STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675402	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwall Nursing Care Center	206 Storrs Street Rockwall, TX 75087

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during medical treatment and personal care and confidentiality of personal and medical records for ten of twenty residents (Residents #9, #10, #19, #35, #40, #55, #56, #71, #75, and #76) reviewed for privacy and confidentiality. 1. The facility failed to ensure RN B secured Residents #10, #19, #35, #40, #55, #56, #71, and #75's medical information before leaving her cart on 03/24/2026. 2. The facility failed to ensure ADON A pulled the privacy curtain and closed the door while doing Resident #76's wound care on 03/25/2026. 3. The facility failed to ensure RN B secured Residents #9's medical information before leaving her cart on 03/25/2026. 4. The facility failed to ensure RN B pulled the privacy curtain or closed the door while checking Resident #10's blood sugar and administering her insulin on 03/25/2026. These failures could place the residents at risk of not having their personal privacy maintained while treatment and care were provided, which could result in the residents feeling uncomfortable during treatment and having their personal and medical record exposed to unauthorized individuals.Findings included: 1. Record review of Resident #10's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #19's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with cerebral infarction (stroke, insufficient oxygen in the brain). Record review of Resident #35's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with insomnia (a sleep disorder characterized by difficulty in falling asleep). Record review of Resident #40's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #55's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension and diabetes mellitus. Record review of Resident #56's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension and diabetes mellitus. Record review of Resident #71's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a cerebral infarction. Record review of Resident #75's Face Sheet, dated 03/25/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. During an observation on 03/24/2026 at 9:13 a.m. revealed an untitled piece of paper was left on top of a cart parked in the hallway. It was observed that written on the paper were Residents #19, #35, #40, #55, #71, and #75's names and their vital signs and Residents #10, #55, and #56's names and their blood sugars. The cart was unattended and was facing the hallway with several staff and residents passing by the cart. During an observation on 03/24/2026 at 9:15 a.m. it revealed that the Administrator passed by the cart and flipped over the paper with the vital signs and blood sugars of the residents on it. During an interview on 03/24/2026 at 9:17 a.m., RN B said she would usually write down the vital signs and the blood sugars of the residents and would put it on PCC (point click care: a software that provides real-time access to (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patient data) afterwards. She said she would usually flip over the paper every time she left her cart. She said maybe she got busy and forgot to do so. She said she should have flipped over her paper or placed it under her laptop so that whatever medical information written on it would not be exposed to everyone to see. She said vital signs and blood sugars were medical information and should be secured to prevent any HIPAA violations. 2. Record review of Resident #76's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with abdominal pain. Record review of Resident #76's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 03/06/2026, reflected that the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 13. The Quarterly MDS Assessment indicated that the resident had a surgical wound. Record review of Resident #76's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had a post-surgical wound on the left abdomen and one of the interventions was to provide treatment. Record review of Resident #76's Physician Order, dated 03/24/2026, reflected POST-SURGICAL WOUND ABDOMEN FULL THICKNESS (a deep wound extending to the fatty layer of the body) . Clean with DAKINS (solution used to prevent infection), apply MUPIROCIN (topical antibiotic)2%, MESALT SHEET (dressing used for heavily discharging wounds) and cover with island gauze W/BDR. one time a day for Wound Treatment AND as needed for WOUND treatment IF SOILED, SATURATED OR DISLODGED. During an observation on 03/25/2026 at 7:14 a.m. it revealed ADON A was about to do Resident #76's wound care. She sanitized her hands, put on a pair of gloves, and sanitized the resident's overbed table. She placed a wax paper on top of the overbed table and put the gauze, dressing, ointment, a Q-Tip, and some gloves on the wax paper. She then pushed the overbed table at the bedside. She washed her hands, put on a gown and a pair of gloves, and proceeded with wound care. She did not close the door while providing wound care. It was observed that Resident #76's roommate was inside the room, in his bed. ADON A did not pull the privacy curtain. During an interview on 03/25/2026 at 7:45 a.m., ADON A said she should have closed the door to provide privacy during Resident #76 wound care. She said since the roommate of Resident #76 was also inside the room, she should have pulled the privacy curtain as well. She said it was important to close the door so that nobody from the hallway could see the treatment she was providing. She said she should have pulled the privacy curtain to provide privacy from the resident's roommate. She said the resident might get embarrassed because others could see that he had a wound. She said it did not matter if the resident got embarrassed or not, but the best practice was to close the door and pull the privacy curtain every time treatment was done. 3. Record review of Resident #9's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dependence on renal (relating to the kidneys) dialysis (a medical treatment that removes waste products from the blood). Record review of Resident #9's Quarterly MDS Assessment, dated 03/11/2026, reflected that the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated that the resident was undergoing dialysis. Record review of Resident #9's Comprehensive Care Plan, dated 03/03/2026, reflected the resident needed dialysis . DIALYSIS DAYS- M-W-F @ 0945AM and one of the interventions was to monitor access site (Shunt [surgically created connection between the artery and the veins]) by palpating for thrill (palpable vibration felt over an area of blood flow) & auscultate (listening to the sounds inside the body using a stethoscope) for bruit (sound produced by the blood flow) every shift. Notify physician of absence of thrill or bruit. Record review of Resident #9's Physician Order, dated 06/23/2022, reflected DIALYSIS - MONITOR AV SHUNT/FISTULA (an access made between the blood vessels) TO (RLA) FOR THRILL & BRUIT Q SHIFT Notify MD/NP for any unusual/unexpected findings. every shift. During an observation on 03/25/2026 at 10:11 a.m. it revealed a form entitled Dialysis Communication Report was on top of a medication cart. On the form was Resident #9's respiratory rate and the form indicated that the resident had no edema, that thrills and bruits were (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents were given privacy for all care. He said they already started an in-service about privacy and confidentiality. Record review of the facility's policy, Residents' Rights undated, reflected Privacy and Confidentiality . You have the right to . Privacy . Have facility information about you maintained as confidential.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for seven of twelve Resident rooms (room [ROOM NUMBER], #2, #3, #4, #5, #6, #7,and #8) in the memory care unit , and one of nine shower rooms observed for cleanliness. The facility failed to ensure Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7,and #8 in the memory care unit were thoroughly cleaned and sanitized.The facility failed to ensure the shower room on the 100 Hall was thoroughly cleaned and sanitized.These deficient practices could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.Findings included:During an observation on 03/24/26 at 11:20 a.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The room floor had gray and brownish stains near the resident's bed and near a nightstand. The bathroom floor had brownish stains all over the center portion of the floor, the corners of the floor, and around the toilet. The bathroom sink had brownish stains behind the faucet. The wall alongside a resident's bed had white and brownish stains. During an observation on 03/24/26 at 11:24 a.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The wall alongside a resident's bed had white and brownish stains. The bathroom floor had brownish stains in the corners of the floor, and around the toilet. During an observation on 03/24/26 at 11:28 a.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The bathroom floor had brownish stains in the corners of the floor, and around the toilet. During an observation on 03/24/26 at 11:31 a.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The bathroom floor had brownish stains in the corners, the center, and around the toilet. During an observation on 03/24/26 at 11:36 a.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The floor near a closet had dark stains. The bathroom floor had brownish stains in the corners of the floor, under the bathroom sink, and around the toilet. During an observation on 03/24/26 at 11:39 a.m., room [ROOM NUMBER] reflected the room floor had built up dirt in the corners of the door frame and corners of the floor. The bathroom floor had brownish and greenish stains along the edges of the floor, dark stains in the corners, brownish stains around the toilet. During an observation on 03/24/26 at 11:48 a.m., room [ROOM NUMBER] reflected the bathroom floor had dark stains along the edges of the floor, dark stains in the corners, and brownish stains around the toilet. The room floor had built up dirt in the corners of the door frame and corners of the floor. During an observation on 03/24/26 at 11:52 a.m., room [ROOM NUMBER] reflected the bathroom floor had dark substances all over the center portion of the floor, the corners of the floor, and around the toilet. The toilet tank had a cover on top that did not fit it, exposing a portion of the inside of the tank. During an observation on 03/24/26 at 2:23 p.m., a shower room on the 100 Hall had dark stains along the edges of the shower floor and along the door entry. During an interview on 03/26/26 at 10:04 a.m., Housekeeper M stated she cleaned the residents' rooms in the Memory care unit. She stated housekeeping were responsible for cleaning the entire rooms, including mopping the floor and cleaning the bathrooms. She was shown photos by the Surveyor of concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, and #8, and the shower room. She stated some of the residents urinated on the floor and the nursing staff were to clean it up immediately, but they did not. She stated she tried scrubbing the floors, but her cleaning tools were not effective, and the floor techs were responsible for deep cleaning the floors. She stated she had mentioned to the Housekeeping Supervisor about the cleaning concerns. She stated not cleaning the rooms thoroughly could impact the residents' health. She stated housekeeping was responsible for (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning the shower rooms and had to clean the walls and floor to ensure no mold was built up.During an interview on 03/26/26 at 10:22 a.m., Floor Tech J stated he cleaned the floors in the Memory Care unit daily. He was shown photos by the Surveyor of concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, and #8. He stated he deep cleaned the floors at least once a week. He stated the machines were too large to clean the corners of the floor and he did not have any other equipment to clean them. He stated the floors not being thoroughly cleaned was nasty to the residents.During an interview on 03/26/26 at 10:29 a.m., the Housekeeping Supervisor was informed of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, and #8, and the shower room. She stated the housekeeping staff were to clean all areas of the resident rooms, and the floor techs were responsible for cleaning the hallways. She stated if the resident floors needed to be stripped and rewaxed the floor tech would do it. She stated the areas observed required housekeeping to clean. She stated housekeeping were to clean the shower rooms. She stated the nursing staff were to clean up the urine and clean bodily fluids on the wall, but they do not do it consistently. She stated she had informed the DON, and the DON had advised the nursing staff to get it cleaned up. She stated she had mentioned to Corporate and the Administrator about not being able to clean the stains up and she was being told to just keep trying. She stated not thoroughly cleaning the rooms could impact the residents' hygiene.During an interview on 03/26/26 at 11:15 a.m., the Administrator was informed by the Surveyor of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, and #8, and the shower room on the 100 hall. He stated he expected all rooms to be cleaned and sanitized. He stated if the areas are not thoroughly cleaned it could impact the residents' ability of having a clean homelike environment.Review of the facility's policy on Resident Rights (11/2021) revealed Resident have the right to live in safe, decent, and clean conditions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three of ten (Resident #9, #38 and #67) reviewed for respiratory care. 1. The facility failed to ensure CNA F did not disconnect, connect, initiate, and titrate Resident #9's oxygen on 03/25/2026.2. The facility failed to ensure Resident #38's nebulizer mask was properly stored on 03/24/2026.3. The facility failed to ensure Resident #67's nebulizer mouthpiece was properly stored on 03/24/2026. These failures could place residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met.Findings included: 1. Record review of Resident #9's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female, admitted [DATE]. The resident was diagnosed with dependence on renal dialysis (a medical treatment that removes waste products from the blood) and obesity (excessive accumulation of body fats). Record review of Resident #9's Quarterly MDS Assessment, dated 03/11/2026, reflected moderately impaired cognition with a BIMS of 11. The Quarterly MDS Assessment indicated that the resident was on oxygen therapy. Record review of Resident #9's Comprehensive Care Plan, dated 03/03/2026, reflected the resident had oxygen therapy and one of the interventions was to give oxygen at 2 lpm per nasal cannula. Record review of Resident #9's Physician Order, dated 01/27/2026, reflected, May use oxygen @ 2 l/m via nasal canula, every shift for Oxygen Therapy. During an observation and interview on 03/25/2026 at 9:20 a.m., revealed after Resident #9 was transferred to her wheelchair, CNA F disconnected the resident's nasal cannula from the oxygen concentrator, connected it to the oxygen outlet of the regulator attached to an oxygen tank, and gave the nasal cannula to the resident. Resident #9 told CNA F to put it in three liters per minute. CNA F then titrated (gradually adjusting the dose of medications) the oxygen to three liters per minute. Observation revealed the was no nurse inside the room when she titrated the resident's oxygen. During an interview on 03/25/2026 at 10:04 a.m., Resident #9 said the CNAs that transferred her were the ones who disconnected her oxygen and connected it to the oxygen behind her wheelchair.During an interview on 03/25/2026 at 10:08 a.m., CNA F said she transferred Resident #9's oxygen every time she transferred her to the wheelchair. When asked if she had a training with regards to initiating and titrating oxygen, she said, I think I had a training, but it was a long time ago. When asked what the training was about, she did not reply. When asked if titrating oxygen was within her scope of practice, she did not reply. During an interview on 03/25/2026 at 11:43 a.m., RN B said CNA F should have called her when Resident #9 was transferred to the wheelchair. She said it was her responsibility to discontinue, initiate, and titrate oxygen. She said it was a treatment, with a doctor's order; therefore, nurses should be titrating it because assessments were needed if the resident needed more oxygen.2 . Record review of Resident #38's Face Sheet, dated 03/26/2026, revealed an [AGE] year-old male, admitted [DATE]. The resident was diagnosed with Chronic Obstructive Pulmonary Disease (COPD - long term lung condition that makes it hard to breath), Asthma (lungs swell and make it difficult to breath).Record review of Resident #38's Comprehensive MDS Assessment, dated 02/04/2026, revealed a BIMS score of 07 (moderate memory and thinking problems, may be confused and need regular help with task and remembering things). The Comprehensive MDS Assessment revealed the resident had COPD and asthma.Record review of Resident #38's Comprehensive Care Plan, dated 02/10/2026, revealed the resident had COPD. The interventions were giving oxygen therapy as ordered by the physician and monitor for difficulty breathing.Record review of Resident #38's Physician Orders, dated 08/26/2025, revealed Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3)MG/3ML (Ipratropium-Albuterol) 1 vial inhaled orally via nebulizer four times a day for COPD and assess before & after a treatment.During an observation and interview on 03/24/2026 at 9:20 a.m. revealed Resident #38 was sitting on his bed (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	awake. It was observed that his nebulizer mask was hung on his shelf and was not properly stored. He stated that he usually left it hanging there when his treatment was done and the nurse puts it in the bag sometimes.3. Record review of Resident #67's Face Sheet, dated 03/26/2026, revealed an [AGE] year-old female, admitted [DATE]. The resident was diagnosed with Chronic Obstructive Pulmonary Disease (COPD - long term lung condition that makes it hard to breath).Record review of Resident #67's Comprehensive MDS Assessment, dated 03/10/2026, revealed a BIMS score of 13 (thinking and memory are mostly normal, with slight or occasional forgetfulness). The Comprehensive MDS Assessment indicated the resident had a diagnosis of COPD.Record review of Resident #67's Comprehensive Care Plan, dated 02/03/2026, revealed that the resident had shortness of breath. The intervention was to notify the charge nurse if the resident was having trouble breathing.Record review of Resident #67's Physician Order, dated 03/04/2026, revealed Albuterol Sulfate inhalation Nebulizer solution (5MG/ML) 0.5%, 1 vial inhale orally via Nebulizer (Machine that turns liquid medicine into a fine mist) every morning and bedtime for COPD. Assess before and after treatment.During an observation and interview on 03/24/2026 at 9:15 a.m., Resident #67 was in his bed, awake. It was observed that the nebulizer mouthpiece was on the walker and not properly stored. Resident #67 stated she usually left it there when the medication in the nebulizer ran out.During an interview on 03/26/2026 at 6:45 a.m., the DON said nurses should titrate oxygen and not CNAs because oxygen was a prescribed medication requiring nursing assessment. She said assessments should be done to prevent complications like hypercapnia (high amount of carbon dioxide in the blood). She said titrating oxygen was not within scope of responsibilities of CNAs and CNAs were not authorized to independently adjust medical gas dosages because too much oxygen and too little oxygen could be harmful. She said she would start an in-service about respiratory care. During an interview on 03/26/2026 at 7:32 a.m., ADON A said oxygen therapy was categorized as a medication, and its administration required a prescription that included dosage, delivery, device, and target level of oxygen, making it a nursing responsibility. She said titration was not just bringing a number up or down, but nurses must assess the resident to determine the appropriate level of oxygen needed. She said too much oxygen was detrimental and too little could lead to not meeting the respiratory need of the resident. She said initiating and titrating was not within the scope of the CNAs' responsibilities. She said she would coordinate with the DON with regard to respiratory care. During an interview on 03/26/2026 at 8:30 a.m., the Administrator said titrating oxygen was for qualified staff. When asked if CNA F was qualified to adjust the resident's oxygen, he did not reply.During an interview on 03/26/26 at 10:15 a.m., the DON stated the facility policy was that all nebulizer mask should be bagged and dated at all times, she stated that the CNAs, should notify the nurse if they noticed any mask not bagged, the nurses also should be checking to make sure after each treatment the masks were bagged to reduce the risk of infection or even insects crawling into the mask which could cause an infection or even injury to the resident. During an interview on 03/26/26 at 10:20 a.m., RN B stated all nebulizer mask should be off the ground and bagged with a date on the bag. She stated the nurse was responsible for making sure that it was done and if the CNAs noticed that the nebulizer mask was not bagged to inform the nurse about it. RN B stated the risk to the resident was possible infection making them sick.During an interview on 03/26/26 at 10:30 a.m., ADON A stated the facility policy was all nebulizer masks were bagged and dated and if they noticed a resident who took off their mask, they should care plan it and conduct regular checks to make sure the masks were bagged at all times. ADON A stated the CNAs checked and reported to the nurse if they found unbagged masks. ADON A stated the risk of not having the mask in a bag and dating them could result in possible infection to the resident. Record review of the facility's policy titled, Medication Administration and General Guidelines P & P, dated revised March 2025, reflected, Policy: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so . Procedure . 1. Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	laws and regulations to administer medications . 2. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. During an interview via email on 03/25/2026 at 10:44 a.m. and 03/26/2026 at 10:59 a.m. with the Administrator, a policy for titrating oxygen was requested but was not provided prior to exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for eight of eighteen residents (Residents #5, #10, #32, #46, #49, #67, #76, and #77) reviewed for medication storage. 1. The facility failed to ensure that Resident #5 did not have an extra strength Tylenol container, a container of eye drops, a tube of antibiotics, and a tube of toothache cream inside the room on 03/24/2026. 2. The facility failed to ensure a container of multivitamins was not inside Resident #49's room on 03/24/2026. 3. The facility failed to ensure vials of eyedrops were not inside Resident #67's room on 03/24/2026. 4. The facility failed to ensure a tube of zinc oxide was not inside Resident #10's on 03/24/2025.5. The facility failed to ensure a tube of zinc oxide was not inside Resident #32's room on 03/24/2026. 6. The facility failed to ensure a tube of zinc oxide was not inside Resident #46's room on 03/24/2026. 7. The facility failed to ensure a tube of zinc oxide was not inside Resident #76's room on 03/24/2026. 8. The facility failed to ensure a tube of zinc oxide was not inside Resident #77's room on 03/24/2026. These failures could place residents at risk of accidental overdose, misuse of medications, and possible adverse reactions. Findings included: 1. Record review of Resident #5's Face Sheet, dated 03/24/2026, reflected a [AGE] year-old female, admitted [DATE]. The resident was diagnosed with a lack of coordination, rheumatoid arthritis (inflammation of the joints), depression (persistent feeling of sadness or loss of interest), and chronic pain.Record review of Resident #5's Comprehensive MDS Assessment, dated 03/06/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a lack of coordination rheumatoid arthritis, depression, and chronic pain.Record review of Resident #5's Comprehensive Care Plan, dated 03/06/2026, reflected that the resident had an ADL self-care performance deficit and used anti-anxiety medications. The interventions included to assist with ADLs. The plan indicated the resident required antidepressant and one of the interventions was to monitor dry eyes.Record review on 03/24/2026 of Resident #5's Assessment Notes reflected no assessment for self-administration of medications.During an observation on 03/24/2026 at 9:15 a.m., Resident #5 was lying in bed inside her room. It was observed that there was an extra strength Tylenol container on top of the resident's overbed table. The container had medications inside.During an observation and interview on 03/24/2026 at 11:46 a.m., Resident #5 was in her bed, awake. It was observed that the resident had a container of eyedrops, a tube of antibiotics, and a tube of toothache cream on top of the resident's overbed table. The resident said those were her medications and she used them. She said the medications had always been on her overbed table, and she was not sure if the staff had seen them.During an interview on 03/26/26 at 10:15 a.m., the DON stated Tylenol should not be in Resident #5's possession, per the facility policy. She stated if the resident preferred her own brand of Tylenol, they could call the Physician, obtain an order for it, and put it on the care plan. She stated the CNAs should notify the nurses if they found personal medications with the residents, and if the nurses found it, to educate the residents and family about not having medication on the resident to prevent duplication of treatment or possible overdose. She stated it was part of the paperwork for admission to make sure families knew not to bring in outside medications without discussing with the nurse first. She stated the risk could be overmedication of the residents or other residents who get a hold of the medication.During an interview on 03/26/26 at 10:20 a.m., RN B stated the policy of the facility did not to allow outside medication in the resident rooms. RN B stated if any outside medication was brought in by the family, a physician's order needed to be obtained, care plan updated, and medication (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kept in the medication cart. She stated the risk of medication in the resident's room was it could result in an overdose of the resident. She stated the family was educated that if they brought in outside medication to always inform the nurse if they preferred to supply certain medications for the resident.During an interview on 03/26/26 at 10:30 a.m., ADON A stated the facility policy did not allow residents to keep medications in their rooms. ADON A stated the resident preferred a particular medication, a physician order was obtained from the physician and care plan updated. She stated all care staff, including CNAs, should report to the nurse if they found medication in the residents' room and the charge nurse was responsible to make sure no personal medications were kept in the residents' rooms. She stated the risk of having medications in the resident room was it could pose a risk to residents who were cognitively impaired, possible overdose, and pose a risk to residents with allergies, if they took the medication mistakenly.2. Record review of Resident #49's Face Sheet, dated 03/24/2026, reflected a [AGE] year-old female admitted [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and anemia (a problem of not having enough healthy red blood cells to carry oxygen to the body's tissue). Record review of Resident #49's Comprehensive MDS Assessment, dated 02/20/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had dementia and anemia. The plan did not indicate that the resident could self-medicate. Record review of Resident #49's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had impaired cognitive function/dementia and one of the interventions was to administer medications as ordered. The plan did not indicate that the resident could administer medication by herself. Record review on 03/24/2026 of Resident #49's Assessment Notes reflected no assessment for self-administration of medications. During an observation and interview on 03/24/2026 at 11:30 a.m., Resident #49 was sitting at the side of her bed. It was observed that a container of multivitamins was on top of her sink. Resident #49 said she took a multivitamin every morning. She said, before she went to breakfast, she would place one multivitamin on her side table so she could remember to take it when she was done with breakfast. She said the staff knew a container of multivitamins was inside her room, and no one asked her about it. 3. Record review of Resident #67's Face Sheet, dated 03/24/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #67's Comprehensive MDS Assessment, dated 03/10/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated that the resident had dementia. Record review of Resident #67's Comprehensive Care Plan, dated 02/04/2026, reflected that the resident had impaired cognitive function/dementia and one of the interventions was to administer medications as ordered. Record review on 03/24/2026 of Resident #67's Assessment Notes reflected no assessment for self-administration of medications. During an observation and interview on 03/24/2026 at 11:43 a.m., Resident #67 was in her bed, awake. It was observed that vials of eyedrops were on the resident's shelf. The resident said the vials were for her dry eyes. She said the vial had always been on her shelf, but she did not know if the staff saw them. During an observation and interview on 03/24/2026 at 1:14 p.m., LVN C went inside Resident #5's room and saw the eyedrops, a tube of antibiotics, and a tube of toothache cream. LVN C talked to Resident #5 and explained to her that those medications should be in the cart. LVN C was then observed entering Resident #67's room and saw the eyedrops on the resident's shelf. She said the residents had the right to have medications inside the room if they wanted their medications inside their rooms. LVN C did not reply when asked if the resident had an assessment for self-medication. She said sometimes families brought medications, and it was hard to monitor them. When asked what the risk could be of medications inside the room, she said it was a commonsense question. LVN C was not observed to go into Resident #49's room. LVN C said the resident could drink her medications by herself. 4. Record review of Resident #10's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female, admitted on the facility 08/02/2024. The resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was diagnosed with dementia and muscle weakness. Record review of Resident #10's Comprehensive MDS Assessment, dated 01/31/2026, reflected the resident had severe impairment in cognition with a BIMS of 07. The Comprehensive MDS Assessment indicated the resident had dementia and was incontinent for bladder and bowel. Record review of Resident #10's Comprehensive Care Plan, dated 03/17/2026, reflected that impaired cognitive function and an ADL self-care performance deficit. The interventions were to administer medications as ordered and to supervise during toilet use. During an observation on 03/24/2026 at 9:21 a.m., Resident #10 was not inside her room. It was observed that a tube of zinc oxide (medicated cream used to prevent skin irritation) was on top of the resident's side table. During an interview on 03/24/2026 at 2:41 p.m., CNA E said they used the zinc oxide after providing incontinent care to the residents. CNA E said he used it and left it inside the room. When asked what could happen if the residents accidentally consumed it, he did not reply. 5. Record review of Resident #32's Face Sheet, dated 03/26/2026, reflected a [AGE] year-old female, admitted to the facility 03/10/2026. The resident was diagnosed with retention of urine (a condition in which the urinary bladder does not empty completely). Record review of Resident #32's Comprehensive MDS Assessment, dated 03/16/2026, reflected that the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident was incontinent of bowel. Record review of Resident #32's Comprehensive Care Plan, dated 03/24/2026, reflected that the resident had an ADL self-care performance deficit and one of the interventions was to supervise during toilet use. Record review of Resident #32's Physician Order, dated 03/10/2026, reflected may use barrier cream as needed every shift. During an observation and interview on 03/24/2026 at 9:17 a.m., revealed Resident #32 was in her bed, awake. It was observed that two tubes of zinc oxide were on the resident's side table. When asked who left the zinc oxides on her table, the resident shrugged her shoulders. During an observation and interview on 03/24/2026 at 12:25 p.m., RN B said she did not think that having a barrier cream inside Resident #32's room was a violation. She went inside Resident #32's room and took the barrier cream. During an observation and interview on 03/24/2026 at 12:26 p.m., the Administrator said she did not think the barrier cream was poisonous. He said it was a topical cream and was safe for humans. During an interview on 03/24/2026 at 1:06 p.m., the Administrator said he researched and said skin barriers with zinc oxide should not be left inside the rooms of the residents. He said everything that read keep out of reach of children could also be harmful to the elderly population. He said most of the residents were confused and could accidentally consume them. He said he did not know the harm if the barrier cream was ingested. 6. Record review of Resident #46's Face Sheet, dated 03/25/2026, reflected an [AGE] year-old female, admitted to the12/16/2025. The resident was diagnosed with malaise (a general feeling of discomfort, illness, or uneasiness). Record review of Resident 46's Comprehensive MDS Assessment, dated 03/05/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #46's Comprehensive Care Plan, dated 12/19/2025, reflected that the resident had incontinence and one of the interventions was to provide peri care each incontinent episode. Record review of Resident #46's Physician's Order, dated 12/16/2025, reflected, May apply barrier cream as needed every shift. During an observation and interview on 03/24/2026 at 9:08 a.m., Resident #46 was in her bed, awake. It was observed that on top of the sink inside the resident's room was a tube of zinc oxide. When asked about the zinc oxide on top of her sink, the resident shrugged her shoulders. During an observation and interview on 03/24/2026 at 9:38 a.m., ADON A said barrier creams should not be inside the rooms of the resident because the residents could accidentally consume them or put them in their eyes. She took the tube of barrier cream from Resident #46's room and said she would put it in the nurses' station. 7. Record review of Resident #76's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old male, admitted to the facility on [DATE]. The resident was diagnosed with major depressive disorder (persistent feeling of sadness or loss of interest) and abdominal pain (discomfort or pain felt between the chest and the stomach). Record review of Resident 76's Comprehensive MDS (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessment, dated 03/06/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #76's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had an ADL self-care performance deficit and one of the interventions was to assist with toilet use. During an observation and interview on 03/24/2026 at 9:09 a.m., Resident #76 was in his bed, awake. It was observed that a tube of zinc oxide was on top of his side table. The resident said the staff would use the cream every time they changed him. He said it was not the first time staff left the zinc oxide on his bedside table. During an observation and interview on 03/25/2026 at 7:45 a.m., there was a tube of skin barrier inside Resident #76's room. She said somebody must have left it inside the room again. She took the skin barrier and said she would put it at the nurses' station. 8. Record review of Resident #77's face sheet, dated 01/30/2025, reflected an [AGE] year-old female, admitted on the facility 12/31/2010. Resident #5 was diagnosed with an overactive bladder. Record review of Resident #77's Comprehensive MDS Assessment, dated 03/08/2026, reflected the resident was moderately cognitively impaired with a BIMS of 12. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #77's Comprehensive Care Plan, dated 03/08/2026, reflected the resident was incontinent for bowel and bladder and one of the interventions was to clean peri-area after each incontinent episode. During an observation on 03/24/2026 at 9:28 a.m., Resident #77 was not inside her room. It was observed that a tube of zinc oxide was on top of the resident's side table. During an interview on 03/25/2026 at 9:15 a.m., CNA F said skin barriers should not be left inside the rooms of the residents because they might accidentally consume them. She said it should not be within the reach of the residents. She said there were residents that would wander around and sometimes go inside the rooms of other residents. She said if residents got hold of the skin barrier, they might use them inappropriately. During an interview on 03/26/2026 at 6:45 a.m., the DON said medications, of any form, should not be inside the residents' rooms. She said eye drops, antibiotics, toothache cream, and barrier creams should be inside the medication carts to secure them. She said the residents might use them inappropriately that could result in adverse reactions and overdose. She said just like the multivitamins, the staff did not know how many times a day the resident was taking, or using, it. She said she would also check if the residents had orders for the medications found inside their rooms. She said she would evaluate the need and would get orders for the said medications. She said there should be proper assessments before residents were permitted to keep and take their own medications, but most of the residents were forgetful and confused. She said she would conduct an in-service about medication storage which would include the CNAs to call the nurses if they saw medications inside residents' rooms. She said they would also educate family members to let the facility know that they were bringing medications. During an interview on 03/26/2026 at 7:32 a.m., ADON A said medications should not be inside the residents' rooms and should be stored inside the medication carts. She said most of the residents were confused and might use the medications inappropriately. She said some residents went from one room to another and might get hold of medications that they were allergic to. She said some residents might overuse the medications resulting in adverse reactions. She said she would coordinate with the DON about the medications inside the rooms of the residents. During an interview on 03/26/2026 at 8:30 a.m., the Administrator said the expectation was for the staff to make sure there were no medications inside the rooms of the residents because so many things could happen. He said he would coordinate with the DON about the medications found inside the rooms of the residents. Record review of the facility's policy titled, Medication Administration and General Guidelines P & P, dated March 2025, reflected, Policy: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so . Procedure . 1. Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications . 2. Medications are administered in accordance with written orders of the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attending physician. Record review of the facility's policy titled, Medication Storage in the Facility P & P, dated March 2025 reflected, Policy: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations . 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications. Record review of the facility's policy titled, Medication Orders P & P, dated March 2025, reflected, Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe.

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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 for the facility's only kitchen, reviewed for food and nutrition services. The facility failed to ensure the trash can in the kitchen area was properly sealed with a lid.The facility failed to properly label and date stored food received by vendors.The facility failed to ensure the tea dispenser was covered once completed brewing.The facility failed to ensure the ice machine in the kitchen was thoroughly cleaned.The facility failed to ensure the sugar and flour bins were thoroughly cleaned.The facility failed to ensure the deep fryer was properly cleaned.These failures placed residents at risk of exposure to food contamination and illness. Findings included:Observations on 03/24/26 from 9:08 a.m. to 9:22 a.m. in the facility's only kitchen revealed: One large trash can in the kitchen area had trash in it and the lid had a large hole cut into it. An ice machine, located in the kitchen had stains along the inside panel wall of the ice machine. Three large packages of tater tots, located in the freezer, were not dated with the month, day, and year it was stored upon receipt from the vendor. One large package of fries, located in the freezer, was not dated with the month, day, and year it was stored upon receipt from the vendor. Two large white storage bins, located in the dry storage area, containing sugar and thickener had brownish stains along the opening and inside of the bins. The deep fryer, in the kitchen area, had light brownish substances floating all over the top of the cooking oil in the fryer. During an observation and interview on 03/25/26 at 11:40 a.m., the tea dispenser, in the kitchen area, was observed uncovered and had a small amount of tea remaining in it. Kitchen Aide J stated he had prepared the tea earlier that morning. He stated he did not know how not covering the tea once it was finished brewing could impact the residents. The Dietary Manager stated she constantly told her staff to ensure the dispenser was covered once the tea had finished brewing to ensure it was not contaminated. During an interview on 03/26/26 at 9:40 a.m., the Dietary Manager was shown photos by the Surveyor of concerns observed in the kitchen area. She stated she had only been the DM for two weeks and the Maintenance Director had placed the trash can with the hole cut into the lid in the kitchen area. She stated she had told the night cook to ensure the deep fryer was cleaned out at the end of the night. She stated she cleaned out the bins weekly but stated they will ensure they are cleaned prior to refilling the bins. She stated she had reminded her team to ensure they labeled and dated the food when they received it from the vender. She stated she cleaned the ice machine weekly. She stated she reminded the kitchen staff to ensure the tea dispenser was covered once the tea had finished brewing. She stated if the concerns observed are not addressed it could contaminate the food.During an interview on 03/26/26 at 11:15 a.m., the Administrator was informed by the Surveyor of the concerns observed in the kitchen area. He stated he expected all foods to be labeled and dated correctly and kitchen equipment to be cleaned. He stated not addressing the concerns could result in food contamination.Record Review of the Facility's policy titled Food Storage and Supplies, dated 2012, revealed, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Dry bulk foods (e.g. flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled. Best practice is that scoops should not be left in food containers or bins, but if so, handles should be upright and not contacting the food item. Containers are cleaned regularly. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires, and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD Texas Chapter 228 Retail Food adopts the U.S FDA Food Code. 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. 3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepare. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #63) of six residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #63 room was in a position that was accessible to the resident on 03/24/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Record review of Resident #63's Face Sheet, dated 03/24/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #63 had diagnoses of repeated falls and lack of coordination. Record review of Resident #63's Initial MDS Assessment, dated 02/25/26, reflected the resident had a BIMS score of 7 (severe cognitive impairment). The MDS Assessment reflected the resident had an active diagnosis of muscle weakness and for ADL care the resident required moderate assistance.Record review of Resident #63's Comprehensive Care Plan, dated 03/18/26, reflected the resident was a fall risk and an intervention included ensuring call light was within reach of the resident.During an observation on 03/24/26 at 11:54 a.m., Resident #63 was observed lying in her bed and her call light was located on the floor, near her nightstand and out of her reach.During an interview on 03/24/26 at 12:05 p.m., RN P was shown by the Surveyor a photo of Resident #63's call light being on the floor and out of the resident's reach. She stated the call light needed to be within reach of the resident so she could contact staff if she needed help. She stated the resident was a fall risk, and if she had bent down to grab the call light she could fall and get injured.During an interview on 03/26/26 at 9:30 a.m., the DON was informed by the Surveyor of Resident #63's call light being observed on the floor and out of the resident's reach. She stated she was informed by the nursing staff of this concern. She stated the call light needed to be within reach of the resident so they could notify staff if she required assistance.During an interview on 03/26/26 at 11:10 a.m., ADON E was informed of Resident #63 lying in bed and not having her call light in reach. She stated all residents were to have their call light within their reach when they are in bed to ensure they were able to contact staff if they needed help. She stated it was the entire staff's responsibility to ensure call lights were within reach. Review of the facility's policy on Resident Rights (11/2021) revealed Resident have the right to live in safe, decent, and clean conditions. You have the right to receive all care necessary to have the highest possible level of health.The Administrator stated there was no policy referencing call lights.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 2 of 6 residents (Resident #47 and #83) reviewed for care plan. The facility failed to ensure Resident #47 and #83's care plan reflected an intervention which included weekly wound assessments. This failure could place residents at risk of their needs not being met. Findings include:Record review of Resident #47's Face Sheet, dated 03/24/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #47 had a diagnosis of anemia (low red blood cells) and dementia (memory loss).Record review of Resident #47's Quarterly MDS Assessment, dated 01/18/26, reflected Resident #47 had a BIMS score of 4 (severe cognitive impairment). The Quarterly MDS Assessment reflected the resident had an active diagnosis of dementia.Record review of Resident #47's Physician Orders, dated 03/24/26, reflected Venous wounds of the Left Dorsal foot, left shin, and right foot. Cleanse areas with wound cleanser. Record review of Resident #47's clinical records, dated 03/24/26, revealed the resident had weekly wound assessments on 03/17/26 and 03/24/26.Record review #47's Comprehensive Care Plan, dated 01/12/26, reflected no intervention for weekly wound assessments. During an observation on 03/24/26 at 11:36 a.m., Resident #47 was observed with wounds on both feet and his left shin.Record review of Resident #83's Face Sheet, dated 03/24/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #83 had a diagnosis of dementia (memory loss).Record review of Resident #83's MDS Assessment, dated 03/21/26, reflected Resident #83 had a BIMS score of 2 (severe cognitive impairment). The Quarterly MDS Assessment reflected the resident had an active diagnosis of dementia.Record review of Resident #83's Physician Orders, dated 03/24/26, reflected non-pressure wounds of the Left toe, left elbow, and right heel. Cleanse areas with wound cleanser. Record review of Resident #83's clinical records, dated 03/24/26, revealed the resident had weekly wound assessments on 03/11/26, 03/17/26 and 03/24/26.Record review #83's Comprehensive Care Plan, dated 03/17/26, reflected no intervention for weekly wound assessments. During an observation on 03/24/26 at 11:40 a.m., Resident #83 was observed with wounds on left arm and both feet.During an interview on 03/25/26 at 10:44 AM, ADON G/Treatment Nurse, stated Resident #47 and #83 had weekly skin assessments because of their wounds. She was informed by the Surveyor of Resident #47 and #83 not having an intervention for weekly skin assessments in their care plans. She stated the residents required wound care and they required weekly skin assessments as an intervention to ensure the wound was healing and not worsening. She stated it was the ADON and DON's responsibility to update care plans with the residents' plan of care.During an interview on 03/26/26 at 08:45 a.m., the DON was informed by the Surveyor of Resident #47 and Resident #83 requiring weekly wound care assessments, but it was not on their Comprehensive Care Plan as an intervention. She stated she was not aware it needed to be an intervention on the residents' care plan because the care plan referred to monitoring the resident's skin, although it did not indicate the frequency. She stated the residents required weekly skin assessments to ensure the wounds were healing and did not become worse. She stated the DON and ADONs were responsible for updating the care plans. Record review of facility's policy, Comprehensive Care Planning, undated, reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for two of eighteen residents (Resident #9 and Resident #46) and one direct care staff (RN B) reviewed for accident hazard. 1. The facility failed to ensure CNA F turned off Resident #9's oxygen tank that was leaking immediately on 03/25/2026. 2. The facility failed to ensure a [NAME] screwdriver, a fixed wrench, an [NAME] wrench, and screws were not inside Residents #46's room on 03/24/2026. 3. The facility failed to ensure that RN D did not leave a container of germicidal wipes on top of the nurse's cart unattended on 03/25/2026. These failures could prevent the residents from having an environment that was free from accidents, potential injury, and exposure to toxic chemicals.Findings included: 1. Record review of Resident #9's Face Sheet, dated 03/25/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dependence on renal dialysis (a medical treatment that removes waste products from the blood) and obesity (excessive accumulation of body fats). Record review of Resident #9's Quarterly MDS Assessment, dated 03/11/2026, reflected that the resident had moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated that the resident was on oxygen therapy. Record review of Resident #9's Comprehensive Care Plan, dated 03/03/2026, reflected that the resident had oxygen therapy and one of the interventions was to give oxygen at 2 lpm per nasal cannula. Record review of Resident #9's Physician Order, dated 01/27/2026, reflected May use oxygen @ 2l/m via nasal canula. every shift for Oxygen Therapy. During an observation on 03/25/2026 at 9:20 a.m. it was revealed that CNA F and CNA G were about to transfer Resident #9 to her wheelchair. It was observed that prior to transferring the resident, CNA F replaced the oxygen tank at the back of the resident's wheelchair. She took the regulator from the empty tank of oxygen and connected it to the new oxygen tank. She turned on the cylinder valve, and it produced a hissing sound. She turned it off and proceeded to transfer it to the resident. When the resident was already in the wheelchair, she disconnected the resident's nasal cannula from the oxygen concentrator, connected it to the oxygen outlet of the regulator, and gave the nasal cannula to the resident. She then turned it on, and it produced again a hissing sound. She turned it off and the resident signed that there was no oxygen coming out of the nasal cannula. She turned the oxygen tank again and it produced a hissing sound again. CNA F turned it off, fixed the regulator, and turned the tank again. It produced a hissing sound again. It was observed that CNA G told CNA F that there should be no sound coming out of the tank. CNA F did not turn the tank off and proceeded to finish fixing the resident. At this point, CNA G went out of the room and called RN B. RN B turned off the oxygen tank and fixed the regulator. During an interview on 03/25/2026 at 9:42 a.m., CNA G said she called the nurse because the oxygen tank was making a sound and looked like there was a leak. During an interview on 03/25/2026 at 10:08 a.m., CNA F said she should have called the nurse the moment she heard the hissing sound because it was an indication that the regulator was not properly attached. She said she turned it on because Resident #9 needed the oxygen but should have asked the nurse to check on the new oxygen tank. She said she did not have any problem before when she would connect a regulator to an oxygen tank. During an interview on 03/25/2026 at 11:43 a.m., RN B said CNA F should have called her when she heard the hissing sound because it meant oxygen could be leaking. She said many things could happen. 2. Record review of Resident #46's Face Sheet, dated 03/25/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with neoplasm (abnormal mass of tissues that could be cancerous or not) of the lung. Record review of Resident #46's Comprehensive MDS Assessment, dated 02/10/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had cancer. Record review of Resident #46's Comprehensive Care Plan, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 12/19/2025, reflected the resident had a terminal prognosis and was receiving hospice services . DX: Malignant Neoplasm of unspecified Bronchus (a major airway) or Lung and one of the goals was that the resident would be free from depression. One of the interventions was to monitor the coping strategies of the resident. During an observation and interview on 03/24/2026 at 9:08 a.m. revealed Resident #46 was in her bed, awake. It was observed that on top of the side of the sink inside the resident's room was a [NAME] screwdriver, a fixed wrench, an [NAME] wrench, and screws. The tools were on top of a gait belt, unattended, and within reach. When asked about the tools on top of the side of her sink, the resident shrugged her shoulders. During an observation and interview on 03/24/2026 at 9:38 a.m., ADON A said the tools should not be inside Resident #46's room because they could cause harm or injury. She said even if the resident was bed bound, other residents could enter Resident #46's room, get hold of the tools, and use them to harm themselves or others. She took the tools and placed them inside the nurse's station. During an interview on 03/26/2026 at 10:56 a.m., the Maintenance Supervisor said the tools found inside resident #46's room were not his tools. He said he did not know who left the tools inside the room. He said the tools should not be inside the rooms of the residents because the residents might hurt themselves with it or use it to hurt other residents and staff. 3. During an observation on 03/25/2026 at 11:20 a.m. it revealed RN B was about to check a resident's blood sugar. She took a container of germicidal wipes from one of the drawers of her cart and cleaned the glucometer. After cleaning the glucometer, she went inside the resident's room to check the blood sugar. She left the container of germicidal wipes on top of her cart. After checking the resident's blood sugar and administering the insulin, she went to another resident to check their blood sugar as well. She went inside the resident's room and closed the door. The germicidal wipes were still on top of the cart. During an interview on 03/25/2026 at 11:43 a.m., RN B said the germicidal wipes should be inside the cart, locked. She said the germicidal wipes had chemicals in them that could cause skin irritation; that was why the staff used gloves when handling them. She said residents might use the wipes to clean their eyes and face that could result in irritation. During an interview on 03/26/2026 at 6:45 a.m., the DON said the container of germicidal wipes should be locked inside the carts when not in use. She said it should be secured inside the carts so that the residents would not be able to access something that had chemicals on them. She said she was not sure what chemicals were on the wipes but considering the wipes were used to disinfect, then the wipes could be harmful to the residents. She said confused residents might get hold of the wipes, used them to clean their eyes, face, and private parts. She said residents might also consume them resulting in adverse reactions such as irritation and upset stomachs. She said there should not be tools inside the rooms of the residents as well because residents were able to get the tools and use them to harm themselves and others. She said the staff should not have turned on the oxygen again when she heard the hissing sound because the hissing sound was an indication that oxygen was leaking and should have called the nurse. She said the expectation was for the staff to not leave the germicidal wipes unattended, call the nurse if the oxygen tank was leaking, and that no tools should be inside the room of the resident. She said she would start an in-service regarding accidents and hazards. During an interview on 03/26/2026 at 7:32 a.m., ADON A said the container of germicidal wipes should be inside the cart when not in use for safety reasons. She said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin, and could result in irritations. She said some residents might consume it. She said anything that had Keep out of reach of children as an instruction should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. She said if the oxygen tank was hissing, it should be turned off and asked for help to troubleshoot the oxygen tank. She said she would coordinate with the DON about the leaking oxygen, about the tools found inside the room that was on plain view, and the germicidal wipes left unattended. During an interview on 03/26/2026 at 8:30 a.m., the Administrator said the wipes should be locked inside the cart when not in use and before the staff leave their cart. He said tools should not be inside the resident's room. He said things (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could happen. He said the room of the resident was far from the smoking area, so he did not believe there was harm with the leaking oxygen, and besides somebody called the nurse. He said he would coordinate with the DON about the issues discussed. Record review of the facility's policy, Residents' Rights undated, reflected Dignity and Respect . Live in safe . conditions. Record review of the facility's policy Medication Storage in the Facility P & P revised March 2025 reflected Policy: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations . 8. Potentially harmful substances (e.g. urine test reagent tablets, household poisons, cleaning supplies, and disinfectants) are clearly identified and stored in a locked area.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for one of three residents (Resident #77) reviewed for incontinence. The facility failed to ensure CNA D used proper technique to clean Resident 77's perineal area on 03/24/2026. This failure could place residents at risk of cross-contamination and development of urinary tract infections.Findings included: Record review of Resident #77's face sheet, dated 01/30/2025, reflected an [AGE] year-old female, admitted to the facility on [DATE]. The resident was diagnosed with an overactive bladder (a bladder control problem which leads to a sudden urge to urinate). Record review of Resident #77's Comprehensive MDS Assessment, dated 03/08/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #77's Comprehensive Care Plan, dated 03/08/2026, reflected the resident was incontinent for bowel and bladder and one of the interventions was to clean perineal (area between the thighs) after each incontinent episode. During an observation on 03/24/2026 at 2:18 p.m., CNA D and CNA E were about to do Resident #77's incontinent care. They washed their hands and put on pairs of gloves. CNA D rolled the resident's and pulled the resident's pants down. Both CNAs unfastened the resident's brief, and CNA E pushed it between the legs of the resident. They removed their gloves, washed their hands, and put on a clean pair of gloves. CNA D wiped the top and sides of Resident #77's perineal area (area between the legs). She then cleaned the middle portion of the perineal area using the front-to-back technique. In the process of cleaning the perineal area from front to back, it was observed that CNA D used a wipe towards the bottom of the resident, semi-folded the soiled wipe, and used the wipe again to clean the middle portion of the perineal area. She did it three times. Both CNAs removed their gloves, sanitized their hands, and put on clean pairs of gloves. After cleaning the perineal area, both CNAs assisted the resident to roll. CNA D started to clean the resident's bottom and pulled the soiled brief after she was done cleaning the resident's bottom. Both CNAs removed their gloves, sanitized their hands, and put on a clean pair of gloves. CNA D took the new brief, placed it under the resident, and fastened it. During an interview on 03/24/2026 at 2:38 p.m., CNA D said the proper technique was to wipe the middle portion of the perineal area and then discard the wipe and get a new one if wiping was still needed. She said using a wipe that already touched the bottom of the resident was already soiled and should not be used again because it might cause urinary tract infection. She said she was not even aware she used a soiled wipe to clean the perineal area again. During an interview on 03/24/2026 at 2:41 p.m., CNA E said wipes that were already used should not touch the perineal area again because it was already soiled and could cause infection.During an interview on 03/26/2026 at 6:45 a.m., the DON said staff should not use wipes that were already soiled to clean again the perineal area because it could cause urinary tract infections. She said after using one wipe, it should have been discarded whether the wipe was soiled or not. The DON said the CNAs should then get another wipe if the perineal area needed to be cleaned some more. She said she would do an in-service about perineal care. During an interview on 03/26/2026 at 7:32 a.m., ADON A said wipes should not be used again during perineal care, especially if the wipes already touched something soiled because it could cause urinary tract infection. She said she would coordinate with the DON regard proper procedure during incontinent care. Record review of facility policy titled, Perineal Care Nursing: Personal Care, dated April 25, 2022 reflected, Purpose: This procedure aims . providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition . Procedure Content . 17. Gently perform perineal care, wiping from clean,' urethral area (a tube where urine exits the body), to ?dirty,' rectal (continued on next page)

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	675402	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwall Nursing Care Center	206 Storrs Street Rockwall, TX 75087

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area, to avoid contaminating the urethral area - CLEAN to DIRTY! Female resident: Working from front to back . Use . pre-moistened cleansing wipes for each stroke

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of eighteen residents (Resident #65 and Resident #77) reviewed for infection control. 1. The facility failed to ensure CNA D did not use soiled wipes to clean Resident #77's perineal area during incontinent care on 03/24/2026. 2. The facility failed to ensure CMA A sanitized the blood pressure cuff while administering medications to Residents #65 and Resident #77 on 03/25/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #77's face sheet, dated 01/30/2025, reflected an [AGE] year-old female, admitted [DATE]. The resident was diagnosed with an overactive bladder. Record review of Resident #77's Comprehensive MDS Assessment, dated 03/08/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #77's Comprehensive Care Plan, dated 03/08/2026, reflected the resident was incontinent for bowel and bladder and one of the interventions was to clean peri-area after each incontinent episode. During an observation on 03/24/2026 at 2:18 p.m., CNA D and CNA E were about to do Resident #77's incontinent care. During the process of incontinent care, CNA D used a wipe that already had contact with the resident's bottom. She did it three times. During an interview on 03/24/2026 at 2:38 p.m., CNA D said she was not even aware that she used a soiled wipe to clean the perineal area again. She said her actions could cause an infection. During an interview on 03/26/2026 at 6:45 AM, the DON said soiled wipes should not be used again because it could cause probable infection. She said she would have an in-service about pericare and would monitor the staff if they were mindful in preventing infections. During an interview on 03/26/2026 at 7:32 AM, ADON A said they already knew that soiled wipes should not be used again to prevent cross contamination and probable infection. She said she would coordinate with the DON about the issue. During an interview on 03/26/2026 at 8:30 AM, the Administrator said they already have a plan-in-place regarding infection control. 2. Record review of Resident #65's Face Sheet, dated 03/27/2026, reflected an [AGE] year-old female, admitted [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #65's Comprehensive MDS Assessment, dated 03/20/2026, revealed a BIMS score of 4, indicating severely impaired cognition. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #65's Comprehensive Care Plan, dated 02/03/2026, reflected the resident had hypertension and one of the interventions was to give meds for hypertension and document response to medication and any side effects. Record review of Resident #65's Physician's Order, dated 03/25/2026, revealed Lisinopril Oral Tablet 40 MG Give 1 tablet by mouth one time a day for Hypertension Hold for SBP less than 110, DBP less than 60 and HR less than 60; Metoprolol Tartrate tablet 50 MG Give 1 tablet by mouth two times a day for Hypertension Hold for SBP less than 110, DBP less than 60 and HR less than 60. Record review of Resident #77's Face Sheet, dated 03/25/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident #77's Comprehensive MDS Assessment, dated 03/08/2026, revealed the resident had a BIMS score of 13. The Comprehensive MDS Assessment indicated that the resident had hypertension (high blood pressure). Record review of Resident #77's Comprehensive Care Plan, dated 03/10/2026, revealed the resident had hypertension and at risk of unstable blood pressure, one of the interventions was to give anti-hypertensive medications as ordered. Monitor side effects such as orthostatic hypotension (low blood pressure) and increased heart rate and effectiveness. Record review of Resident #77's Physician Orders, dated 02/26/2026, revealed Lisinopril Oral Tablet 5 MG Give 1 tablet by mouth one (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time a day for Hypertension, Hold for SBP less than 110, DBP less than 60 and HR less than 60. 2) Metoprolol Tartrate tablet 50 mg, give 1.5 tablet by mouth 2 times a day, Hold for SBP less than 110, DBP less than 60 and HR less than 60. Diltiazem HCL ER oral capsule, extended release 24-hour 240 mg. Record review of Resident #77's Physician Orders, dated 02/26/2026, revealed Metoprolol Tartrate tablet 50 mg, give 1.5 tablet by mouth 2 times a day, Hold for SBP less than 110, DBP less than 60 and HR less than 60. During an observation on 03/25/26 starting at 8:20 a.m. to 8:43 a.m., MA I was preparing Resident #65's medication. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, she placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #65. She did not sanitize the blood pressure cuff. She then went to Resident #77's room to check the resident's blood pressure. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, MA I placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #77. She did not sanitize the blood pressure cuff between Resident #65 and Resident #77's blood pressure checks. During an interview on 03/25/26 at 9:05 a.m., MA I stated the facility protocol was the BP cuff needed to be sanitized after checking resident BP. She stated that failure to sanitize BP cuff could result in the spread of infection between residents. During an interview on 03/25/26 at 9:10 a.m., RN C stated the Medication Aide should have followed the facility protocol to sanitize the BP cuff immediately after checking BP to prevent a possible spread of infection to other residents. During an interview on 03/25/26 at 9:15 a.m., the DON stated it is the facility protocol to have the BP cuff sanitized as soon as it is used to prevent possible spread of infection. Record review of the facility's policy, Medication Administration and General Guidelines P & P revised March 2025 revealed The person administering medications adheres to Universal Precautions, using proper hand hygiene, gloves when appropriate, before beginning a medication pass, prior to handling any medication, and after coming into direct contact with a resident. Gloves will be worn before administration of any ophthalmic, otic (relating to the ear), intranasal, inhaled, topical, vaginal, or rectal medication. Record review of the facility's policy titled, Infection Control Plan: Overview Infection Control Policy & Procedure Manual, dated 2019, updated March 2024, reflected, Infection Control: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

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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 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for two of four residents (Resident #100 and #101) reviewed for pharmaceutical services. The facility failed to ensure the MARs for Resident #100 and #101 both deceased residents were signed after administering PRN controlled medication. The facility failed to ensure that in two of five medications carts, the diagnosis listed on medication blister pack matched the physician ordered diagnosis. The facility failed to ensure that no personal staff items were stored in the medication cart. The facility failed to ensure that one of five medication carts did not contain expired Covid-19 test strips. This failure could place residents at risk of not receiving medications as ordered, ineffective treatment, potential overdose, and potential decline in condition.Findings included: Record review of Resident #100's Face Sheet, dated [DATE], revealed a [AGE] year-old male admitted [DATE]. The resident was diagnosed with Acute respiratory failure (when the lungs suddenly cannot get enough oxygen in or remove carbon dioxide). Record review of Resident #100's Comprehensive Care Plan, dated [DATE], revealed the resident had alteredrespiratory status/difficulty breathing /shortness of breath related to respiratory failure with hypoxia (low oxygen levels in the body) and receiving hospice care. Interventions included, administer medication/puffers as ordered. Monitor for effectiveness and side effects. Record review of Resident #100's Physician's Order, dated [DATE], revealed Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 3 hours as needed for PAIN/DYSPNEA (feeling short of breath). Record review of Resident #101's Face Sheet, dated [DATE], revealed a [AGE] year-old male admitted [DATE]. The resident was diagnosed with chronic respiratory failure (Long term inability of the lungs to enough oxygen in or remove carbon dioxide) chronic obstructive pulmonary disease (COPD - long term ung condition that makes it hard to breath), asthma (your lungs swell and make it difficult to breath). Record review of Resident #101's Comprehensive Care Plan, dated 03/042026, revealed that the resident has chronic obstructive pulmonary disease (COPD - Long term Lung condition that makes it hard to breath), asthma (your lungs swell and make it difficult to breath) and was on hospice services. Interventions included give oxygen therapy as ordered by the physician. Record review of Resident #101's Physician's Order, dated [DATE], revealed Morphine Sulfate (Concentrate) oral Solution 100 MG/5ML Give 0.25 ml sublingually (under the tongue) every 3 hours as needed for PAIN/Shortness of breath. During an observation and interview on [DATE] at 9:17 AM revealed Resident #126 was in his bed, awake. It was observed that there were two dry pills on the resident's overbed table. According to the resident, the staff gave him the pills and told him to take the pills when he was done eating his candy. It was observed that there was a child inside the room. During an observation and record review on [DATE] at 9:30 am, of Resident #100 and Resident #101, the controlled medication sign out sheet and and MAR, it was revealed that the medication sign out sheet was signed, but the MAR was not signed to show the medication was administered to both residents. Interview on [DATE] at 7:47 am with ADON A, she stated that the policy for medication pass was to make sure the right medication is given to the right resident, they have pictures on the MAR for the resident that cannot self-identify. She stated for PRN medications, the nurse needs to assess first, give medication, if necessary, sign the MAR and complete a follow-up assessment for effect of the medication given. She stated the risk of not signing the MAR after PRN medications are given could result in double dosing the resident which can lead to an overdose. Interview on [DATE] at 8:30 am with DON, she stated that the facility policy is that all medications given must be signed off on the MAR, for PRN medications a follow up assessment has to be done for effectiveness of the medication. She stated if the MAR is not signed at the time of administration, it could result in over (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	medication and for certain medications could lead to toxicity or even death. She stated the ADON and DON run a MAR report every morning to make sure all medications are signed for. Record review of Resident #12's Face Sheet, dated [DATE], revealed a [AGE] year-old male admitted to the facility on [DATE]. The resident was with diagnosed mood disorder (Ongoing sadness, highs or mood swings) Record review of Resident #12's Comprehensive MDS Assessment, dated [DATE], revealed a BIMS score of 02 (Very severe cognitive impairment). Record review of Resident #12's Comprehensive Care Plan, dated [DATE], revealed the resident had mood problems with interventions to Administer medications as ordered. Intervention included, Monitor/document for side effects and effectiveness. Record review of Resident #12's Physician Orders, dated [DATE], revealed Depakote Tablet Delayed Release 125 MG(Divalproex Sodium) Give 1 tablet by mouth at bedtime for Mood disorder DO NOT CRUSH and Depakote Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for Mood disorder DO NOT CRUSH. Observation and record review on [DATE] at 11:00 a.m. of medication cart in the secured male unit revealed Resident #12's Depakote blister pack was labeled for seizures, the physician order dated [DATE] revealed it was ordered for Mood disorder. Record review of Resident #34's Face Sheet, dated [DATE], revealed a [AGE] year-old female admitted to the facility on [DATE]. The had a diagnosis of Epilepsy (Repeated seizures). Record review of Resident #34's Comprehensive MDS Assessment, dated [DATE], revealed a BIMS score of 07 (moderate memory and thinking problems, may be confused and need regular help with task and remembering things), a diagnosis of epilepsy. Record review of Resident #34's Comprehensive Care Plan, dated [DATE], revealed The resident has an alteration inneurological status r/t Vascular dementia (memory and thinking problems caused by a reduced blood flow to the brain). Interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #34's Physician Orders, dated [DATE], revealed Divalproex Sodium Oral Tablet Delayed Release 250MG (Divalproex Sodium) Give 1 tablet by mouth three times a day related to epilepsy. During an observation and record review on [DATE] at 11:00 a.m. of medication cart in the secured male unit revealed Resident #34's Divalproex blister pack was labeled for Admission, the physician order dated [DATE] revealed it was ordered for epilepsy. Her Gabapentin blister pack was labeled for admission, the physician order dated [DATE] revealed it was ordered for neuropathy (Nerve damage that causes numbness, tingling or pain). During an interview on [DATE] at 7:47a.m. The ADON A stated all medication blister packs should match the indication for use on the doctors' orders, if there is a change in indication for medication use a change of indication sticker needs to be place on the medication card. She stated the Nurses, ADON and DON are responsible for making sure that all medication cards match the indication for use on the Doctors order. She stated the risk of not matching the medication card and the doctors' orders could result in missed doses of the medication, over medication or under medicating the resident. Interview on [DATE] at 8:30 am with DON, She stated that the medication cards should match the indication for use as ordered by the doctor and if there is a change for the use of the medication, a change of indication sticker should be place on the medication card and update the order. She state the risk of the medication card not matching the order could result in the wrong medication being given to the resident and result in toxicity, over medication and unnecessary medication given to the resident. She stated the nurses, ADON and DON are responsible for making sure that the indication for the medication matches what is on the card and if there is a change in the indication to place a change of indication sticker and update the order. During an observation on [DATE] at 11:25 a.m. of the medication cart in the secure female unit, revealed a bag of chocolate candy, deodorant spray, and lotion in the cart. Interview on [DATE] at 11:30 am with RN D, she stated she does not know the policy on storing personal items in the medication cart. She stated that if unapproved items were put in the cart and used by the resident, it could be detrimental to them and if a personal deodorant spray was used around the resident, it could affect those with respiratory issues and exacerbate their symptoms. Interview on [DATE] at 11:35 am with the DON, she stated that per the facility policy, personal items should not be place in the (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	resident medication cart at any time to avoid cross contamination and possibility of resident getting a hold of it and cause harm to themselves or others. Interview on [DATE] at 7:47 am with ADON A, She stated that the facility policy is that personal items should not be in the medication cart or medication room. She stated the risk of using personal items like the spray found in the medication cart could pose a danger to residents with asthma or who were allergic to the spray. She stated no one knows where those items have been, having them in the medication cart could be an infection control issue for the residents on the unit. She stated the nurses, ADON and DON are responsible for checking the cart weekly to make sure no personal items are in them. During an observation on [DATE] at 11:40 a.m. of medication cart on hall 200 revealed an expired Covid-19 test strip with use by date of [DATE] in the cart. During an interview on [DATE] at 11:45 a.m., RN C stated the facility policy was to discard any expired items that were found in the medication cart. She stated that an expired covid test could give a false covid positive test result and the risk to the resident was they may not be treated or could be treated unnecessarily if they have a false positive test. She also stated that if the resident has a false negative, they could be walking around with covid and cause a wide spread infection in the facility. During an interview on [DATE] at 11:50 pm, the DON stated that all expired items should be immediately removed from medication cart and discarded as per the facility policy. She stated that the nurses should check the cards daily as they pass medication, the ADON and DON also check periodically to make sure all expired items are removed from the cart. She stated that the risk of having an expired covid test in the cart could be a false negative or false positive test and could result in a lack of treatment or unnecessary treatment of covid which could adversely impact the resident and possible spread of covid in the facility. Interview on [DATE] at 7:47 am with ADON A, she stated the facility policy requires all expired items to be discarded immediately, the nurses, ADON and DON are responsible to check for that weekly. She stated the expired covid test kid found in the cart if used could give a false positive and result in unnecessary treatment, if false negative could result in no treatment and will adversely impact the resident and spread the virus to other resident and staff in the building. Record review of the facility's Medication Administration and General Guidelines, dated ??, revealed: Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. The interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate When PRN medications are administered, the following documentation is provided. - Date and time of administration, dose, route of administration (if other than oral), and if applicable the injection site - Complaints or symptoms for which the medication was given - Results achieved from giving the dose and the time results were noted - Signature or initials of person recording administration and signature or initials of person recording effects, if different from person administering Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. Facility personnel will contact PharmcareUSA if any discrepancies are noted.