STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675441	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1400 Blackshill Dr Gainesville, TX 76240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for five of 15 residents (Residents #58 , #62, #51, #8, and #4) reviewed for comprehensive care plans. 1. The facility failed to include, in the care plan for Resident #58, his left-hand contracture and interventions to prevent further decline. 2. The facility failed to include, in the care plan for Resident #62, her contracture to her right hand and arm and interventions to prevent further decline. 3. The facility failed to develop care plans for Resident #51's Activity of Daily Living assistance needs, and his antianxiety medication. 4. The facility failed to develop a care plan for Resident #8's contractures in both hands and left elbow contracture. 5. The facility failed to ensure Resident #4's dementia diagnosis was care planned. These failures could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life and care and did not represent a person-centered coordination of care.1. Record review of Resident #58's Annual MDS assessment, dated 04/21/26, reflected a [AGE] year-old male with an admission date of 05/13/25. Resident #58 had a BIMS score of 7 which indicated he was severely cognitively impaired. He required partial to moderate assistance for personal hygiene and had not refused care. He had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days prior to the assessment. Record review of Resident #58's care plan initiated 05/02/26 reflected, The resident had a cerebral vascular accident (CVA/Stroke) .Goal-The resident will be free from sign/symptoms of complications of CVA .contractures (a permanent tightening or shortening of muscles, tendons that cause joints to become rigid and stiff) .) Interventions- Activity as tolerated. Out of Bed in chair if tolerated. The contracture to his left hand and arm had not been care planned and did not address interventions to reduce worsening of the contractures. Record review of Resident #58's physician orders dated 06/04/26 reflected, Occupational Therapy Clarification Order - Skilled Occupational Therapy one time to include education and transfer to restorative care for control of LUE tone for Medical/Treatment. Verbal Pending confirmation. Order was discontinued on 09/30/25. There were no orders for splints to left hand and arm. Record review of Resident #58's Occupational Therapy Discharge summary dated [DATE] reflected, Diagnosis: Contracture, left hand- Long term goal-met on 05/08/26- Patient will tolerate wearing Left elbow extension and wrist extension splint for up to 4 hours with no adverse skin reactions or redness, demonstrating proper positioning and improved tone management with caregiver assistance as needed.Patient discharged to this long term care facility for continued skilled nurses supervision and care. During an observation and interview on 06/02/26 at 9:20 a.m. Resident # 58 was observed lying in bed. His left hand was contracted with his thumb pushing down toward his palm. No splint was in use. The nails on his left hand were clean, but all of the nail were approximately 1/4 inch in length. Two splints were observed on the resident's (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chest of drawers beside his bed. Resident #58 stated they used to put a splint on his left hand, but he believed they borrowed it for someone else. Resident #58 stated he was not able to open his left hand. During an observation on 06/03/26 at 12:21 p.m., Resident #58 was observed in his wheelchair in the dining room eating lunch. The resident did not have a splint on his left hand or arm. 2. Record review of Resident #62's Annual MDS assessment, dated 03/17/26, reflected a [AGE] year-old female with an admission date of 07/28/22. Resident #62 had a BIMS score of 9 which indicated she was moderately cognitively impaired. She required maximum assistance for personal hygiene and had not refused care. She had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). She had not received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days prior to the assessment. Record review of Resident #62's care plan initiated 09/10/25 reflected, The resident has an ADL self-care performance deficit related to hemiplegia. Has a splint to right arm but will refuse to wear it at times The contracture to her hand had not been cared planned and did not address interventions to reduce worsening of the contractures or who was responsible for splint placement. Record review of Resident #62's physician orders dated 06/04/26 did not reflect any orders for splints to right hand and arm. Record review of Resident #62's Occupational Therapy Discharge summary dated [DATE] reflected, Diagnosis: Contracture, right hand- Discharge reason-discharged per physician or Case manager.Progress and Response to treatment: Patient demonstrated less flexor tone (passive muscle tension in the flexor muscles) .Patient discharged to this long-term care facility for continued skilled nurses' supervision and care. During an observation and interview on 06/02/26 at 9:55 a.m., Resident #62 was observed sitting in her wheelchair at the sink in her room preparing to brush her teeth. Her right hand was drawn into a fist, and she was unable to open her hand. Two splints were observed on a chair by her bed. Resident #62 stated she had been asking for a splint for her arm and some therapy for over 5 months. She stated she wanted to get as much movement back as she could. During an interview on 06/03/26 at 12:20 p.m. with the DON, she stated they did not have a restorative program and currently do not have anyone on restorative care. She stated, at the moment, therapy was placing splints and braces while residents were on therapy, either skilled or part B. She stated she was not aware of any residents that nursing staff were placing splints on. During an interview on 06/04/26 at 12:20 p.m. with PTA H, she stated they were told by the previous Administrator to stop writing restorative care plans for residents who were discharged from therapy, because the facility was not providing restorative care. She stated they were not writing any orders for nursing to continue any form of restorative care since this is what they were told. During an interview on 06/04/26 at 12:25 p.m. with OT G, she stated they had been instructed not to refer residents for restorative care once they were discharged from therapy since the facility no longer had a restorative aide. She stated Resident #58 and Resident #62 both needed elbow extension and hand splints to prevent further contractures and decline in tone and flexibility. She stated she had discharged Resident #62 from services around January 2026 and had discharged Resident #58 last month (May). She stated they were both tolerating the splints for 4 hours at time, and that would be what she would have recommended for ongoing daily needs post discharge. She stated she had not been asked to teach any of the aides or nursing staff on splint placement. During an interview on 06/04/26 at 12:30 p.m. with the DON, she stated she had recently requested a list of residents with contractures, but she had not received it yet from therapy. She stated contractures needed to be care planned on any resident and interventions needed to be in place to improve or prevent further decline. 3. Review of Resident #51's quarterly MDS dated [DATE] reflected Resident #51 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (progressive, inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure) and diabetes mellitus. Resident #51 had a BIMS score of 15 indicating he was cognitively intact. Resident #51 required partial to moderate assistance with most ADLs including showering, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing and personal hygiene Review of Resident #51's Comprehensive Care plan last revised on 03/12/26 reflected no care plan for ADL assistance. An observation and interview on 06/02/2026 at 9:50 AM with Resident #51 revealed he stated he would like his fingernails trimmed. His nails were half an inch long on left hand, and half an inch on a couple of fingers on right hand. He stated it had been at least a week, but was not sure how long. He stated the podiatrist came out once to see him about 3 months ago. He stated he needed to have his toenails trimmed. An observation and interview on 06/02/2026 at 12:52 PM revealed Resident #51 was lying in bed. CNA J stated Resident #51 needed assistance with ADLs. Record review of Resident #51's consolidated current physician orders and June MAR revealed a physician order dated 03/12/26 of of Buspirone tablet 10 mg - Give 1 tablet orally two times a day for anxiety. An interview on 06/03/2026 at 2:45 PM with LVN I revealed Resident #51 did not have a care plan for his assistance with ADL needs. He stated the care plan helped staff know the resident assistance needs and baseline to know how residents perform their ADLs. He stated the MDS Coordinator was doing care plans, and no longer at facility for about 2 weeks. An interview on 06/04/26 at 10:50 AM with LVN I revealed he could not find the antianxiety medication care planned for Resident #51, and it should have been care planned to address the interventions in place for antianxiety medication management. 4. Record review of Resident #8's face sheet undated reflected Resident #8 was an [AGE] year old female admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (chronic autoimmune disease that affects the brain and spinal cord), paraplegia (partial or complete paralysis of the lower half of the body) and congestive heart failure (condition when your heart can't pump blood well enough to give your body a normal supply). Record review of Resident #8's quarterly MDS assessment dated [DATE] reflected Resident #8 had a BIMS score of 15 indicating she was cognitively intact. Resident #8 was dependent with ADLs. Resident #8 had functional limitation in range of motion of her upper extremity on both sides and lower extremity on one side . Interview on 06/03/2026 at 11:25 AM with Occupational Therapist G revealed Resident #8 had contractures in both hands, and for her right hand, Resident # 8 not able to open 4 out of 5 fingers, and the Resident's left arm was contracted. She stated the last time she worked with Resident #8 was in February 2025 and attempted to encourage Resident #8 to wear splint in right hand and left elbow. She stated Resident #8 did not want to continue therapy, and refused the splints to help with contracture management. An observation and interview on 06/03/26 at 2:43 PM with LVN I revealed Resident #8 lying in bed. She had contracture on right hand with no splint in resident's hand and left elbow, and hand had contractures with no splints. Resident #8 stated she did not want therapy or any splint devices in her hands. An interview on 06/03/26 at 2:45 PM with LVN I revealed Resident #8 had contractures for both hands and a left elbow contracture since admission. He stated she refused therapy and contracture splint devices. He stated Resident #8's contractures and limited range of motion should be care planned. He stated Resident #8's refusal for therapy and contracture splints should be care planned to ensure staff were aware of resident's preferences and put interventions in place for resident preferences. An interview on 06/03/26 at 2:58 PM with CNA E revealed Resident #8 had contractures in both hands and was dependent on staff for ADLs. An interview on 06/04/2026 at 12:46 PM with the DON revealed Regional MDS Coordinators were responsible for completing comprehensive care plans like ADLs and medications based on the MDS assessment. She stated Resident #8 should have been care planned for contractures and limited range of motion. She was aware Resident #8 had refused therapy and contracture splints per her preferences. She stated it was important to care plan resident refusals so their preferences could be followed. She stated ADLs should be care planned to address resident assistance levels and interventions put in place for ADLs. She stated medications like antianxiety should be care planned to ensure interventions in place to monitor medications and their side effect monitoring. 5. Record review of Resident #4's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of Cachexia (severe, involuntary weight loss), dementia (decline in thinking and memory skills), Alzheimer's disease (brain disorder slowly destroys memory, thinking (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skills), and cerebrovascular disease (condition affecting blood flow and the blood vessel in the brain). Record review of Resident #4's MDS assessment, dated 03/11/2026, reflected a BIMS score of 04, which indicated severe cognitive impairment. Section I-Active Diagnoses revealed a diagnosis of Non-Alzheimer's Dementia. Record review of Resident #4's Comprehensive Care Plan reviewed 06/04/2026 revealed no measurable goals and interventions addressed for the care and treatment for Resident #4's dementia diagnosis. During an interview on 06/04/26 at 9:10 a.m., LVN I stated Resident #4's dementia diagnosis was not addressed in the care plan. He stated he was unsure why. He stated there was no Social Worker nor MDS Coordinator that worked at the facility. He stated he addressed changes to the care plan as they arose since taking over the care plan duties three weeks ago. He stated he was not trained on care plans. He stated measurable goals and interventions, pertaining to Resident #4's dementia diagnosis, were important, for staff to know the needs and care of the resident. He stated the MDS Coordinator was responsible for addressing Resident #4's diagnosis in the care plan. Record review of the facility's policy titled, Prevention of Decline in Range of Motion, dated December 2025, reflected, Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motions is unavoidable.Based on the comprehensive assessment, the facility will provide interventions, exercises, and/or therapy to maintain or improve range of motion.Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner.A Nurse with the responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercised will be documented in the medical record. Modification to the plan of care will be made as needed. Review of facility's policy Comprehensive Care Plans dated 10/01/25 reflected policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.The comprehensive care plan will describe, at a minimum, the following: a. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for two of five Residents (Resident #58 and Resident #62) reviewed for quality of care. 1. The facility failed to implement interventions to prevent further decline of Resident #58's contracture to his left hand and arm. 2. The facility failed to implement interventions to prevent further decline of Resident #62's contracture to her right hand and arm. This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included:1. Record review of Resident #58's Annual MDS assessment, dated 04/21/26, reflected a [AGE] year-old male with an admission date of 05/13/25. Resident #58 had BIMS score of 7 which indicated he was severely cognitively impaired. He required partial to moderate assistance for personal hygiene and had not refused care. He had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days prior to the assessment.Record review of Resident #58's care plan initiated 05/02/26 reflected, The resident had a cerebral vascular accident (CVA/Stroke) .Goal-The resident will be free from sign/symptoms of complications of CVA .contractures (a permanent tightening or shortening of muscles, tendons that cause joints to become rigid and stiff) .)-Interventions- Activity as tolerated. Out of Bed in chair if tolerated. The contracture to his left hand and arm had not been cared planned and did not address interventions to reduce worsening of the contractures. Record review of Resident #58's physician orders dated 06/04/26 reflected, Occupational Therapy Clarification Order - Skilled Occupational Therapy one time to include education and transfer to restorative care for control of Left upper extremity tone for Medical/Treatment. Verbal Pending confirmation. Order was discontinued on 09/30/25. There were no orders for splints to left hand and arm.Record review of Resident #58's Occupational Therapy Discharge summary dated [DATE] reflected, Diagnosis: Contracture, left hand- Long term goal-met on 05/08/26- Patient will tolerate wearing Left elbow extension and wrist extension splint for up to 4 hours with no adverse skin reactions or redness, demonstrating proper positioning and improved tone management with caregiver assistance as needed.Patient discharged to this long term care facility for continued skilled nurses supervision and care. During an observation and interview on 06/02/26 at 9:20 a.m., Resident # 58 was observed lying in bed. His left hand was contracted with his thumb pushing down toward his palm. No splint was in use. The nails on his left hand were clean, but all of the nail were approximately 1/4 inch in length. Two splints were observed on the resident's chest of drawers beside his bed. Resident #58 stated they used to put a splint on his left hand but stated he thinks they borrowed it for someone else. Resident stated he was not able to open his left hand. During an observation on 06/03/26 at 12:21 p.m. Resident #58 was observed in his wheelchair in the dining room eating lunch. The resident did not have a splint on his left hand or arm. 2. Record review of Resident #62's Annual MDS assessment, dated 03/17/26, reflected a [AGE] year-old female with an admission date of 07/28/22. Resident #62 had BIMS score of 9 which indicated she was moderately cognitively impaired. She required maximum assistance for personal hygiene and had not refused care. She had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). She had not received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days prior to the assessment.Record review of Resident #62's care plan initiated 09/10/25 reflected, The resident has (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an ADL self-care performance deficit related to hemiplegia. Has a splint to right arm but will refuse to wear it at times The contracture to her hand had not been cared planned and did not address interventions to reduce worsening of the contractures or who was responsible for splint placement.Record review of Resident #62's physician orders dated 06/04/26 did not reflect any orders for splints to right hand and arm.Record review of Resident #62's Occupational Therapy Discharge summary dated [DATE] reflected, Diagnosis: Contracture, right hand- Discharge reason-discharged per physician or Case manager.Progress and Response to treatment: Patient demonstrated less flexor tone (passive muscle tension in the flexor muscles) .Patient discharged to this long-term care facility for continued skilled nurses' supervision and care.During an observation and interview on 06/02/26 at 9:55 a.m. Resident #62 was observed sitting in her wheelchair at the sink in her room preparing to brush her teeth. Her right hand was drawn into a fist, and she was unable to open her hand. Two splints were observed on a chair by her bed. Resident #62 stated she had been asking for a splint for her arm and some therapy for over 5 months. She stated she wanted to get as much movement back as she could. During an interview on 06/03/26 at 12:20 p.m. with the DON she stated they do not have a restorative program and currently do not have anyone on restorative care. She stated at the moment therapy was placing splints and braces while residents were on therapy, either skilled or part B. She stated she was not aware of any residents that nursing staff were placing splints on. During an interview on 06/03/26 at 2:45 p.m. with LVN A, she stated she was not aware of the residents they were supposed to be putting daily splints on. She stated usually if a resident had splints, they had an order for how long the splint was to be applied and then they were required to assess the skin after removal of the splint. She stated she did not have any resident who currently had orders for splint placement. During an interview on 06/03/26 at 2:50 p.m. with LVN B, she stated she had not been instructed on splint placement on any of the residents. She stated she was not aware Resident #58 or Resident #62 had splints. During an interview on 06/03/26 at 2:55 p.m. with CNA E, she stated she mainly worked hall 100 and 200, but had worked all over the building. She stated she took care of Resident #58 and Resident #62. She stated she saw Resident #62 with a splint on her right arm in the past but had not seen it on her in over a month. She stated she was not aware Resident # 58 had a splint. She stated both of the residents had contracted hands from a stroke. She stated she assumed therapy was responsible for putting the splints on and taking them off the residents. She stated she had not been told they were responsible for putting on splints. She stated they used to have a restorative aide, but they had moved him to transportation. During an interview on 06/03/26 at 3:00 p.m. with CNA D, she stated she had worked at the facility for about 3 weeks. She stated she had not had any instruction or training on placing splints on any of the residents. During an interview on 06/04/26 at 12:20 p.m. with PTA H she stated they were told by the previous Administrator to stop writing restorative care plans for residents who were discharged from therapy because the facility was not providing restorative care. She stated they were not writing any orders for nursing to continue any form of restorative care since this is what they were told. During an interview on 06/04/26 at 12:25 p.m. with OT G she stated they had been instructed not to refer residents for restorative care once they were discharged from therapy since the facility no longer had a restorative aide. She stated Resident #58 and Resident #62 both needed elbow extension and hand splints to prevent further contractures and decline in tone and flexibility. She stated she had discharged Resident #62 from services around January 2026 and had discharged Resident #58 last month (May). She stated they were both tolerating the splints for 4 hours at time and stated that would be what she would have recommended for ongoing daily needs post discharge. She stated she had not been asked to teach any of the aides or nursing staff on splint placement. During an interview on 06/04/26 at 12:30 p.m. with the DON she stated they had a restorative aide but had not had one for several months. She stated therapy had not been letting them know of any needs for ongoing splint placement, and they were only told when a resident was being discharged . She stated all therapy had to do was let them know, and they would write an order for the splint and make sure the staff was (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trained on the splints. She stated they really did not have a good communication process in place between nursing and therapy. She stated she had recently requested a list of residents with contractures but stated she had not received it yet from therapy. She stated contractures needed to be care planned on any resident and interventions needed to be in place to improve or prevent further decline. During an interview with CNA F on 06/04/26 at 1:22 p.m. he said he used to provide restorative care at the facility. He said he would perform range of motion exercises, walk the residents, and put splints on if they had them, but they pulled him from that and placed him on transportation. He stated it had probably been about a year since he had done any restorative care. He stated he was never asked to train any of the CNAs on what restorative care any of the residents were getting or needed. During an interview on 06/04/26 at 1:40 p.m. with the Regional [NAME] President, she stated she believed there were a lot of miscommunications which resulted in the breakdown between therapy and nursing. She stated the facility no longer had a billable restorative program, but they were still required to provide functional restorative care for any resident who had ongoing needs once discharged from therapy. She stated the risk of not providing those services were decline in the resident mobility and quality of life. Record review of the facility's policy titled, Prevention of Decline in Range of Motion, dated December 2025, reflected, Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motions is unavoidable.Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion.Based on the comprehensive assessment, the facility will provide interventions, exercises, and/or therapy to maintain or improve range of motion.This includes, but is not limited to.Specialized rehabilitation, restorative, maintenance.braces or splints.Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner.

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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 observations, interviews, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in: 1. The facility failed to ensure refrigerator food items were dated when received, and freezer item were properly sealed on 06/02/26. 2. The Dietary Manager and Dietary [NAME] K failed to wear effective hair restraints during breakfast meal preparation on 06/04/26. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness and food contamination. Findings included: 1. Observation of walk-in refrigerator on 06/02/26 at 8:59 AM revealed two packages of cabbage, were not dated when received, and two packages of carrots, were not dated when received. Observation of walk-in freezer on 06/02/26 at 9:02 AM revealed hamburger patties not sealed in the bag in an open box. Interview on 06/03/26 at 9:04 AM with the Dietary Manager revealed the carrots and cabbage must have been taken out of the original box last night, but it should have had a receive date on it. He stated the hamburger patties should be sealed and dietary staff must have forgotten to seal it when they got hamburger patties out last. 2. An observation on 06/04/26 at 7:20 AM revealed the Dietary Manager was wearing a hair restraint with 0.5 inches hair uncovered above both ears while taking hot food temperatures of eggs, gravy, mashed potatoes, grits, sausage, and oatmeal. At 7:38 AM, the Dietary Manager was covering the breakfast meal plates An observation on 06/04/26 at 7:36 AM revealed Dietary [NAME] K had a hair restraint not covering about 0.5 inches near both ears and 0.5 inches of back of hair while he was plating breakfast food for the resident meal trays. An interview on 06/04/26 9:03 AM with Dietary [NAME] K revealed he was not aware his hair restraint was not covering all of his hair. In an interview on 06/04/26 at 9:05 AM, the Dietary Manager stated he thought all of his hair was covered. He stated it was important for all hair to be covered to keep hair out of food and prevent cross contamination. Review of the facility's policy Food Storage last revised March 2019 reflected Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination.4. All food items should be dated with the received date, unless labeled with a readable label from the food vendor.18. Frozen foods.c. Foods must be covered, labeled and dated. Review of the facility's policy Nutrition Services Department Dress Code last revised December 2025 reflected The following are department specific standards:.g. Hair must be covered with a hairnet/bonnet, including bangs. Review of the Food and Drug Administration US Food Code 2022 reflected under section 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints. Review of the Food and Drug Administration Food Code, dated 2017, reflected, .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 3-305.11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675441	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1400 Blackshill Dr Gainesville, TX 76240

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented and systematically organized for one of eight (Resident #61) reviewed for administration. The facility failed to ensure staff documented Resident # 61's wound care on the MAR/TAR, that was provided or declined on 05/05/26, 05/07/26, 05/08/26, 05/12/26, 05/13/26, 05/15/26, 05/19/26, 05/21/26, 05/22/26, 05/25/26, 05/27/26, 05/28,26, 05/29/26, 05/31/26, and 06/03/26. This failure could place residents at risk of not receiving treatments as ordered which could impact the residents' health and recovery. Findings included:Record review of Resident #61's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female admitted [DATE]. She had a BIMS of 7 which indicated she was severely cognitively impaired, had a urinary catheter, and was dependent for all ADLS. Diagnoses included multiple sclerosis (chronic neurological disorder) and pressure ulcer. Record review of Resident #61's care plan initiated 06/10/25 reflected, The resident has a stage 4 pressure ulcer to the right buttock.Interventions. Administer treatments as ordered and monitor for effectiveness. Record review of Resident #61's latest Wound Care physician assessment and orders dated 05/29/26 reflected, .Wound location: right ischium (buttocks).Pressure injury/ulcer-Wound stage: 4-pressure injury.Signs of infection: None.Wound Progress: Wound has decreased in size.clean wound with NS (normal Saline). Pat dry. Mix collagen powder (used in advanced wound care to manage complex, draining, or hard-to-heal wounds) with a few drops of saline, then apply to open wound. Cover with dry dressing. Change daily and prn.follow up at an interval of 1 week. Record review of Resident #61's Electronic Record reflected no evidence that wound care was provided or declined on 05/05/26, 05/07/26, 05/08/26, 05/12/26, 05/13/26, 05/15/26, 05/19/26, 05/21/26, 05/22/26, 05/25/26, 05/27/26, 05/28,26, 05/29/26, 05/31/26, and 06/03/26. During an interview and observation on 06/02/26 at 9:25 a.m. with Resident #61, she stated she was getting daily wound care and stated she thought her wounds were getting better. Resident #61 was observed to have a low air loss mattress and was offloaded with pillows. During an observation and interview on 06/03/26 at 11:09 a.m. of wound care with the Treatment Nurse revealed staff preparing the wound care supplies. The Treatment Nurse and CNA E performed hand hygiene and put on gowns and gloves and positioned Resident #61 on her left side, revealing a small dressing on her right hip dated 06/02/26. The Treatment Nurse stated the residents wound had made significant progress. He stated she originally had 2 wounds on her right ischium that were over a year old, and they had healed one and the other one was slowing healing. He stated the only other wound the resident had was an abrasion on her right kneecap which they were treating with skin prep. The Treatment Nurse removed the old dressing revealing slight amount of serous drainage, he performed hand hygiene and changed gloves and cleaned the wound with normal saline. He changed gloves and performed hand hygiene and applied collagen powder to the wound bed and covered with a dry dressing. Changed gloves, performed hand hygiene and applied triad paste to area surrounding the wound including the healed wound above the current wound. He changed gloves, performed hand hygiene and rolled resident back onto back, cleaned scabbed area on right kneecap and sprayed with skin prep. During an interview on 06/03/26 at 03:20 p.m. with the Treatment Nurse, he stated all of the missing documentation on the MAR/TAR were the days he provided the wound care treatments. He stated he did the treatments as ordered, but admitted his weakness was making sure he documented it on the MAR/TAR. He stated he knew it was important to document the administration of any treatment, otherwise, he had no proof the wound care had been completed. He stated he had worked very hard on the wound care progress, and he had just failed to complete the documentation. During an interview 06/04/26 at 11:25 a.m. with the DON, she stated it was the expectation that all (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatments were documented at the time the treatment was provided. She stated the record was the only proof they had that care was provided, and it was the means of communications with the staff on what care had been provided or still needed to be provided. Record review of the facility's policy, Wound Treatment Management, dated December 2025, reflected, .Wound treatments will be provided in accordance with physician orders.Treatments will be documented on the Treatment Administration Record. Review of the facility's policy, Documentation in Medical Record, dated December 2025, reflected, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for two of five residents (Resident #58 and Resident #51) reviewed for quality of life. The facility failed to ensure Resident #58 had his nails cut and cleaned. The facility failed to ensure Resident #51's fingernails were trimmed. These failures could place residents, who were dependent on staff for ADL care, at a loss of dignity and a decreased quality of life. Findings include: 1. Record review of Resident #58's Annual MDS assessment, dated 04/21/26, reflected a [AGE] year-old male with an admission date of 05/13/25. Resident #58 had BIMS score of 7 which indicated he was severely cognitively impaired. He required partial to moderate assistance for personal hygiene and had not refused care. He had functional limitation in range of motion both upper and lower extremities on one side. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had not received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills) or restorative nursing services in the 7 days prior to the assessment. Record review of Resident #58's care plan initiated 05/02/26 reflected, The resident had a cerebral vascular accident (CVA/Stroke) .Goal-The resident will be free from sign/symptoms of complications of CVA .contractures.) Interventions- Activity as tolerated. Out of Bed in chair if tolerated. There were no interventions listed for resident's Activity of Daily needs. During an observation and interview on 06/02/26 at 9:20 a.m., Resident # 58 was observed lying in bed. The nails on his right hand had a black/brown substance under all the nails. His left hand was contracted with his thumb pushing down toward his palm. The nails on his left hand were clean, but all of the nail were approximately 1/4 inch in length. Resident #58 stated he was not sure when his nails were last cut. During an observation on 06/03/26 at 12:21 p.m. Resident #58 was observed in his wheelchair in the dining room eating lunch. The nails on his right hand still had black/brown substance under them and had not been trimmed. Resident #58 was observed feeding himself. During an observation and interview on 06/03/26 at 3:00 p.m. with LVN B, Resident #58's fingernails were observed to still have black/brown substance under his nails on his right hand. LVN B stated having dirty nails posed the risk for infections. She stated the nurses were responsible for trimming the diabetic resident's nails, but the CNAs should make sure the nails were clean. She stated they would be cleaned and trimmed today. 2. Review of Resident #51's quarterly MDS dated [DATE] reflected Resident #51 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (progressive, inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure) and diabetes mellitus. Resident #51 had a BIMS score of 15 indicating he was cognitively intact. Resident #51 required partial to moderate assistance with ADLs of personal hygiene. Review of Resident #51's Comprehensive Care plan last revised on 03/12/26 reflected no care plan for ADL assistance. Observation on 06/02/2026 at 9:50 AM with Resident #51 revealed he would like his fingernails trimmed - 1/2 inch long on left hand, 1/2 inch on a couple of fingers on right hand. He stated it had been at least a week not sure how long. He stated podiatrist came out once to see him about 3 months ago. He stated he needed to have his toenails trimmed. An observation and Interview on 06/02/2026 at 12:52 PM, with CNA J revealed Resident #51 stated he would like his fingernails trimmed. CNA J stated she ensured fingernails were cleaned during showers but she did not look at the fingernails to see if the fingernails needed trimming. She could not recall the last time she asked about Resident #51's fingernails trimmed. She stated CNAs were responsible for trimming resident fingernails. CNA J stated nurses were responsible for trimming the nails for resident with diabetes. An interview on 06/04/26 at 9:38 AM with RN C revealed she trimmed fingernails for Resident #51 yesterday after it was brought to her attention by CNA J. She stated charge nurse was responsible for trimming fingernails of diabetic residents, like Resident #51. She (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she did not know the specific policy on how often to check to ensure fingernails were trimmed. She stated she did not know the last time Resident #51's fingernails were trimmed. During an interview with the DON on 06/04/26 at 3:42 p.m., she stated the CNAs should be checking all the residents' nails to ensure they were clean. She stated diabetic residents required the nurse to trim the nails, and the CNAs should be getting the nurse to trim them on the resident's shower days since the nails were softer and easier to trim. The DON stated they should be checking for cleanliness daily to prevent the risk of infections. Review of the facility's policy titled Activities of Daily Living dated 12/01/25 reflected The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices.Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good.grooming, and personal.hygiene.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one of eight residents (Resident #39) reviewed for pharmacy services. The facility failed to ensure RN C followed the manufacturer's instructions to keep the needle in Resident #39's skin for 5 seconds to ensure complete administration of the Humalog insulin on 06/06/26. This failure placed residents at risk of not receiving the full dosage of medication. Findings included: Record review of Resident #39's, Face sheet, dated 06/04/26 reflected a [AGE] year-old female with an admission date of 02/01/22. Resident #39 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) Record review of Resident #39's Physician's Orders for June 2026, reflected, Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: .150- 199 = 2u; 200 - 249 = 4u; 250 - 299 = 6u; 300 - 349= 8u; 350 - 399 = 10u;.subcutaneously before meals and at bedtime. with a start date of 12/08/25. During an observation on 06/02/26 at 11:42 a.m. revealed RN C put on gloves and entered Resident #39's room to obtain the resident's blood sugar readings. RN C checked the resident's continuous glucose monitor which revealed a blood sugar reading of 389. RN C returned to the medication cart, reviewed the orders, and stated Resident #39 would get 10 units of Humalog. She pulled the resident's vial of Humalog (lispro insulin) insulin and a U-100 insulin syringe and drew up 10 units of insulin. RN C then sanitized her hands, put on gloves, and entered Resident #39's room. She cleaned the resident's lower left abdomen and inserted the needled, pushed down the plunger and immediately pulled the needle away from the skin without waiting 5 seconds. During an interview on 06/02/26 at 11:55 a.m. with RN C, she stated she was not aware she had to keep the needle in the resident's skin for 5 seconds. She stated she was aware they had to hold the insulin pen for 5 seconds, but she was not aware it was required with the use of an insulin syringe. She stated going forward she would make sure she was holding the needle against the skin for the required amount of time. During an interview on 06/03/26 at 12:55 p.m. with the DON, she stated she was not aware of the guidelines on the amount of time needed to hold the insulin needle in the skin to ensure the resident received the full dose of insulin. She stated she was aware of the insulin pen requiring 5 seconds, but she was not aware it was required with the syringe and needle. She stated the expectation was to follow the manufacture guidelines and stated she would in-service the staff on the proper procedure. She stated she was not sure if they had a policy on Insulin administration. Review of the manufacturer's instructions for Humalog insulin obtained from https://uspl.lilly.com/humalog/humalog.html#u searched on 06/02/26 reflected, .Supplies needed to give your injectiona multiple-dose HUMALOG viala U-100 insulin syringe and needleStep 3:Remove the Needle Shield from the syringe by pulling the Needle Shield straight off. Hold the syringe with the needle pointing up. Pull down on the Plunger until the Plunger Tip reaches the line for the number of units for your prescribed dose.Step 6:Turn the vial and syringe upside down and slowly pull the Plunger down until the Plunger Tip is a few units past the line for your prescribed dose.Step 7:Slowly push the Plunger up until the Plunger Tip reaches the line for your prescribed dose.Check the syringe to make sure that you have the right dose.Do not inject where the skin has pits, is thickened, or has lumpsDo not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skinStep 10:Insert the needle into your skin.Step 11:Push down on the Plunger to inject your dose.The needle should stay in your skin for at least 5 seconds to make sure you have injected all of your insulin dose.