident #26 did not have an enhanced barrier precaution sign on her door nor did she have a PPE cart outside of her room. During an observation on 01/05/26 at 8:35 AM Resident #26 did not have an enhanced barrier precaution sign on her door nor did she have a PPE cart outside of her room. During an interview on 01/07/26 at 12:40 PM the ADON said the Treatment Nurse and DON should have been wearing a gown and gloves for enhanced barrier precautions. The ADON said there should have been a sign on the door and the cart in the hallway fully stocked for Resident #1 and Resident #26. The ADON said the Nursing management (DON, ADON, and Treatment Nurse) were responsible for ensuring the enhanced barrier precaution signs and carts were on the halls. The ADON said the failure placed a risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/07/26 at 1:32 PM The Administrator said he said he expected the EBP signage and carts on the hallway for Resident #1 and Resident #26. The Administrator said the failure of having no EBP placed a risk of infection. The Administrator said the DON and nursing department were responsible for ensuring the EBP signage and carts were in place. During an interview on 01/07/26 at 2:51 PM The DON said EBP should have been used with foley catheter care, intravenous line care, and when residents have wounds. The DON said Resident #1 and Resident #26 should have EBP signage and PPE carts outside of their rooms. The DON said the failure placed a risk for infection. The DON said the DON and ADON were responsible for ensuring the EBP signage and the carts were in place. The DON said she asked the Administrator for carts for PPE, but she thought it fell by the side, and she forgot about it. Record review of the facility policy Enhanced Barrier Precautions undated indicated: Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply (see MDRO list on page 3); or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Communication to Staff the facility will utilize postings outside the room and Point Click Care to communicate to staff if a resident requires EBP. Record review of the facility's policy titled, Perineal Care, effective 05/11/2022 indicated, 10) Perform hand hygiene 11) [NAME] gloves and all other PPE per standard precautions.17) Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area – CLEAN to DIRTY! Female resident: Working from front to back, wipe one side of the labia majora, the outside folds of perineal skin that protect the urinary meatus and the vaginal opening.20) Reposition the resident to their side 21) Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area.24) Doff gloves and PPE 25) Perform hand hygiene 26) Provide resident comfort and safety by re-clothing (if applicable - incontinence pad(s) and briefs), straightening bedding, adjusting the bed and/or side rails, and placing call light within resident's reach 27) Clean and store reusable items 28) If visibly soiled or contaminated during the procedure, disinfect or discard the barrier towel on the table 29) Return resident items on the table 30) Tie off the disposable plastic bag of trash and/or linen 31) Perform hand hygiene 32) Thank you: thank the resident for assisting in self-care.