STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675471	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 9 residents (Resident #4) reviewed for quality of life. The facility failed to provide Resident #4's showers as scheduled on Saturdays. This failure could place residents at risk of not receiving the services and care needed, decreased self-esteem, and a decreased quality of life. Findings included: Record review of a face sheet dated 10/23/2025 indicated Resident #4 was a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included unspecified combined systolic and diastolic congestive heart failure (heart is unable to pump enough force to push enough blood into circulation) and schizoaffective disorder bipolar type (mood disorder that can include depression, delusions, hallucinations, disorganized thoughts, speech and behavior). Record review of Resident #4's Comprehensive MDS assessment dated [DATE] indicated Resident #4 was understood by others and understood others. Resident #4 had a BIMS score of 15, which indicated her cognition was intact. Resident #4 required substantial/maximal assistance with showering/bathing herself. Record review of Resident #4's care plan dated 08/28/2024, indicated she had an ADL self-care performance deficit related to impaired balance. Resident #4's care plan indicated she was able to wash the upper front and lower front of her body and staff was to wash her back areas. Record review of Resident #4's Shower/Bathe Task Record for October 2025 indicated she received showers on Tuesday, Thursday, and Saturday on the 2 PM-10 PM shift. Resident #4's Shower/Bathe Task Record did not indicate she missed any showers. During an interview on 10/21/2025 at 4:04 PM, Resident #4 said she was not getting showers sometimes on Saturdays. Resident #4 said the staff told her they were short-handed, so they could not give her a shower. During an interview on 10/22/2025 at 11:27 AM, CNA E said there were some residents who complained about not receiving showers on the 2 PM-10 PM shift and on Saturdays. CNA E said Resident #4 was one of them. CNA E said the ADON and DON were aware of the missed showers. CNA E said when a resident reported to her they had not received a shower, she gave them one. CNA E said she had given Resident #4 a shower yesterday,10/21/2025. CNA E said Resident #4 requested a shower from her because she did not get one on Saturday,10/18/2025. CNA E said the residents not receiving showers as scheduled could result in skin breakdown, rashes, and make them feel down. During an interview on 10/22/2025 at 1:42 PM, LVN F said she worked the weekends (6 AM- 10PM) and a lot of times they were short staffed. LVN F said usually they had 1 CNA on each side of the building and 2 nurses. LVN F said the past weekend the ADON worked because they were short staffed. LVN F said she was not the nurse for Resident #4 over the weekend that LVN D was the nurse and MA H was the CNA on Saturday (10/21/2025) for Resident #4. LVN F said when they were short staffed it was not possible to provide the required care, and if they were not able to provide the required care due to being short staffed, this could be considered neglect. During an attempted phone interview on 10/22/2025 at 1:51 PM, LVN D did not answer the phone. During an interview on 10/23/2025 at 10:38 AM, MA H said she worked Saturday, 10/18/2025. MA H said they were short and she worked all over the building, and she did not know if the residents' received showers. MA H said they were short staffed frequently, and sometimes they missed the showers. MA H said Saturdays were awful. MA H said she did not give any showers on 10/18/2025. MA H said the residents not receiving their showers as scheduled could affect their skin and them being clean. During an interview on 10/23/2025 at 11:39 AM, the ADON said she was aware showers were not given as scheduled. The ADON said Saturday, 10/18/2025, she worked and gave medications to the residents for 12 hours and then worked as a CNA the last 4 hours of her shift. The ADON said she did not give any showers on 10/18/2025. The ADON said she completed the charting for MA H on, 10/18/2025, and she was under the impression MA H had given Resident #4 her shower, so she signed it off as being completed. The ADON said the nurses were responsible for ensuring the residents received their showers. The ADON said if the residents did not receive their showers, it could cause skin breakdown and odors. During an interview on 10/23/2025 at 1:17 PM, the DON said the only person that had complained to her about not receiving showers was Resident #4. The DON said a couple weekends ago Resident #4 informed her she had not received a shower, and she gave her one herself. The DON said she monitored if the residents were getting their showers by checking the task records, and she had not noticed any issues. The DON said if the residents did not receive their showers it could result in low self-esteem, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 1 of 1 facility reviewed and 3 of 20 residents (Resident #2, Resident #4, and Resident #5) for care and services. 1. The facility failed to ensure Resident #2 medications were administered during the scheduled time. 2. The facility failed to ensure sufficient staff was provided to ensure Resident #4 received her showers on Saturdays. 3. The facility failed to ensure sufficient staff was provided to ensure Resident #5 was able to get out of bed when requested. 4. The facility failed to provide sufficient nursing staff according to the facility assessment on 05/03/2025, 05/04/2025, 05/10/2025, 05/11/2025, 06/20/2025, 06/21/2025, 06/28/2025, 07/01/2025, 07/05/2025, 07/06/2025, 07/12/2025, 08/02/2025, 08/03/2025, 09/01/2025, 09/20/2025, 09/21/2025, 10/5/2025, 10/12/2025, and 10/18/2025. These failures placed residents at risk of not having sufficient staff to provide for their care/treatment needs.Findings included: 1. Record review of Resident #2's face sheet, dated 10/23/25, reflected Resident #2 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included Parkinson's (a disorder that affects movement, balance, and coordination) with dyskinesia (involuntary, uncontrolled, and abnormal muscle movements). Record review of the order summary report dated 10/23/25 indicated Resident #2 was ordered: Carbidopa-Levodopa 25-100mg 1 tablet by mouth three times a day. Buspirone 5 mg 1 tablet by mouth three times a day. Record review of the Medication Administration Audit Report dated 10/23/25 reflected Resident #2 received her medications on 10/05/25 by MA B as listed: Carbidopa-Levodopa 25-100mg 1 tablet given at 11:06 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Buspirone 5 mg 1 tablet given at 11:06 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Carbidopa-Levodopa 25-100mg 1 tablet given at 11:46 a.m. of the scheduled medication pass 12:00 p.m. Buspirone 5 mg 1 tablet given at 11:46 a.m. of the scheduled medication pass 12:00 p.m. During an interview on 10/23/25 at 10:39 a.m., MA B stated medications should be administered one hour before or one hour after the scheduled time. MA B stated medications were given late due to short staff and her being the only MA that worked that day. MA B stated she did not remember given Resident #2 the second dose of Buspirone and Carbidopa-Levodopa that was scheduled at 12:00 p.m. MA B stated she probably just clicked it off on the MAR as given to show the task was completed. MA B stated she did not notify the physician or the DON about the second dose not given, or medications given late. MA B stated it was important medications were given on time to ensure the dose was effective and prevent an overdose. Record review of the Medication Administration Audit Report dated 10/23/25 reflected Resident #2 received her medications on 10/18/25 by the ADON as listed: Buspirone 5 mg 1 tablet given at 11:25 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Carbidopa-Levodopa 25-100mg 1 tablet given at 11:25 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Carbidopa-Levodopa 25-100mg 1 tablet given at 11:26 a.m. of the scheduled medication pass 12:00 p.m. Buspirone 5 mg 1 tablet given at 11:26 a.m. of the scheduled medication pass 12:00 p.m. During an interview on 10/23/25 at 11:27 a.m., the ADON stated medications should be given within the scheduled time. The ADON stated she rarely passed medications, and she did not know the medications like the staff that normally administered the medications. The ADON stated she did not notify the MD that the medications were given late nor the 12:00 p.m. dose of Buspirone or Carbidopa-Levodopa were not given. The ADON stated she guessed when she was clicking off the medications on the MAR, she did not realize it was duplicate. The ADON stated it was important medications were given as scheduled to prevent overmedication and a medication error. During a telephone interview on 10/23/25 at 12:24 p.m., the MD stated staff should have notified him if the medications were given late or if the second dose was close to the first dose that was administered. The MD stated he had received text messages about medications been administered late but not frequently. The MD stated he did not know anything about culture time window just the one hour before and one hour after. The MD stated the risk of not administering medications on time was if the resident received a blood pressure medication it could affect their blood pressure. During an interview on 10/23/25 at 12:54 p.m., the DON stated medications can be given one hour before or one hour after. The DON stated the facility did have a culture time which means a window for medication administration. The DON stated if the first dose was given close to when the second dose should be given, the second dose should be held and the MD notified. The DON stated she was responsible for monitoring and overseeing by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed provide pharmaceutical services, which included procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 3 residents (Resident #2) reviewed for pharmacy services. The facility failed to ensure Resident #2 medications were administered during the scheduled time. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications.Findings included: 1. Record review of Resident #2's face sheet, dated 10/23/25, reflected Resident #2 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included Parkinson's (a disorder that affects movement, balance, and coordination) with dyskinesia (involuntary, uncontrolled, and abnormal muscle movements). Record review of the order summary report dated 10/23/25 indicated Resident #2 was ordered:Carbidopa-Levodopa 25-100mg 1 tablet by mouth three times a day. Buspirone 5 mg 1 tablet by mouth three times a day. Record review of the Medication Administration Audit Report dated 10/23/25 reflected Resident #2 received her medications on 10/05/25 by MA B as listed: Carbidopa-Levodopa 25-100mg 1 tablet given at 11:06 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Buspirone 5 mg 1 tablet given at 11:06 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Carbidopa-Levodopa 25-100mg 1 tablet given at 11:46 a.m. of the scheduled medication pass 12:00 p.m.Buspirone 5 mg 1 tablet given at 11:46 a.m. of the scheduled medication pass 12:00 p.m. During an interview on 10/23/25 at 10:39 a.m., MA B stated medications should be administered one hour before or one hour after the scheduled time. MA B stated medications were given late due to short staff and her being the only MA that worked that day. MA B stated she did not remember given Resident #2 the second dose of Buspirone and Carbidopa-Levodopa that was scheduled at 12:00 p.m. MA B stated she probably just clicked it off on the MAR as given to show the task was completed. MA B stated she did not notify the physician or the DON about the second dose not given, or medications given late. MA B stated it was important medications were given on time to ensure the dose was effective and prevent an overdose. Record review of the Medication Administration Audit Report dated 10/23/25 reflected Resident #2 received her medications on 10/18/25 by the ADON as listed: Buspirone 5 mg 1 tablet given at 11:25 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m.Carbidopa-Levodopa 25-100mg 1 tablet given at 11:25 a.m. instead of the scheduled medication pass 7:00 a.m.-10:00 a.m. Carbidopa-Levodopa 25-100mg 1 tablet given at 11:26 a.m. of the scheduled medication pass 12:00 p.m. Buspirone 5 mg 1 tablet given at 11:26 a.m. of the scheduled medication pass 12:00 p.m. During an interview on 10/23/25 at 11:27 a.m., the ADON stated medications should be given within the scheduled time. The ADON stated she rarely passed medications, and she did not know the medications like the staff that normally administered the medications. The ADON stated she did not notify the MD that the medications were given late nor the 12:00 p.m. dose of Buspirone or Carbidopa-Levodopa were not given. The ADON stated she guessed when she was clicking off the medications on the MAR, she did not realize it was duplicate. The ADON stated it was important medications were given as scheduled to prevent overmedication and a medication error. During a telephone interview on 10/23/25 at 12:24 p.m., the MD stated staff should have notified him if the medications were given late or if the second dose was close to the first dose that was administered. The MD stated he had received text messages about medications been administered late but not frequently. The MD stated he did not know anything about culture time window just the one hour before and one hour after. The MD stated the risk of not administering medications on time was if the resident received a blood pressure medication it could affect their blood pressure. During an interview on 10/23/25 at 12:54 p.m., the DON stated medications can be given one hour before or one hour after. The DON stated the facility did have a culture time which means a window for medication administration. The DON stated if the first dose was given close to when the second dose should be given, the second dose should be held and the MD notified. The DON stated she was responsible for monitoring and overseeing by pulling the medication administration audit report in PCC randomly. The DON stated there have been issues in the past and when she investigated it the staff stated it was given on time just documented late. The DON stated it was important medications were given on time to ensure the residents received the accurate dose and decrease their risk of complications. During an interview on 10/23/25 at 2:08 p.m., the Administrator stated she expected the medications to be administered according to the schedule to ensure effectiveness

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	675471	A. Building B. Wing	12/01/2025

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review the facility failed to provide sufficient support personnel to carry out the functions of the food and nutrition service for 1 of 4 dietary staff (Dietary Aide G). The facility failed to ensure that dietary staff (Dietary Aide G) serving in the kitchen maintained a current Food Handler Certificate. This failure could place residents at risk of the facility not having staff to provide dietary services requirements. Findings included: During an interview on 10/21/2025 at 2:28 PM, the Dietary Manager said Dietary Aide G's food handler certificate was expired. Record review of Dietary Aide G's employee file indicated her date of hire was 07/17/2025, and her Texas Food Handler Certificate was issued 10/06/2022 and expired 10/05/2024. During an interview on 10/21/2025 at 4:21 PM, the Dietary Manager said the food handler certificate should be obtained within 30 days of hire. The Dietary Manager said she did not pay attention to when Dietary Aide G's food handler certificate expired. The Dietary Manager said she and the human resources department were responsible for ensuring the dietary staff had their food handler certificates. The Dietary Manager said it was important for the kitchen staff to have food handler certificates, so they knew the importance of food temperatures and cleaning. During an interview on 10/21/2025 at 4:29 PM, Dietary Aide G said she realized her food handler certificate expired 3-4 days ago. Dietary Aide G said she did not renew it because she did not have the money to pay for the renewal. Dietary Aide G said it was important to have a food handler certificate to know how to handle food and prevent cross contamination. During an interview on 10/23/2025 at 2:30 PM, the Interim Administrator said she was not aware Dietary Aide G's food handler certificate had expired. The Interim Administrator said the Dietary Manager was responsible for ensuring the food handler certificates were maintained up to date. The Interim Administrator said she did not know the risks associated with dietary staff having an expired food handler certificate. During an interview on 10/23/2025 at 2:33 PM, the Interim Administrator said the facility did not have a policy regarding food handler certificates.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to provide rehabilitative services as the physician ordered, for 1 (Resident #5) of 12 residents reviewed for rehabilitative services. The facility failed to ensure that Resident #5 received physical therapy (PT) or occupational therapy (OT) treatments as ordered by the physician from 06/16/25 through 06/20/25 and again from 06/23/25 through 06/24/25. This deficient practice could place residents who require rehabilitative services at risk of a decline or decrease in their physical capabilities.The findings included: Record review of Resident #5's face sheet, dated 10/23/25, indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Atrial Fibrillation (an irregular heartbeat, or arrhythmia), muscle weakness, unsteadiness on her feet, and cognitive communication deficit. Record review of Resident #5's OBRA (Omnibus Budget Reconciliation Act) MDS dated [DATE] indicated a BIMS score of 15 which meant she was cognitively intact. The MDS also indicated she required total assistance with toileting, transfers, bathing, and bed mobility, and required setup assistance for eating. The MDS indicated she received at least 663 minutes of OT and 649 minutes of PT during the 7-day look-back period. Record review of Resident #5's care plan dated 02/25/25 indicated she had an ADL self-care performance deficit related to impaired mobility, cellulitis (bacterial infection of the skin), and a history of a fracture. The interventions were for staff to help with toileting, transfers, bed mobility, bathing, and personal hygiene. The care plan also indicated she was at risk for falls due to an unsteady gait and a history of falls. The intervention was for therapy screening. Record review of Resident #5's order summary report of active orders dated 06/01/25 indicated an order for OT to evaluate and treat. Patients receive OT services 5 times a week for 30 days for therapeutic exercise, therapeutic acts, neuro re-education, coordination, activities of daily living re-education, safety training, and modalities as indicated. Record review of Resident #5's order summary report of active orders dated 06/01/25 indicated an order for PT to evaluate for plan of care (POC). PT Clarification: Skilled PT to treat 5 times a week for 60 days per POC with modalities as indicated. Record review of a NOMNC dated 6/13/25 with service ended on 6/15/25 for OT and PT. Record review of a NOMNC dated 6/26/25 with service ended on 6/28/25 for OT and PT. Record review of OT progress notes dated 06/12/25 through 6/26/25 indicated she did not have a change in function. Record review of PT progress notes dated 06/12/25 through 6/26/25 indicated she did not have a change in function. Record review of Resident #5's service log matrix dated 06/01/25 through 6/31/25 indicated she did not receive any therapy from 06/14/25 through 06/25/25. She did receive therapy on 06/26/25, 06/27/25, and 06/28/25 for 3 days of therapy during the week of 06/23/25 through 06/27/25. Resident #5 missed a total of 7 days in June 2025. During an observation and interview on 10/21/25 at 10:35 a.m., Resident #5 was observed to be lying in bed. The resident said she had a problem receiving her therapy a few months ago. She said she was upset that she did not receive the therapy as she should have because her goal was to go home. She said that since then, she had received her therapy. During a phone interview on 10/21/25 at 12:10 p.m., the RP said Resident #5 did not receive her therapy from approximately 1 week in June of 2025. She said she had told the therapist that her appeal was won, but they did not start Resident #5's therapy back for about a week. She said Resident #5 just laid in bed and did not receive her therapy. She said Resident #5's goal was to receive therapy and go home. During an interview on 10/22/25 at 4:00 p.m., the DOR said when a resident was given an NOMNC, they had 24 hours to file an appeal. She said once the resident/family let them know they would be filing an appeal, they would send in the paperwork to the insurance company to review. She said they would continue therapy until they heard back from the insurance company. She said if the resident did not win the appeal, then the resident/family was aware that they might incur charges. She said they had some confusion with Resident #5 and her appeal process. She said they had problems reaching the RP, and they only became aware that Resident #5 had won the appeal through the RP in June 2025. She said once she was aware Resident #5 had won her appeal, during the period of June, when she missed therapy, she forgot to add her to the therapy schedule. She said it was an oversight. She said she was responsible for ensuring residents received their ordered therapy. She said failure to receive therapy could cause a decline in a resident's function. During an interview on 10/23/25 at 11:55 a.m., the ADON said she knew Resident #5 had mentioned she was not getting up, but she had asked the aides, and they said they were getting her up. She said the aides should never tell a resident that they were shorthanded, but they might have. She said she agreed they were short-handed during the period