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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/04/2026
NAME OF PROVIDER OR SUPPLIER Prairie Meadows Rehabilitation and Healthcare Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Eleventh St Floresville, TX 78114	

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure personal privacy for 1 of 6 residents (Resident #8) reviewed for privacy, in that: LVN J provided tracheostomy care for Resident #8 with the resident room door open, curtain separating A and B bed open and window blinds open. This failure could affect residents receiving tracheotomy care by resulting in loss of dignity and low self-esteem. The findings were: Record review of Resident #8's undated face sheet revealed Resident #8 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (complete lack of oxygen to the brain leading to brain damage), dementia (a general term for impaired ability to remember, think, or make decisions) and tracheostomy status (surgical procedure that creates an opening through the neck into the windpipe that helps maintain an airway for a person who has difficulty breathing). Record review of Resident #8's quarterly MDS assessment, dated 09/23/2025, revealed Resident #8 had severely impaired cognitive skills for daily decision making. Section GG - Functional Abilities revealed Resident #8 had impaired upper and lower extremities and was dependent on staff for all ADL's and bed mobility. Section H - Bladder and Bowel revealed Resident #8 had an indwelling catheter. Section K - Swallowing/Nutritional Status revealed Resident #8 had a feeding tube for nutrition. Section O- Special Treatments, Procedures, and Programs, revealed Resident #8 received tracheostomy care and received oxygen therapy and suctioning. Record review of Resident #8's December 2025 treatment and medication administration orders revealed an order, change trach ties every day and prn soiling every shift daily and prn, order date 06/17/2025. During an observation on, 12/31/2025 at 9:37 a.m., LVN J was observed providing tracheostomy care to Resident #8 without closing Resident #8's room door, curtain or blinds to provide Resident #8 privacy and dignity during care. During an interview with LVN J, 12/31/2025 at 9:45 a.m., LVN J stated she had received training on resident privacy, and she should have closed Resident #8's room door and pulled the privacy curtain when LVN J provided tracheostomy care to Resident #8. LVN J stated it was important to provide a resident privacy when care was performed, for their dignity. During an interview with the DON on, 12/31/2025 at 2:40 p.m. the DON said staff members should pull the privacy curtains and close a resident's room door when any resident care was provided including tracheostomy care. The DON stated staff had received training on resident privacy and stated privacy was important, for the resident dignity. Record review of a facility policy titled, Resident Rights (Federal) (Edit 12.19.23; 1.11.24), revealed, Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside facility. Facility must protect and promote the rights of each resident, including each of the following rights: 1. Exercise of rights. E. Resident has the right to be treated with dignity and respect for the personal integrity of the individual.

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 0656 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interview, and record review, the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' mental, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 Residents (Resident #1) reviewed for care plans.The facility failed to develop and implement a care plan that addressed Resident #1's wound on his left buttock identified as a stage 3 pressure ulcer (a bed sore which is an open wound that extends through the skin down into the fatty tissue, appearing as a deep crater but the bone, tendon or muscle are not exposed) by the Wound Care NP A on 11/20/2025 until 12/31/2025, 41 days later; did not address his refusals of skin assessments or wound care in the care plan and incorrectly listed the wound on his right buttock instead of his left. On 12/24/2025 maggots were observed in the stage 3 pressure ulcer, and the wound had increased from 4 cm x 5 cm x 0.2 cm on 12/10/2025 to 6 cm x 3.5 cm x 2 cm on 12/24/2025.An IJ was Identified on 01/02/2026. The template was provided to the facility on [DATE] at 09:13 PM. While the IJ was removed on 01/04/2026 the facility remained out of compliance at a scope of isolation and a severity level of no actual harm that was not immediate due to the to the need for monitoring of corrective measures and the effectiveness of its corrective plan.Findings included: Record review of Resident #1's admission Record (Face sheet) dated 01/02/2026 revealed he was [AGE] years old, admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes (chronic elevated levels of sugar in the blood that can affect organs and delay healing), morbid obesity (excess body weight), and severe protein-calorie malnutrition (inadequate intake of protein resulting in breakdown of tissue and muscle loss). Resident #1 was listed as his own responsible party and his doctor was Physician A. Record review of Resident #1's MDS, a Quarterly Assessment, dated 09/30/2025 revealed his BIMS score was 12 out of 15, he was independent in his decision making; was occasionally incontinent of urine and always incontinent of bowel; was at risk for pressure ulcers and he did not have any unhealed pressure ulcers. Record review of Resident #'1s Care Plan for I have a Stage 3 pressure injury/ulcer Rt [right] buttock r/t [related to] immobility, refusal of care was created and revised on 12/31/2025 by the Corporate Clinical Specialist 41 days after the pressure ulcer was assessed and identified on his left buttock not his right, and had an initiation date of 11/20/2025; and it did not have any interventions for his refusals. Record review of Resident #1's Wound Assessment Report, dated 07/11/2025, completed by Wound Care NP revealed he had a stage 3 pressure ulcer on his left buttock that was present when he was readmitted to the facility on [DATE]. Record review of Resident #1's Wound Assessment Report, dated 09/30/2025, completed by Wound Care NP revealed the stage 3 pressure injury on his left buttock that was present when he was readmitted on [DATE] had resolved. Record review of Resident #1's Weekly Body Skin Check from 10/05/2025 to 10/19/2025 revealed Resident #1 allowed the DON to complete the skin check, and the resident did not have any skin or wound issues. Record review of Resident #1's Weekly Body Skin Check dated 10/26/2025 revealed the CNA reported Resident #1's healed wound on his bottom had reopened. Resident #1 refused to allow the DON to assess the wound and the Wound Care NP was notified. Record review of Resident #1's Weekly Body Skin Check dated 11/03/2025 at 11:48 (11:48 AM) revealed Resident #1 refused to allow the DON to assess the open area identified by the CNA on 10/26/2025, Resident #1 did not want the DON or the charge nurse to look at his skin. Resident #1 reported his skin was healed. The resident's Physician was notified, and the Wound Care NP would attempt to assess his skin. Record review of Resident #1's Weekly Body Skin Check dated 11/03/2025 at (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/03/2025 completed by the DON, revealed Resident #1 did not allow the DON to complete the weekly wound assessment and was noted No I [Resident #1] don't feel like turning. The DON offered additional pain medications and Resident #1 accepted but declined assessment. Record review of Resident #1's Weekly Wound Observation, dated 12/10/2025 completed by the DON, revealed he had stage 3 wound on his left buttock that was acquired in the facility on 11/20/2025, and measured 4 cm length x 5 cm width x 0.2 cm depth; the resident's physician was notified on 11/20/2025; education provided was on-going; and it was checked Resident #1 was mostly non-compliant with recommended interventions for wound healing and skin health. Resident receives re-education and encouragement from staff/family upon refusals but continues to elect to be non-compliant; and slowed wound healing or non-healing of the wound was an expected outcome. Record review of Resident #1's Weekly Wound Observation, dated 12/24/2025 completed by the DON, revealed he had stage 3 wound on his left buttock that was acquired in the facility on 11/20/2025, and measured 6 cm length x 3.5 cm width x 2 cm depth; the resident's physician was notified; educated provided was on-going; and it was checked Resident #1 was mostly non-compliant with recommended interventions for wound healing and skin health. Resident received re-education and encouragement from staff/family upon refusals but continues to elect to be non-compliant; and slowed wound healing or non-healing of the wound was an expected outcome; and the resident frequently declines bed baths and frequently refusing to be changed by staff. Record review of Resident #1's Physician Order Summary Report, dated 01/02/2026, revealed a wound care order for his left buttock, to be cleansed with Dakins 0.25% solution, pat dry, collagen with silver, and cover with silicone bordered superabsorbent dressing daily and as need when loose or soiled everyday shift, with a start date of 11/28/2025. On 12/24/2025, a wound care order with a start date of 12/24/2025 for the left buttock to be cleansed with Dakins 0.25%, pat dry, collagen with silver, and cover with silicone bordered superabsorbent dressing every night shift and as needed was added to augment the treatment Resident #1 received during the day shift. Record review of Resident #1's November 2025 TARs revealed he refused the daily wound care treatment to the stage 3 pressure ulcer on his left buttock on 11/29/2025 and 11/30/2025. Record review of Resident #1's December 2025 TAR revealed he refused the day shift wound care treatment to the stage 3 pressure ulcer on his left buttock on 12/1/2025, 12/2/2025, 12/3/2025, 12/5/2025, 12/6/2025, 12/7/2025, 12/9/2025, 12/10/2025, 12/11/2025, 12/12/2025, 12/14/2025, 12/15/2025, 12/16/2025, 12/17/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025. Resident #1 refused the twice a day wound care treatment to the stage 3 pressure ulcer on his left buttock on day shift on 12/27/2025, 12/28/2025, and 12/29/2025; and on the evening shift on 12/26/2025, 12/29/2025, and 12/30/2025. Record review of Resident #1's Nurses Note, dated 12/24/2025, the ADON noted Resident evaluated due to concerns related to hygiene and skin integrity and personal care needs.Nursing staff have made repeated attempts to provide care using redirection, choice of caregivers and modified approaches. Staff has provided resident with options for choices. Record review of Resident #1's Nurses Note dated 12/24/2025 at 10:34 AM, the DON noted This nurse and ADON went to talk with resident about refusing wound care.Asked resident about wound care and refusing. Resident reported that he didn't know why, just doesn't want to. Explained to resident that wound care was going to be changed to every shift to keep it clean and if resident wanted someone specific that day to do it. Resident explained that he would be okay with that. Reviewed with resident that his pain medication was as needed, and he could ask for a pain medication prior and once the medication took effect the staff could perform wound care and if the pain medication wasn't working that we could ask the doctor for a change in pain medication. Resident verbalized understanding and stated , 'yeah I know'. Record review of Resident #1's Nurses Note, dated 12/24/2025 at 3:04 PM, the DON noted she had (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	informed LVN E the Wound Care NP had been notified about Resident #1's wound concerns but had not received a response back. LVN E reported she reached out to Resident #1's physician, left a message and would reach out to the physician's NP if he did not respond back. LVN E reported she reached out to the Psychiatric NP and was waiting for a response back. Record review of Resident #1's Nurses Note dated 12/24/2025 at 6:38 PM, the DON noted she followed up with LVN E if the nurse was able to reach Resident #1's physician and if any orders were obtained. LVN E reported she called Physician A twice with no response but reached out to Physician A's NP and explained the concern with no new orders received. Record review of Resident #1's Nurses Note dated 12/27/2025 at 5:08 AM, LVN F noted resident refused to be checked and changed through out the whole shift 6pm-6am. Refused wound care and shower. Offered 4x. Record review of Resident #1's Nurses Note dated 12/28/2025 at 3:55 AM, LVN F noted Resident refused to get checked and changed, refuses wound care x3. Will not give a reason why. Record review of Resident #1's Nurses Note dated 12/28/2025 at 4:55 PM, LVN G noted Attempted to provide wound care to resident, refused x2. Resident unwilling to give reason for refusal, vocalized understanding of importance of wound care, peri care and risks associated with delayed care. Resident stopped responding verbally and faced wall. Record review of Resident #1's Nurses Note dated 12/29/2025 at 5:43 AM, LVN F noted Resident refused to be checked and changed throughout the night asked x4. Resident refused wound care, gets upset when we ask and does not answer why he is refusing and turns his face towards the wall. Record review of Resident #1's Nurses Note dated 12/29/2025 at 4:30 PM, the DON noted she followed with the resident refusing wound care during the weekend with the Social Worker present. The DON Explained to resident that eating is important for wound healing. Resident rolled his eyes and verbalized understanding, and he reported will eat when he is hungry. Noted resident does have three cases of soda at bedside and snacks in bedside drawers. Asked resident if there was anything the staff can assist with. Resident rolled his eyes and reported no. Explained to resident that tomorrow was Tuesday and the wound NP would be rounding and if resident wanted to do his bed bath prior to wound care and wanted this nurse present. Resident rolled his eyes and stated we will see. Explained to resident that it was important for the wound NP to see wound. Resident rolled his eyes and stated he knows. Record review of Resident #1's Nurses Note dated 12/29/2025 at 11:27 PM, LVN A noted Resident refused wound care treatment this evening. Resident also refused bed bath and refused to allow staff to provide him with personal care or personal hygiene care. Resident was educated on the risk associated with lack of proper peri care and wound care. Resident became extremely agitated and stated, ‘I am fine, leave me alone'. Nurse attempted to ask again just for reassurance and clarity, and resident raised his voice and closed his eyes and would no longer communicate with nurse. Record review of Resident #1's Nurses Note dated 12/30/2025 at 3:13 PM, the DON noted she had notified Physician A's NP to inform them Resident #1 was refusing wound care, bed baths, and not wanting to eat. Explained that the dietitian was present in the facility and visiting with the resident. Explained that the Psychiatric NP visited with Resident #1 and would follow up later in the week. Record review of Resident #1's Nurses Note dated 12/31/2025 at 12:29 AM, LVN H noted the resident refused care and wound care, was educated on importance of clean and dry skin but continued to decline any care. Resident was offered choice of staff to provide care and he continued to decline care from all staff and wound care. Record review of Resident #1's Nurses Note dated 12/31/2025, the DON noted she and the ADON went to speak to the resident about wound care. The DON offered to perform wound care with assistance but Resident #1 refused. When the DON asked what barriers he had to wound care, Resident #1 stated that he did not want to talk about it. The DON offered pain medication to the resident so wound care could be performed and the resident declined to have wound care (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she had just walked into the facility when she was asked to speak to Resident #1 about trying to convince him to be showered or given a bed bath. Resident #1 had a very large bowel movement and had been refusing care days prior. LVN A asked him if they could provide care and Resident #1 said no, but agreed to a bed bath after conversing with him. LVN A said when Resident #1 was turned to the side and was wiped, she saw bugs (maggots). In a telephone interview on 01/01/2026 at 1:00 PM, the Wound Care NP stated Resident #1 used to agree to let her see his skin weekly and would only refuse once out of every 30 times, but now he refuses care every time which the facility would notify her about. The Wound Care NP stated she was notified about the maggots found in the wound. The Wound Care NP stated she tried to see Resident #1's wound after the maggots were found on her next visit, but Resident #1 refused, so she continued with the order that was previously in place because she couldn't change the order without seeing the wound first to assess what treatment would be appropriate. The Wound Care NP stated the last time Resident #1 allowed her to see his wound was on 11/20/2025. In a telephone interview on 01/02/2026 at 1:15 PM, Resident #1's Physician A stated he had been the resident's physician for several months, he was notified of the resident's refusal of care. Physician A stated he had even tried to bribe Resident #1 to get staff to bathe/shower him but it didn't work Physician A stated he was notified of the bugs in Resident #1's wound, he recommended wound care services and for the room to be fumigated. In an interview on 01/01/2026 at 6:31 PM, the DON stated it was brought to her attention Resident #1 had maggots in his wound when he was given a bed bath on 12/24/2025. In an interview on 01/01/2026 at 5:15 PM, the Administrator stated she came into the facility 12/24/2025, was informed Resident #1 had been refusing for days to let staff provide incontinent care or wound care and when they changed him that day, they found insects on him. The Administrator stated Resident #1's Physician A was notified along with Physician A's NP and the Wound Care NP. In an interview on 01/02/2026 from 5:43 PM to 6:24 PM the DON said Resident #1's care plan for the stage 3 pressure ulcer was revised on 01/01/2026 and she did not know why it was not created after his wound reopened. The DON stated residents' care plans were revised when there were changes to a resident's care. In an interview on 01/03/2026 from 4:00 PM to 4:25 PM, the Administrator said the harm that could result in a resident's care plan not being revised in a timely manner was that the other staff would not know what to implement for the resident. In an interview on 01/03/2026 from 5:31 PM to 5:36 PM, the DON stated the harm that could happen from a resident's care plan not being revised or reviewed in a timely manner was the resident might not get the care that was in their plan. In an interview on 01/03/2026 from 5:46 PM to 5:57 PM, the MDS Nurse stated resident's care plans were reviewed quarterly unless there is a change in the resident. The MDS Nurse said Resident #1's care plan for the stage 3 pressure ulcer on his left buttock was revised on 12/31/2025 and the resident had a history of refusing showers, incontinent care and wound care. The MDS Nurse stated the care plan was where staff could see what should be done for a resident and if their care was not updated on the care plan, they might miss an action in providing care to the resident. In an interview on 01/04/2026 at 11:36 AM, the Corporate Clinical Specialist stated Resident #1's care plan for the stage 3 pressure ulcer was created and revised on 12/31/2025 and the initiation date of 11/20/2025 was chosen because that was when the wound was staged. Record review of the facility's policy Care Plans, Comprehensive Person-Centered, reviewed 06/02/2025 revealed A comprehensive, person-centered care plan that incudes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.13. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Meadows Rehabilitation and Healthcare Cent	1615 Eleventh St Floresville, TX 78114

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. An IJ was identified on 01/02/2026. The template was provided to the Administrator on 01/02/2026 at 9:13 PM. The following Plan of Removal submitted by the facility was accepted on 01/03/2026 at 2:45 PM and indicated the following: Plan of Removal 1/2/2026F656Immediate ActionsUpon identification of the deficient practice, Resident #l's care plan was immediately updated to address:Refusal of skin assessmentsRefusal of wound treatmentAssociated risks related to pressure injury deterioration and infectionThe updated care plan includes person-centered, measurable interventions addressing refusal management, education, monitoring, and escalation.Nursing leadership reviewed the updated care plan with staff to ensure awareness and implementation. Systemic ChangesThe DON or designee conducted in-service education for licensed nurses on 01/02/2026 on the following:l)Requirements for person-centered care planning under F656Incorporating care refusals into care plans when refusals impact medical or nursing needsEnsuring care plans include measurable objectives, timeframes, and specific interventionsThe DON or designee conducted in-service education on 01/02/2026 for licensed nurses and CNAs on:l)Proper management and documentation of refusal of skin assessments and wound treatmentRequired escalation and notification when refusals place a resident at riskBalancing resident rights with professional standards of care and safetyOn 01/02/2026 a care plan review process was reinforced requiring care plans to be updated when:Refusals of treatment or assessment are ongoingA resident's clinical condition changesIdentified risks increase due to refusal behavior No staff will be able to work until education and competency is completed.All education will be incorporated into new hire on-boarding by Administrator on01/02/2026.Process When a Refusal Occurs: When a resident refuses an assessment or treatment, the refusal is immediately communicated through the chain of care:CNAs notify the licensed nurse caring for the resident.The licensed nurse (RN/LVN) assesses the situation, provides education to the resident regarding risks of refusal, documents the refusal, and notifies the charge nurse and DON or designee when refusals involve assessment, wound care, or other high-risk treatments.The physician is notified when refusals impact the ability to assess or treat a condition requiring medical oversight. Responsibility for Updating the Care Plan: The licensed nurse, in collaboration with the interdisciplinary team, is responsible for initiating updates to the care plan when refusals are ongoing or impact medical, nursing, or psychosocial needs. The DON or designee provides oversight to ensure updates are completed timely and implemented. Continuity of the Process: Yes. This is a continuous process. Care plans are updated as long as refusals persist or risks remain, and are revised based on changes in the resident's condition, response, or acceptance of care. Monitoring of Updates: The DON or designee monitors care plan updates through routine audits and clinical oversight, including review of documentation related to refusals, care plan accuracy, and staff implementation. Staff Training on Refusals: Education on refusal of care has been provided to all direct care staff, including licensed nurses and CNAs. Training addresses identification of refusals, required reporting, documentation, escalation, and implementation of person*centered interventions.Monitoring and QA:The DON or designee will conduct weekly audits for four (4) weeks, then monthly thereafter, of:1} Residents with pressure injuries2} Residents with documented refusals of careAudits will verify:Refusals are reflected in the care planCare plans include measurable objectives and interventionsStaff are implementing care plan interventions as writtenAudit results will be reviewed through the QAPI process, and corrective actions will be implemented as indicated. The facility's Plan of Removal verification was as follows: Record review of Resident #1's care plans revealed a new care plan, created on 01/01/2026 for Noncompliance with plan of care r/t [related to] skin integrity due to refusal of splints or devices for contracture management, refusal (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to allow staff to turn and reposition frequently, refusal to all use of offloading devices such as cushions, pillows, mattress, boots, refusal to change clothing, refusal to elevate legs, refusal to receive incontinent care timely or at all, refusal to shower or bathe, resident refusing meals/alternates, resident refusing prescribed treatment regimen, resident refusing weekly wound assessments , staying in bed for extended periods of time/refusing position changes, weekly skin checks: resident refusing weekly skin checks, was initiated on 01/01/2026 by the DON. Interventions listed included: Actively listen to the resident's reasons for refusing care and address any anxiety or fears they might have about the process. Determine if pain is a factor of resident refusal and notify MD as appropriate. Discuss with resident what they would be willing to allow and notify physician. Encourage resident compliance. Ensure resident understands their specific plan of care. Educate on why certain supplies are used and why techniques are important to prevent infection. Explore pain management strategies to minimize discomfort during wound care/dressing changes to potentially improve the resident's willingness to cooperate. If resident refuses treatment, offer to come back at a later time in the day. Involve other healthcare professionals, family members, care givers to support the resident's understanding and compliance. Notify MD of any identified wound worsening or development of any new wounds. Refer to dietitian to ensure resident is receiving appropriate nutrition to help promote healthy skin as needed. Refer to Wound Care Physician as applicable/needed. See also actual wound care plans. Supplements as ordered to promote healthy skin and aid in wound healing. Record review of Resident #1's Social Service note, dated 01/01/2026, revealed the Social Worker, DON, Activity Director and Dietary Manager meet with the resident to discuss care in an IDT meeting. The resident's care plan was reviewed with the resident. Record review of an unda

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure that a resident received care, consistent with professional stands of practice, to prevent pressure ulcers for 1 of 3 residents (Resident #95) reviewed for Pressure Ulcers. The facility failed to implement the Wound Care NP recommendations for 8 days when Resident #1 was identified with a stage 3 pressure injury to the left buttock from 11/20/2025 to 11/28/2025. Resident #1 refused wound care 22 times from 11/28/2025 to 12/24/2025, and refused further assessment of the wound from the Wound Care NP. On 12/24/2025, Resident #1 had maggots in his wound and the wound had increased in size from 4 cm x 5 cm x 0.2 cm on 12/10/2025 to 6 cm x 3.5 cm x 2 cm on 12/24/2025. An IJ situation was identified on 01/02/2026. The IJ template was provided to the facility on [DATE] at 09:13 PM. While the IJ was removed on 01/04/2026, the facility remained out of compliance at a scope of isolation and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to the need for monitoring of corrective measures and the effectiveness of its corrective plan. Findings Included: Record review of Resident #1's admission Record (Face sheet) dated 01/02/2026 revealed he was [AGE] years old, admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes (chronic elevated levels of sugar in the blood that can affect organs and delay healing), morbid obesity (excess body weight), and severe protein-calorie malnutrition (inadequate intake of protein resulting in breakdown of tissue and muscle loss). Resident #1 was listed as his own responsible party and his doctor was Physician A. Record review of Resident #1's MDS, a Quarterly Assessment, dated 09/30/2025 revealed his BIMS score was 12 out of 15, he was independent in his decision making; was occasionally incontinent of urine and always incontinent of bowel; was at risk for pressure ulcers and he did not have any unhealed pressure ulcers. Record review of Resident #'1s Care Plan for I have a Stage 3 pressure injury/ulcer Rt [right] buttock r/t [related to] immobility, refusal of care was created and revised on 12/31/2025 by the Corporate Clinical Specialist 41 days after the pressure ulcer was assessed and identified on his left buttock not his right, and had an initiation date of 11/20/2025; and it did not have any interventions for his refusals. Record review of Resident #1's Wound Assessment Report, dated 07/11/2025, completed by Wound Care NP revealed he had a stage 3 pressure ulcer on his left buttock that was present when he was readmitted to the facility on [DATE]. Record review of Resident #1's Wound Assessment Report, dated 09/30/2025, completed by Wound Care NP revealed the stage 3 pressure injury on his left buttock present when he was readmitted on [DATE] had resolved. Record review of Resident #1's Weekly Body Skin Check from 10/05/2025 to 10/19/2025 revealed Resident #1 allowed the DON to complete the skin check, and the resident did not have any skin or wound issues. Record review of Resident #1's Weekly Body Skin Check dated 10/26/2025 revealed the CNA reported Resident #1's healed wound on his bottom had reopened. Resident #1 refused to allow the DON to assess the wound and the Wound Care NP was notified. Record review of Resident #1's Weekly Body Skin Check dated 11/03/2025 at 11:48 (11:48 AM) revealed Resident #1 refused to allow the DON to assess the open area identified by the CNA on 10/26/2025, Resident #1 did not want the DON or the charge nurse to look at his skin. Resident #1 reported his skin was healed. The resident's Physician was notified, and the Wound Care NP would attempt to assess his skin. Record review of Resident #1's Weekly Body Skin Check dated 11/03/2025 at 14:50 (2:50 PM) revealed Resident #1 refused to allow the DON to assess the open area identified by the CNA on 10/26/2025, Resident #1 reported his previous wound had healed, he was fine, the Wound Care NP tried twice last week to assess the wound and would try this week. Record review of Resident #1's Weekly Body Skin Check dated 11/04/2025 revealed Resident #1 refused to allow the nurse (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to assess the open area identified by the CNA on 10/26/2025, Resident #1 reported his previous wound had healed, he was fine, the Wound Care NP attempted today, and Resident #1 declined her visit. Record review of Resident #1's Weekly Body Skin Check dated 11/16/2025 revealed Resident #1 refused to allow the nurse and the Wound Care NP to assess the open area identified by the CNA on 10/26/2025. Record review of Resident #1's Weekly Body Skin Check dated 11/18/2025 at 14:50 (2:50 PM) revealed Resident #1 refused to allow the nurse to assess the open area identified by the CNA on 10/26/2025, Resident #1 reported his previous wound had healed, he was fine, the Wound Care NP attempted today, Resident #1 declined her visit. Record review of Resident #1's skin and wound progress note dated 10/28/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the open area identified by the CNA on 10/26/2025 because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 10/30/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the open area identified by the CNA on 10/26/2025 because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 11/04/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the open area identified by the CNA on 10/26/2025 because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 11/11/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the open area identified by the CNA on 10/26/2025 because the resident refused care today. Record review of Resident #1's Wound Assessment Report dated 11/20/2025 by Wound Care NP revealed the healed pressure ulcer on his left buttock reopened, was a stage 3 pressure ulcer that measured 4 cm length x 5 cm width x 0.2 cm depth and was to be cleansed with 0.25% Dakins solution, apply collagen with silver, and cover with a silicone bordered superabsorb dressing. Record review of Resident #1's skin and wound progress note dated 11/25/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the stage 3 pressure ulcer on his left buttock because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 12/02/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the stage 3 pressure ulcer on his left buttock because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 12/09/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the stage 3 pressure ulcer on his left buttock because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 12/16/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the stage 3 pressure ulcer on his left buttock because the resident refused care today. Record review of Resident #1's skin and wound progress note dated 12/31/2025 by Wound Care NP revealed Resident #1 was unable to be evaluated by the Wound Care NP to assess the stage 3 pressure ulcer on his left buttock because the resident refused care today. Record review of Resident #1's Weekly Wound Observation, dated 11/21/2025 completed by the DON, revealed he had stage 3 wound on his left buttock was acquired in the facility on 11/20/2025, and measured 4 cm length x 5 cm width x 0.2 cm depth. The resident's physician was notified on 11/20/2025, the resident was educated on the importance of incontinent care, importance of hygiene, importance of off-loading; and it was checked the resident's care plan was updated. Record review of Resident #1's Weekly Wound Observation, dated 12/03/2025 completed by the DON, revealed Resident #1 did not allow the DON to complete the weekly wound assessment and was noted No I [Resident #1] don't feel like turning. The DON offered additional pain medications and Resident #1 accepted but declined assessment. Record review of Resident #1's Weekly Wound Observation, dated 12/10/2025 completed by the DON, revealed he had stage 3 wound on (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	his left buttock that was acquired in the facility on 11/20/2025, and measured 4 cm length x 5 cm width x 0.2 cm depth; the resident's physician was notified on 11/20/2025; education provided was on-going; and it was checked Resident #1 was mostly non-compliant with recommended interventions for wound healing and skin health. Resident receives re-education and encouragement from staff/family upon refusals but continues to elect to be non-compliant; and slowed wound healing or non-healing of the wound was an expected outcome. Record review of Resident #1's Weekly Wound Observation, dated 12/24/2025 completed by the DON, revealed he had stage 3 wound on his left buttock that was acquired in the facility on 11/20/2025, and measured 6 cm length x 3.5 cm width x 2 cm depth; the resident's physician was notified; educated provided was on-going; and it was checked Resident #1 was mostly non-compliant with recommended interventions for wound healing and skin health. Resident received re-education and encouragement from staff/family upon refusals but continues to elect to be non-compliant; and slowed wound healing or non-healing of the wound was an expected outcome; and the resident frequently declines bed baths and frequently refusing to be changed by staff. Record review of Resident #1's Physician Order Summary Report, dated 01/02/2026, revealed a wound care order, with a start date of 11/28/2025, for his left buttock, to be cleansed with Dakins 0.25% solution, pat dry, collagen with silver, and cover with silicone bordered superabsorbent dressing daily and as need when loose or soiled everyday shift. Record review of Resident #1's November 2025 TARs revealed he refused the daily wound care treatment to the stage 3 pressure ulcer on his left buttock on 11/29/2025 and 11/30/2025. Record review of Resident #1's December 2025 TAR revealed he refused the day shift wound care treatment to the stage 3 pressure ulcer on his left buttock on 12/01/2025, 12/02/2025, 12/03/2025, 12/05/2025, 12/06/2025, 12/07/2025, 12/09/2025, 12/10/2025, 12/11/2025, 12/12/2025, 12/14/2025, 12/15/2025, 12/16/2025, 12/17/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025. Record review of Resident #1's Nurses Note, dated 12/24/2025, the ADON noted Resident evaluated due to concerns related to hygiene and skin integrity and personal care needs.Nursing staff have made repeated attempts to provide care using redirection, choice of caregivers and modified approaches. Staff has provided resident with options for choices. Record review of Resident #1's Nurses Note dated 12/24/2025 at 10:34 AM, the DON noted This nurse and ADON went to talk with resident about refusing wound care.Asked resident about wound care and refusing. Resident reported that he didn't know why, just doesn't want to. Explained to resident that wound care was going to be changed to every shift to keep it clean and if resident wanted someone specific that day to do it. Resident explained that he would be okay with that. Reviewed with resident that his pain medication was as needed, and he could ask for a pain medication prior and once the medication took effect the staff could perform wound care and if the pain medication wasn't working that we could ask the doctor for a change in pain medication. Resident verbalized understanding and stated, ‘yeah I know'. Record review of Resident #1's Nurses Note, dated 12/24/2025 at 3:04 PM, the DON noted she had informed LVN E the Wound Care NP had been notified about Resident #1's wound concerns but had not received a response back. LVN E reported she reached out to Resident #1's physician, left a message and would reach out to the physician's NP if he did not respond back. LVN E reported she reached out to the Psychiatric NP and was waiting for a response back. Record review of Resident #1's Nurses Note dated 12/24/2025 at 6:38 PM, the DON noted she followed up with LVN E if the nurse was able to reach Resident #1's physician and if any orders were obtained. LVN E reported she called Physician A twice with no response but reached out to Physician A's NP and explained the concern with no new orders received. Observation and interview on 12/31/2025 at 2:25 PM, Resident #1 was lying in bed on his back with the foot of his bed by the window and the bed linen was clean. A dead fly was observed on the window ledge. The surveyor asked (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 if he was aware of any bugs in his bed or wounds, he responded oh yeah, that happened but it was my fault. When asked further probing questions, Resident #1 stated he didn't want to talk about it. In an interview on 12/31/2025 at 1:50 PM, CNA I stated he took care of Resident #1 on 12/24/2025. He asked Resident #1 at the start of the shift if the CNA could provide incontinent care and the resident said no, so the CNA told LVN E who said to try again later. The CNA said later Resident #1 turned on his call light and wanted the charge nurse; the CNA informed LVN E who said she would talk to Resident #1. CNA I stated sometime after breakfast but before lunch, LVN E told him Resident #1 needed to be cleaned up because the resident was very dirty. CNA I said other CNAs assisted with providing a bed bath to Resident #1. CNA I said he saw maggots in the bed and around the upper part of Resident #1's leg. In a further interview on 01/04/2026 at 10:17 AM, CNA I stated if Resident #1 refused care, he would tell the nurse; then 10 to 15 minutes later he would ask the resident again to see if the resident was receptive to care and if the resident continued to refuse, he would inform the nurse again. In a telephone interview on 01/01/2026 at 11:58 AM, CNA B reported on 12/24/2025 she was called to Resident #1's room to assist with providing the resident with a bed bath because he refused to be showered. CNA B stated when she had pulled back the bedding, she saw maggots in Resident #1's groin area. The CNA stated she and the other CNAs who were in the room had explained to Resident #1 that day that this was why he needed to let the CNAs change him. CNA B stated she would ask Resident #1 if he needed to be changed and he would tell the CNA to leave him alone or he would state he was fine. In a further interview on 01/02/2026 at 2:42 PM, CNA B stated when Resident #1 would refuse incontinent care or a shower, she would try to pursued the resident several times to let her provide care, and if he continued to refuse, she would inform the nurse. In an interview on 01/01/2026 at 1:55 PM, CNA C stated when she was assisting with providing Resident #1 a bed bath on 12/24/2025, she saw maggots on the resident and in his feces. In an interview on 01/02/2026 at 2:48 PM, LVN E stated on 12/24/2025 Resident #1 called her into his room around 9:30 AM to talk to her. The resident requested her to wash his hand which she did, then he pointed down to his incontinent brief and asked her to look at something. When she did, LVN E said she saw the resident had stool (feces) in his brief and there appeared to be maggots in the fecal material. LVN A came into the room, they explained to the resident the situation needed to be taken care of. Resident #1 wanted to be cleaned up later in the evening. LVN E said she gave Resident #1 options of taking a pain pill, waiting 30 minutes, then letting staff provide a bed bath but the resident agreed to have the bed bath done first, then the nurse could administer the pain medication. LVN E stated when the CNAs have informed her Resident #1 refused care, she would talk with the resident. Sometimes when she does this, he will become upset and ask to be left alone. Other times he would say maybe later, then when she goes back he would say the same thing and would keep putting off the In an interview on 01/01/2026 at 6:13 PM, LVN A stated on 12/24/2025 she had just walked into the facility when she was asked to speak to Resident #1 about trying to convince him to be showered or given a bed bath. Resident #1 had a very large bowel movement and had been refusing care days prior. LVN A asked him if they could provide care and Resident #1 said no, but then agreed to a bed bath after conversing with him. LVN A said when Resident #1 was turned to the side and was wiped, she saw bugs (maggots). In a telephone interview on 01/01/2026 at 1:00 PM, the Wound Care NP stated Resident #1 used to let her see his skin weekly and would only refuse once out of every 30 times, but now he refuses care every time. The Wound Care NP stated she was notified about the maggots found in the wound, she tried to see Resident #1's wound after the maggots were found on her next visit, but Resident #1 refused to let her see his wound. So, she continued with the order that was previously in place because she couldn't change the order (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	without seeing the wound first to assess what treatment would be appropriate. The Wound Care NP stated the last time Resident #1 allowed her to see his wound was on 11/20/2025. In a further telephone interview on 01/02/2026 at 3:58 PM, the Wound Care NP stated when she assessed Resident #1's wound on 11/20/2025 she had recommended the wound order of cleaning the wound with Dakins solution, applying collagen silver, and covering with superabsorbent dressing. The Wound Care NP stated she does not put orders into the resident's electronic clinical record, they were provided to the DON, who contacts Resident #1's Physician A who reviews the order and the DON would let her know if the physician agreed or disagreed with her recommendations. The Wound Care NP stated the facility did not share with her the wound care order she recommended was not started until 11/28/2025, and stated the delay might have been waiting on Physician A's approval and she did not think it would have made a difference in the condition of Resident #1's wound due to his refusal history. The Wound Care NP said Resident #1's wound on his left buttock was completely unavoidable because he would refuse to receive incontinent care and would refuse to be repositioned. In a telephone interview on 01/02/2026 at 1:15 PM, Resident #1's Physician A stated he had been the resident's physician for several months and was notified of the resident's refusal of care. Physician A stated he had even tried to bribe Resident #1 to get staff to bathe/shower him but that didn't work. Physician A stated he was notified of the bugs in Resident #1's wound, he recommended wound care services and for the room to be fumigated. In an interview on 01/01/2026 at 6:31 PM, the DON stated it was brought to her attention Resident #1 had maggots in his wound when he was given a bed bath on 12/24/2025. In an interview on 01/01/2026 at 5:15 PM, the Administrator stated she came into the facility 12/24/2025, was informed Resident #1 had been refusing for days to let staff provide incontinent care or wound care and when they changed him that day, they found insects on him. The Administrator stated Resident #1's Physician A was notified along with Physician A's NP and informed the Wound Care NP. In a further interview on 01/02/2026 from 5:43 PM to 6:24 PM, the DON did not give a reason why the wound order recommendation from the Wound Care Practitioner provided to the DON on 11/20/2025 was not started until 11/28/2025, and stated she would have to look into it and did not provide an explanation for the delay before the surveyor exited the facility on 01/04/2026. Record review of the facility's policy Pressure Injury Prevention Program, revised 06/27/2025 revealed All residents will be assessed for the risk of pressure injury development at the time of admission, on a quarterly basis, and up on significant change in condition thereafter. Each resident will also receive a weekly skin check to identify new areas of concern or the development of new pressure injuries to ensure a timely adjustment to the resident's change in condition/risk level. Based on the result of these assessments, specific interventions will be implemented to prevent the development of avoidable pressure injuries, or, to treat new existing pressure injuries. An IJ was identified on 01/02/2026. The template was provided to the Administrator on 01/02/2026 at 9:13 PM. The following Plan of Removal submitted by the facility was accepted on 01/03/2026 at 2:45 PM and indicated the following: Plan of Removal 1/2/2026F686 Immediate Actions:-On 12/24/2025, Resident #1 received immediate wound assessment and cleansing following identification of maggots. Appropriate wound care interventions were performed.-The attending physician was notified immediately, and wound care orders were reviewed and confirmed.-Nursing leadership and the wound care provider reassessed the resident's condition and treatment needs.-The Corporate Clinical Nurse conducted an immediate in-service with the Director of Nursing (DON) on January 2, 2026, addressing:1. Expectations for timely submission and tracking of wound care recommendations requiring physician approval.2. Leadership accountability for ensuring physician orders are obtained and implemented without delay.3. Required escalation when wounds cannot be assessed or treated due to resident refusal, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	including physician notification, IDT involvement, and documentation of education regarding risks of refusal. Systemic Changes: On 01/02/1026 DON/Designee completed a facility-wide audit of all residents with active wounds to confirm: Timely wound identification, Timely physician notification, No delays between wound care recommendations and physician orders. On 01/02/2026 a standardized physician order tracking process was implemented requiring nursing leadership to monitor pending wound care recommendations and escalate unresolved orders. The DON or designee conducted in-service education on 01/02/2026 for licensed nurses and CNAs on: Proper management and documentation of refusal of skin assessments and wound treatment; Required escalation and notification when refusals place a resident at risk; Balancing resident rights with professional standards of care and safety. No staff will be able to work until education and competency is completed. All education will be incorporated into new hire on-boarding by Administrator on 01/02/2026.Physician NotificationThe licensed nurse {RN/LVN) caring for the resident is responsible for notifying the physician of any change in condition, inability to complete wound assessment or treatment due to refusal, or identified need for new or revised orders. The Director of Nursing (DON) or designee provides oversight to ensure notification occurs timely and is documented appropriately.Systemic Changes - Physician Order Tracking:Responsible Party for Monitoring: The Director of Nursing or designee is responsible for monitoring physician order tracking related to wound care recommendations and approvals.Frequency of Monitoring: Physician order tracking is reviewed daily for any pending wound care recommendations until orders are received and implemented.Duration of Practice: This process is an ongoing practice and has been incorporated into routine nursing leadership oversight. It was not limited to this incident and will continue as part of standard clinical operations. Monitoring and QA: The DON or designee will conduct weekly wound care and physician order audits for four (4) weeks, then monthly thereafter. Audits will include review of: Timeliness of wound assessments and treatment initiation; Documentation of refusals and escalation; Care plan updates related to wounds and refusals. Audit findings will be reviewed through the QAPI process, with corrective actions implemented as indicated. Verification of the facility's POR was as follows:Record review of Resident #1's Weekly Wound Observation form, dated 12/24/25, revealed the wound on his left buttock was acquired on 11/20/25, was a stage 3 Pressure Injury and measured 6.0 cm x 3.5 cm x 2.0 cm, there was no odor to the wound and did not show any signs of a wound infection. Record review of Resident #1's physician orders revealed his physician ordered on 12/24/2025 wound care to left buttock; cleanse with Dakins 0.25%, pat dry, collagen with silver, and cover with silicon bordered superabsorbent dressing every night shift and when loose or soiled. Record review of Resident #1's nurse's notes dated 12/24/25 revealed the resident's wound was assessed by the DON. Record review of the in-service education provided to the DON on 1/2/26 by the Corporate Clinical Specialist revealed the exception of the DON was for timely submission and tracking of wound care recommendations requiring physician approval, leadership accountability for ensuring physician orders are obtained and implemented without delay, required escalation when wounds cannot be assessed or treated due to resident refusal, including physician notification, IDT involvement, and documentation of education regarding risk of refusal. Record review of an undated employee list revealed there were 31 CNAs, 9 LVNs, and 6 RNs for a total of 46 nursing staff. Record review of the in-service signature page, dated 1/2/26, for the in-service on Management of Pressure Injuries, Care Refusals, and Escalation revealed 46 nursing staff (CNAs, LVNS, RNs) had received the training. The training covered how to respond when a resident refuses a personal care, skin assessment or wound care, when refusals required escalation to leadership and the physician, and documentation expectations. The training covered the resident had a right to refuse care but staff still had a duty to educate the (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident on the risks of refusal, offer care again at appropriate intervals, escalate refusals that place a resident at risk, and document thoroughly. The training specified when refusals become high risk when they involve a wound assessment, wound treatment, signs of infection, deterioration or re-opening of a pressure injury, and repeated refusals over time. The required escalation process for CNA was to report immediately to the nurse, document refusal per facility process, and continue to offer care respectfully. The required escalation process for the nurse was to attempt assessment and/or treatment, educate resident on risk of refusal, notify the nurse manager or DON, the physician and ensure the care plan reflects refusals and risks. The training specified the documentation expectations which included what care was offered, exact nature of refusal, education provided to the resident, resident response, notifications made and follow-up actions planned. The nursing staff was given a quiz as part of the training. Record review of the quiz given to the CNAs on 1/3/26 on Management of Pressure Injuries, Care Refusals, and Escalation revealed 31 CNAs had taken the quiz in person or over the phone and all CNAs scored 100%. Review of the quiz given to the nurses on 1/3/26 on Management of Pressure Injuries, Care Refusals, and Escalation revealed 16 nurses had taken the quiz in person or over the phone and all nurses scored 100%. Record review of the Facility Wide Audit of residents with active wounds, dated 1/2/26, revealed 8 residents had wounds and all had been audited for notification of the physician, if there were delays between wound care recommendations and physician orders, when they were last seen by a specialist and if their orders had been updated by their primary care physician. Record review of the Monitoring Log revealed residents with wounds would be monitored for wound care recommendations that were not approved and implemented within 24-hours would be escalated and the log would be reviewed daily. Record review of the undated Monitoring Log for F686, had handwritten on 1/3/26 was no pend [pending] wound orders and was initialed by the DON. Interviews on 1/4/26 from 9:24 AM to 12:32 PM with 9 nursing staff (6 CNAs, 2 LVNs, 1 RN) which included 2 night shift nursing staff (1 CNA and 1 LVN) revealed they had been in-serviced on what to do when a resident refuses care which included approaching the resident several times, asking the resident if they would let another caregiver perform the care, notifying the nurse/physician immediately, documenting the refusal in the Point of Care system or the resident's clinical record, notification to the DON and Administrator of the resident's refusal and ensuring the care plan was updated. In an interview on 1/4/26 from 3:30 PM to 3:45 PM, the DON stated she assessed Resident #1's wound on 12/24/25, his physician was contacted who gave orders for wound care, the Wound NP was notified. The DON stated she was in-serviced by the Corporate Clinical Specialist on residents' refusal of wound care, timeliness of completing wound assessments and updating resident's care plans. The DON stated she would conduct weekly rounds on residents with wounds, would review their orders, review the timeliness of the wound assessment, review if the resident was allowing treatment to be provided and if not if it was documented and the care plan reflected the resident's refusal. The DON stated she would review physician orders daily for new wound care orders. The DON said the nurses and CNAs were in-serviced on what to do when a resident refused wound care, to make sure the care plan was updated to reflect the resident's refusal, to notify the physician the resident was refusing care, informing the DON/Administrator of the refusal of care, and documentation of residents refusal, education provided and the resident's response. The DON stated she would be monitoring the physician orders daily along with resident refusals documented on the MARS/TARS. In an interview on 1/4/26 from 4:00 PM to 4:25 PM, the Administrator stated Resident #'1 physician was notified of the issue on 12/24/25, the wound was assessed by the DON and the resident's orders were updated. The Administrator said when the Wound Care NP makes recommendations a copy of the recommendations would be given to the Administrator (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and DON to ensure the physician acted on the recommendation and if not why so the Wound NP could be notified of the physician's rationality. The Administrator stated if a physician continues to not implement the recommendations from the Wound Care NP, then she would have the Medical Director speak with the physician. The Administrator stated the DON would monitor the resident's wound treatments, if the resident was refusing the wound treatment, it the wound care orders were current, and if the refusal of treatment was documented along with the education provided to the resident. The audit would be done weekly for 4 weeks, then monthly until it was no longer needed. On 01/04/2026 at 7:05 PM, the Administrator was notified the IJ was removed on 01/04/2026 at 6:29 PM. However, the facility remained out of compliance at a scope of isolated and severity of no actual harm with a potential for more than minimal harm due to the facility's need to monitor the implementation and effectiveness of its POR.

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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 on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #8) reviewed for infection control in that: LVN J did not wear a gown when providing direct care to Resident #8 who had a tracheotomy and was on enhanced barrier precautions (EBP). This failure could affect residents on enhanced barrier precautions and place them at risk for infection. The findings were: Record review of Resident #8's undated face sheet revealed Resident #8 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (complete lack of oxygen to the brain leading to brain damage), dementia (a general term for impaired ability to remember, think, or make decisions) and tracheostomy status (surgical procedure that creates an opening through the neck into the windpipe that helps maintain an airway for a person who has difficulty breathing). Record review of Resident #8's quarterly MDS assessment, dated 09/23/2025, revealed Resident #8 had severely impaired cognitive skills for daily decision making. Section GG - Functional Abilities revealed Resident #8 had impaired upper and lower extremities and was dependent on staff for all ADL's and bed mobility. Section H - Bladder and Bowel revealed Resident #8 had an indwelling catheter. Section K - Swallowing/Nutritional Status revealed Resident #8 had a feeding tube for nutrition. Section O- Special Treatments, Procedures, and Programs, revealed Resident #8 received tracheostomy care and received oxygen therapy and suctioning. Record review of Resident #8's December 2025 treatment and medication administration orders revealed an order, enhanced barrier precautions (EBP) every shift, order date 06/18/2025. Resident #8 had an order, change trach ties every day and prn soiling every shift daily and prn, order date 06/17/2025. Record review of Resident #8's undated comprehensive care plan revealed a care plan, [Resident] has a tracheostomy, date initiated 03/03/2025 and revised 06/27/2025. Resident #8 had a care plan that revealed, Resident requires enhanced barrier precautions r/t feeding tube, tracheostomy, date initiated 03/03/2025. During an observation on 12/31/2025 at 9:37 a.m., Resident #8's room door had a sign beside the entry to the room that revealed Resident #8 was on enhanced barrier precautions and had a PPE supply cart outside of the room door. LVN J was observed entering Resident #8's room for tracheotomy care. LVN J donned gloves and proceeded to remove Resident #8's oxygen mask over Resident #8's tracheostomy and then attached a new oxygen mask to Resident #8's tracheostomy. LVN J was observed not wearing a gown during the tracheostomy care. During an interview with LVN J on, 12/31/2025 at 9:45 a.m., LVN J stated residents who had a foley catheter, and infections or trachs like her were on enhanced barrier precautions. LVN J stated residents on enhanced barrier precautions were identified by a sign outside of their doorway that revealed the resident was on enhanced barrier precautions. LVN J stated, when caring for a resident on enhanced barrier precautions, staff were supposed to wear gloves and maybe, it depends, sometimes gowns. LVN J stated Resident #8 was on enhanced barrier precautions for her tracheostomy and she did not think she needed to wear a gown for tracheostomy care. LVN J stated she had received training on enhanced barrier precautions and stated it was important to use enhanced barrier precautions, so we don't get extra bacteria into a resident who is immune compromised and stated, more infections could happen to the resident. During an interview with the DON on, 12/31/2025 at 2:40 p.m., the DON stated residents who had indwelling devices such as tracheostomies would have been on enhanced barrier precautions and stated staff would have worn a gown and gloves when staff provided direct care to residents on enhanced barrier precautions. The DON stated staff had received training on wearing the appropriate PPE for enhance (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	barrier precautions and stated it was important for enhanced barrier precautions to be followed, to prevent MDROs and transferring of MDRO's to patients or staff. Record review of the enhanced barrier precaution sign posted outside of Resident #8's room revealed 2 large stop signs in the top corners and revealed, providers and staff must also: wear gloves and gown for the following High Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound care: any skin opening requiring a dressing. Record review of a facility policy titled, Enhanced Barrier Precautions (Enhanced Barrier Precautions EBP Policy and Procedure 4/1/2024; Reviewed 3/19/2025, Reviewed 06/20/25), revealed, 'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities and EBP are indicated for residents with any of the following: Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that it was free of pests and rodents for 1 of 1 residents (Resident #1) reviewed for pest control program. The facility failed to ensure Resident #1 was not found with maggots in his left stage 3 buttock wound on 12/24/25. An IJ was identified on 1/1/26. The IJ template was provided to the facility on 1/1/26 at 8:25 p.m. While the IJ was removed on 1/3/26 at 7:24 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility's need to monitor the implementation and effectiveness of its Plan of Removal. The failure could place residents with wounds at risk for infection or infestations from pests. The findings include: Record review of Resident #1's face sheet revealed he was a [AGE] year-old male who readmitted to the facility on [DATE] with diagnoses that included: seizures (abnormal release of electrical activity in the brain), type 2 diabetes mellitus with hyperglycemia (a condition resulting from insufficient production of insulin, causing high blood sugar), and hemiplegia and hemiparesis (complete paralysis to one side and weakness to one side of the body). Record review of Resident#1's MDS, dated [DATE], reflected a BIMS score of 12, indicative of moderate impairment in cognition. The ADLs for: B/B bowel was always incontinent. Transfer was not applicable; and bed mobility substantial assistance. Mobility devices were listed as non-used. Range of motion was documented as an impairment on one side to upper and lower extremities. Record review of Resident #1's clinical record revealed on 10/26/25 a CNA reported the wound on the resident's bottom reopened, but the resident declined to let the nurse see the wounds. Record review of Resident #1's wound progress note completed on 11/20/2025 written by the NP reflected a left buttock pressure ulcer/injury with measurements of 4 cm x 5 cm x 0.2 cm stage 3, 40% slough (puss) and moderate amount of serosanguinous (mix of blood and serum). Record review of Resident #1's wound assessment report dated 11/20/2025 and signed 11/21/2025 by the NP revealed a reopened wound of the left buttock reflected the following measurements: 4.0 Length by 5.0 Width by 0.20 Depth. Record review of Resident #1's care plan provided on 1/1/26 recorded a focus area for the following: I have a Stage 3 pressure injury/ulcer #18 Rt Buttock r/t Immobility, Refusal of Care initiated on 11/20/25, with interventions including Administer treatments as ordered and monitor for effectiveness initiated on 11/20/2025. Record review of Resident #1's NP's orders dated 11/28/25, read: Wound care to left buttock: cleanse with dakins 0.25%, pat dry, collagen with silver, and cover with silicone bordered superabsorbent dressing. Record review of pest control documents revealed a list of facilities receiving pest control services that included the facility with an effective date of 2/7/2021. Record review of the pest control service statement, dated 12/16/2025, revealed, Met with DON, she reported no issues. Kitchen manager said she's seen some roaches by the drains. During interview on 1/1/26 at 11:58 a.m. CNA B stated on 12/24/25 a nurse told her that Resident #1 needed to be changed, he smelled, and maggots were found in his groin area. CNA B stated when she got in Resident #1's room, after following EBP protocols, preparing to give Resident #1 a bed bath, she pulled down his covers and saw maggots in Resident #1's groin area. CNA B stated after witnessing the maggots she then was moved up to Resident #1's head to wash his hair. During interview on 1/1/26 at 1:55 p.m., CNA D stated on 12/24/25 while giving Resident #1 a bed bath they saw maggots on Resident #1 and in their feces. CNA D stated after seeing the maggots she still proceeded to give Resident #1 a bed bath. Observation on 1/1/26 at 2:40 p.m., revealed a dead fly on the window ledge in Resident #1's room. Observation on 1/1/26 at 3:00 p.m., of the area outside the exit door on hallway 300 revealed a box, with one side cut out, (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a blanket, and what appeared to be a bowl with some sort of food in it. Observation on 1/1/26 at 3:01 p.m., of the exit door on hallway 300 revealed the bottom of the door not reaching the floor allowing for a gap between the floor and bottom of the door. Observation on 01/01/2026 at 4:13 p.m., of Resident # 1's room revealed a small black electronic item on the resident's overhead light. The appliance had a hollow round circle with a UV colored light. Interview on 1/1/26 at 4:13 p.m. Resident #1 stated an insect fan was provided around the time insects were identified in his wound. Resident #1 stated prior to having the insect fan he had an issue with files in his room. He stated he notified several staff members of the files in his room including the DON and Administrator. Observation on 1/1/26 at 4:50 p.m. of the facility's windows revealed more than 3 screens missing or ill-fitting on each hall, 1 window in the lobby with no screen and opened approximately a quarter of an inch, and 1 window on the 400 hall with a torn screen and open approximately 3 inches. During interview on 1/1/26 at 5:15 p.m., the Administrator stated she had only one report of a pest in the past month which was in the therapy room. The administrator confirmed the torn screens, missing screens, and opened windows and stated that it could possibly allow for small pests to enter the facility. The administrator stated flies were treated by fly lights, insect fans and window screens and that pest control comes once a month or by special visit if requested by the facility. When asked about what appeared to be food in a bowl outside of the exit door on the 300 hall the administrator stated she had no idea what it was and when it got there. The administrator stated pest control was not notified of the maggots on 12/24/2025. When asked what harm could come to a resident who was exposed to pests the administrator stated she would have to ask the nursing staff. During an interview on 1/1/26 at 5:56 p.m., the Administrator confirmed the last time pest control came out to treat the facility was 12/16/2025. During an interview on 1/1/26 at 6:13 p.m., LVN B stated they had not heard any concerns regarding flies from residents since being hired. LVN B stated as she entered the facility on 12/24/25 the nursing staff approached her and asked her to speak to Resident #1 regarding bathing. LVN B stated the resident approved of a bed bath and while the CNAs were turning Resident #1 to the side she saw bugs. When asked what harm could come to a resident who was exposed to pests LVN B stated it could be an infection control problem and could make the residents sick. During an interview on 1/1/26 at 6:21 p.m., the DON stated she had not heard any concerns regarding flies in the past 90 days. The DON stated she was informed that Resident #1 had maggots in his wound by LVN B but did not witness any bugs herself. When asked what harm could come to a resident who was exposed to pests the DON stated they could get sick or an infection depending on what insect they were exposed to. Record review of facility's Pest Control policy dated revised May 2008 read, .Our facility shall maintain an effective pest control program 3. Windows are screened at all times. This was determined to be an Immediate Jeopardy (IJ) on 1/1/26 at 8:18 p.m. The Administrator was notified of the IJ and provided the IJ Template on 1/1/26 at 8:25 p.m. Observation on 1/2/26 at 9:50 a.m., of the kitchen and kitchen prep area revealed a dead roach in the cabinet that was under the 2-compartment sink by the microwave. During an interview on 1/2/26 at 9:51 a.m., the [NAME] stated the only insects he had seen was maybe just a fly last week, and the pest control guy did a round last week in the kitchen. Observation on 1/2/26 at 10:57 a.m. of the outside exit door at the end of the 300 hallway revealed it did not have a flying insect trap. During an interview on 1/2/26 at 11:25 a.m., the Maintenance Director stated the facility was treated monthly for pest control which included treating the building for insects such as ants, flies, roaches, scorpions. The Maintenance Director stated, the pest control company, sends him a text message the day they were going to be in the facility to service the building and if staff saw any insect activity between treatments, they were to put it in the pest control (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Prairie Meadows Rehabilitation and Healthcare Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 Eleventh St Floresville, TX 78114	

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	logbook that was located behind the nurse's station under the fire extinguisher. Observation on 1/2/26 at 11:29 a.m., of the dining room revealed it had 2 flying insect traps by the 2-exit doors that were in the dining room. Observation on 1/2/26 at 11:29 a.m., of the dining room exit door close to 300 hall where there was an outdoor courtyard between the dining room and 300 hall, the door was left propped open for an outdoor activity while various staff members brought residents out to the outdoor area and back inside. During an interview on 1/2/26 at 11:36 a.m., the activity director stated she was doing an outside activity with the residents so they could get some sunshine and that she was waiting for a CNA to come out and take a resident back in. Observation on 1/2/26 at 11:47 a.m., of the dining room exit door close to 300 hall activity revealed the activity director closing the door to the outside and setting the door alarm which beeped. During an interview on 1/2/26 at 11:49 a.m., the activity director stated she left the door open to the outdoor courtyard so residents could be brought outside and that she usually closes it and can open the door from the outside but sometimes it catches so she has to knock on the window for someone to let her into the building. Observation on 1/2/26 at 11:56 a.m., of the exit door at the end of 400 hall revealed not having a flying insect trap by the door. Observation on 1/2/26 at 12:00 p.m., of exit door at the end of 100 hall by the therapy department revealed it not having a flying insect trap by the door. During an interview on 1/2/26 at 2:28 p.m., CNA D stated they currently saw flies in the building because the facility has been doing construction on the halls, and the doors have been open. The plan of removal was accepted 1/2/26 at 3:31pm. During an interview on 1/3/26 at 12:36 p.m., the administrator stated the vendor who would be replacing the window screens would start installing them on 1/6/26 and would have all the window screens that needed to be replaced installed on 1/7/26. The administrator stated there were about 42 window screens that had to be replaced, and the vender removed any screen that was bent from the window because those screens had to be replaced and could not be repaired. During an interview 1/3/26 at 2:21 p.m., the maintenance director stated he had not seen any flies recently. The maintenance director stated he was to contact the pest control company anytime pests were seen and was to conduct walks around the facility every day to check for anything that needs to be repaired. During an interview on 1/3/26 at 3:35 p.m., Resident #1 stated he had the pest control device since Christmas and it was to kill pests that were in his room. It was documented as follows: Facility: Tag: F925 - Pest Control IJ Identified: 1/1/26 Resident: #1 Immediate Actions On 12/24/25, upon identification of maggots in Resident #1's left buttock stage 3 pressure injury, nursing staff immediately cleansed the wound, removed all visible insects, and applied a clean, secure dressing. The attending physician was notified and wound care orders were reviewed and implemented by DON on 12/24/2025. Resident #1 was assessed for signs of infection and discomfort and monitored per nursing protocol by DON/Designee on 12/24/25. An insect fan was placed in the resident's room to reduce fly exposure by DON/Designee on 12/26/2025. Emergency pest control services were contacted by Administrator on 1/1/2026 to provide additional services. Pest control services confirmed appointment 1/2/2026. On 1/1 /26, the Administrator and Maintenance Director conducted a facility-wide inspection. All missing, torn, or ill-fitting window screens were repaired, replaced, or secured by maintenance/ designee on 1/1/2026. DON/Nursing Admin conducted a visual assessment of all residents with wounds to ensure free of pests on 1/1/2026. On 1/1/2026, the Administrator notified Medical Director of Immediate Jeopardy. Systemic Action Regional Director of Operations in-serviced Administrator and DON on 1/1/2026 on the following: Prompt reporting of insects, or environmental concerns, updating pest controllog to reflect any issues noted, maintaining screened and closed windows, Monitoring wounds for contamination risks, Pest control policy and emphasizing that windows must remain screened, to include prompt follow (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	up on addressing resident complaint. A quiz will be conducted post education to determine competency in the education material.Staff will not be able to work until quiz is passed with a grade of 100. All staff received immediate education 1 /1/26 by Administrator/Designee on: Prompt reporting of insects or environmental concerns, maintaining screened and closed windows, Monitoring wounds for contamination risks, Pest control policy and emphasizing that windows must remain screened. A quiz will be conducted post education to determine competency in the education material. Staff will not be able to work until quiz is passed with a grade of 100. No staff will be able to work until education and competency is completed. All education will be incorporated into new hire on-boarding by Administrator on 1/1/26. Monitoring Maintenance will complete weekly documented inspections of all windows and screens. Deficiencies will be corrected immediately, or the window taken out of service. Routine pest control services will continue as scheduled. Pest control logs will be reviewed weekly by the Administrator or designee. Any evidence of insect activity will trigger immediate treatment including prompt assessment, wound protection, removal of insects, physician notification as needed, and immediate environmental and pest control interventions at the time insect activity is identified. DON/designee will conduct weekly audits of residents with open wounds to ensure wounds are clean, covered, and free from environmental exposure. Findings will be documented and reviewed through QA/QAPI. The Administrator and DON will conduct weekly environmental rounds for 30 days to verify sustained compliance. The facility's POR verification was as follows: Record review of Resident #1's Weekly Wound Observation form, dated 12/24/25, revealed the wound on his left buttock was acquired on 11/20/25, was a stage 3 Pressure Injury and measured 6.0 cm x 3.5 cm x 2.0 cm, there was no odor to the wound and did not show any signs of a wound infection. Record review of Resident #1's physician orders revealed his physician ordered wound care to left buttock; cleanse with dakins 0.25%, pat dry, collagen with silver, and cover with silicon bordered superabsorbent dressing every night shift and when loose or soiled. Record review of Resident #1's nurse's notes dated 12/24/25 revealed the resident's wound was assessed by the DON. Record review of an undated employee list revealed the facility had 84 employees. Record review of an In-Service Attendance signature page for the topic of Pest Control presented 1/1/2026, Environmental Safely and Wound Protection revealed 84 employees had received in-service training in person or via telephone. Review of the attached training content revealed staff were responsible for observing and reporting environmental concerns immediately which included flies, maggots, roaches, ants or other insects in resident rooms or common areas, report any open windows or missing/torn/loose window screens. All windows were to remain closed and properly screened at all times. Residents with open wounds were at risk for increased contamination and staff were to report immediately if any insects were observed near or around a wound, and if the dressings were loose, soiled or compromised. A copy of the quiz given to employees was attached, which included 9 questions that covered the in-services they received. Record review of the quiz provided to employees revealed 84 employees had completed the quiz, the quiz was checked by the DON and ADON, and all employees scored 100%. Record review of the in-service training presented to the Administrator and DON on 1/1/2026 by the Regional Director of Operations revealed they were in-serviced on ensuring prompt reporting and follow-up of insect or environmental concerns, maintain oversite to ensure all windows remain closed and properly screened, ensure residents with wounds are protected from contamination risks, enforce pest control policy requirements, and ensure resident complaints are promptly addressed, investigated and resolved. The Administrator and DON were provided with a quiz on the in-service and both passed with 100% accuracy. Record review of the wound monitoring log revealed 6 residents with open wounds were monitored on 1/1/26 by the DON with no signs of insect activity. Record review of (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the Bid from Window Company A, dated 1/2/26, revealed 13 window screens would be replaced, and 37 screens would be repaired and rescreened. Record review of the Weekly Window & Screen Inspection form dated 1/1/26 listed every window in the facility; the screens were inspected with 7 window screens temporarily repaired. The Window Screen Inspection form dated 1/2/26 noted there were 37 screens that had been un-bended or would be rescreened. Record review of the undated QAPI Meeting log, revealed a QAPI meeting was held on 1/1/26, and future QAPI meetings would be held weekly for 3 months. Record review of the QAPI signature page, dated 1/1/26, revealed the Administrator, DON, Social Worker, Activity Director, BOM, Human Resources, ADON and Housekeeping Director attended the meeting that was held at 9 PM on 1/1/26. Record review of an email dated 1/1/26 from the Administrator to Pest Control Company A, was sent at 5:59 PM, requesting a technician to service the facility for an emergency visit as soon as possible. Record review of an invoice dated 1/2/26 from Pest Control Company A revealed Technician D came to the facility at 5 PM to service the building for flies. The report noted the technician met with the DON who reported a fly was found in room [ROOM NUMBER]. The technician was escorted to the room and performed a fly wipe down treatment throughout the room and bathroom. A fly wipe down was performed throughout the rest of the facility treating all hallways, doorways, nurses' station, kitchen, dining and all common areas. A liquid bait was applied in and around the dumpsters, and doorways. Record review of the undated Pest Control monitoring form, revealed the Administrator reviewed the pest control log for the week on 1/1/26, verified the Pest Control Company A Technician D had signed the log when he was in the facility to show he had reviewed the log. Record review of the undated Pest Log that was kept in the Pest Control binder, revealed Pest Control Company A Technician D had signed the log on 12/13/25 and 1/2/26. Record review of the Life Satisfaction Rounds, completed on 1/2/26, revealed all 58 residents of the facility were asked if they had any concerns or experienced any flies in their room and who would they tell if they noticed pest control issues. Residents who were non-verbal or could not answer the questions, staff had verified there were no pests in their room. In a telephone interview on 1/1/26 at 1:15 PM, the Medical Director stated he had been informed of the maggots that were in Resident #1's wound, recommended the wound care practitioner look at the resident's wound and to fumigate the resident's room. In an interview on 1/3/26 at 10:49 AM, the DON stated she and the ADON had reviewed the quiz the employees took, and all employees had passed the quiz the first time they took it. In an interview on 1/3/26 at 12:36 PM, the Administrator stated the vendor who was replacing the torn, bent, and missing window screens would install them on 1/6/26 and 1/7/26. The Administrator stated there were about 42 window screens that had to be replaced because they were bent, and the bent screens were removed from the window by the vendor on 1/2/26. In a telephone interview on 1/3/26 at 2:21 PM, the Maintenance Director stated the facility had been inspected for flies and all the window screens were checked to determine if they were missing or needed to be replaced. He said windows that had the screen removed because it was broken were covered with a screen mesh that was taped to the windows. The Maintenance Director stated he would check the Pest Control log book weekly to see if there were any new entries for signs of pest, and if so, he would contact the pest control company to come and service the facility. Interviews on 1/3/26 from 11:43 AM to 4:15 PM with 23 employees (2 housekeepers, 1 Laundry, Housekeeper Supervisor, Activity Director, Social Worker, Dietary Manager, Cook, 2 Dietary Aides, 2 LVN, 4 CNAs, 2 RNs, 1 MDS Nurse) which included 4 night shift employees (1 RN, 2 CNAs, 1 LVN) revealed they had been in-serviced on prompt reporting of insects or environmental concerns, maintaining screened and closed windows, Monitoring wounds for contamination risks, Pest control policy and emphasizing that windows must remain screened. All employees stated they were given a quiz on the topics they were (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in-serviced on. In a telephone interview on 1/3/26 at 5:10 PM, the RDO stated she had in-serviced the DON and Administrator on the regulations, the policy and procedures for pest control, reporting insects and environmental concerns was the responsibility of all the staff; she reviewed the in-service that would be presented to the employees, if the windows had screens that were torn would be replaced and to make sure the screens that were in place were secured. In an interview on 1/3/26 from 6:00 PM to 6:20 PM, the Administrator stated that Resident #1 was bathed, received wound care, his bed was cleaned and sanitized, his physician was notified, the wound care NP was notified, she bought a fly light that was placed in his room, they cleaned his room but the resident refused to let staff do a deep cleaning of his room. The nursing staff were monitoring Resident #1's wound for infection along with his vital signs. The Administrator said the pest control company was contacted on 1/1/26 with an email request and they were in the facility on 1/2/26 to treat the building and Resident #1's room. The Administrator said she reviewed all the window screens; screens that were out of place were put back in place. On 1/2/26 a window repair company representative looked at the screens on the windows and removed any screen that was bent so it could be repaired. The Administrator said window where the screens were removed were covered with a mesh material that was taped to the window that she is checking twice a day to make sure the tape is secured. The Administrator said the DON reviewed all the residents with open wound, and the wound NP would be reviewing the residents' wounds weekly in addition to the facility nurses. The Administrator stated she and the DON were trained by the Regional Director of Operations to take all resident complaints and escalate them as appropriate, look at the root cause, inform the resident what the solution would be. The Administrator said all the staff have been trained on reporting pest to the charge nurse or administrator, report any pest seen or reported by a resident so it could be recorded in the pest control log book so the pest control company can be contacted to treat the facility. The Administrator stated she and the Maintenance Director would do daily environmental rounds of the facility. Observation and interview on 1/3/26 at 3:35 PM in Resident #1's room revealed on top of the overbed light was a black pest control device that emitted a purple light. Resident #1 stated it was to kill pests that were in his room, and he had it since Christmas. Observation on 1/3/26 from 4:35 PM to 4:44 PM of the facility windows from the outside of the building revealed there were 46 windows covered with a window mesh screen that was taped to the window until the original window screen could be replaced or repaired. On 1/03/2026 at 7:33 PM, the Administrator was notified the IJ was removed on 1/3/26 at 7:24 PM. However, the facility remained out of compliance at a scope of isolated and severity of actual harm with a potential for more than minimal harm due to the facility's need to monitor the implementation and effectiveness of its POR.