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	07/02/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interviews and record review, the facility failed to ensure residents had a right to personal privacy for 3 of 3 confidential residents reviewed for resident rights to receive personal mail. The facility did not ensure residents promptly receive mail on Saturdays.This failure could place residents at risk with a decline in a resident's psychosocial well-being and quality of life.Findings include: During a confidential group interview at an undisclosed date and time, 3 residents stated they did not always receive their mail on Saturdays. The residents stated they had to wait until Monday when the Activity Director passed it out. During an interview on 07/01/26 at 9:14 a.m., the Activity Director stated mail should be delivered to residents on Saturdays. The Activity Director stated the facility had gotten cited for not delivering mail to residents on Saturdays previously, and the solution was for the RN Supervisor to deliver the mail to the residents on Saturday. The Activity Director stated there were times she delivered mail to residents from Saturday on Monday that was given to her by the Business Office Manager. The Activity Director stated it was important residents received their mail because it was their right. During an interview on 07/01/26 at 9:20 a.m., the Business Office Manager stated the mail that was delivered on Saturday was placed in a locked box outside her door from the weekend staff. The Business Office Manager stated she was the only one that had a key to the locked box. The Business Office Manager stated there were times she gave the mail from Saturday to the Activity Director to distribute to residents. The Business Office Manager stated either the RN Supervisor, or the nurses were responsible for checking the mailbox and distributing mail on the weekends. The Business Office Manager stated it was important for residents to receive their mail because it was their right. During an interview on 07/02/26 at 4:08 p.m., the DON stated she was unaware residents were not receiving their mail on Saturdays. The DON stated she expected mail to be delivered on Saturdays. The DON stated the RN Supervisor was responsible for checking the mailbox and distributing mail on the weekends. The DON stated it was important for residents to receive their mail because it was their right. During an interview on 07/02/26 at 4:40 p.m., the Administrator stated she expected mail to be delivered to residents on Saturdays. The Administrator stated she did not know who was responsible for distributing mail on the weekends. The Administrator stated there was no system in place to ensure residents receive their mail on Saturdays. The Administrator stated this failure could affect resident's rights. An attempted telephone interview on 07/02/26 at 5:01 p.m. with RN A, the RN supervisor for the weekends was unsuccessful, voicemail left. The policy provided by the facility gave no relevant reference regarding resident's promptly receiving mail.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate with the appropriate, State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition received care and services in the most integrated setting appropriate to their needs for 3 of 6 residents (Resident #6, Resident # 31, and Resident #5) reviewed for resident assessments. 1.The facility failed to coordinate with the appropriate state authority to ensure Resident #6 had PASRR Comprehensive Service Plan (PSCP) meetings annually. 2. The facility failed to provide documentation of Resident #31's PASRR PCSP meetings held quarterly in the year 2025.3. The facility failed to provide documentation of Resident #5's habilitation coordination and independent living skills services as requested in the PCSP Form.These failures could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings included: 1.Record review of Resident #6's face sheet, dated 07/02/26 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with no discharges and included diagnoses of spina bifida (Intellectual and Developmental Disabilities also known as IDD). Record review of Resident #6's admission MDS assessment, dated 03/26/26, indicated Resident #6 understood and was understood by others. Resident #6's BIMS score was 12, which indicated his cognition was moderately impaired. The MDS indicated Resident #6 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS reflected Resident #6 had an active diagnosis of Spina Bifida. Record review of Resident #6's comprehensive care plan, revised 05/11/26, indicated, Resident #6 had a positive diagnosis of Spina bifida. The intervention was for staff to have specialized services as requested by resident and staff of habilitation coordination, independent living skills training, behavioral support and specialized OT. Record review of the PASRR Level 1 Screening form, dated 05/01/26, reflected Resident #6 had Intellectual and Developmental Disabilities. Record review of the PASRR Evaluation Screening form, dated 05/04/26, reflected Resident #6 had Intellectual and Developmental Disabilities. Record review of Resident #6's medical record did not indicate an annual PCSP meeting occurred in 2025. The last meeting was held 10/23/24. 2. Record review of Resident #31's face sheet dated 7/2/26 indicated she was a [AGE] year-old female who originally admitted on [DATE] with diagnoses which included mild intellectual disabilities (typically characterized by an IQ between 50 and 70, delayed academic learning, and minor deficits in everyday functioning), major depressive disorder (a severe mood disorder characterized by persistent sadness, emptiness, and a loss of interest in daily activities), anxiety (excessive, persistent fear that interferes with daily life), and mixed obsessional thoughts and acts. Record review of Resident #31's annual MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 12 which (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated she had moderate cognitive loss. The MDS also indicated was considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Record review of Resident #31's comprehensive care plan dated 3/30/26 indicated she was PASRR positive for intellectual disabilities with the interventions for PASRR PCSP meetings to be held with the LMHA and RP at least quarterly. Record review of Resident #31's EMR on 7/2/26 indicated there were no PASRR PCSP meetings held quarterly in the year 2025. 3. Record review of Resident #5's face sheet, dated 07/02/26, reflected Resident #5 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included intellectual disability (a condition that limits intelligence and disrupts ability necessary for living independently) and developmental disorder of scholastic skills (neurological condition that caused significant, unexpected difficulty in acquiring basic academic skills). Record review of Resident #5's significant change in status MDS assessment, dated 05/8/26, reflected Resident #5 understood others, and made himself understood. Resident #5's BIMS score was 9, which reflected his cognition was moderately impaired. Record review of Resident #5's comprehensive care plan, revised 05/22/26, reflected Resident #5 was PASRR positive for IDD for diagnosis of intellectual disability and developmental disorder of scholastic skills. The care plan interventions included: habilitation and specialized services as requested by resident and staff. habilitation coordination. Record review of Resident #5's PCSP meeting dated 05/13/26 reflected that habilitation coordination and independent living skills services were recommended for Resident #5. Record review of Resident #5's EMR dated 07/01/26 reflected no documentation of habilitation coordination or independent living skills training notes. During a telephone interview on 07/01/26 at 9:01 a.m., the Habilitation Coordinator stated she came to the facility monthly to ensure Resident #5's needs were met. The Habilitation Coordinator stated she had never been told to leave any documentation for the monthly visits. The Habilitation Coordinator stated she particularly did not speak to staff during the visits. During an interview on 07/02/26 at 3:55 p.m., the MDS Coordinator stated she was responsible for ensuring visits were conducted by the Habilitation Coordinator. The MDS Coordinator stated she was not aware when the habilitation coordinator came to visit. The MDS Coordinator stated she did not make a point of contact with the habilitation coordinator because she went straight to the resident. The MDS Coordinator stated the previous MDS Coordinator should have notified the family, LIDDA, and DON 7-10 days prior to give the date and time of the initial and annual meetings. The MDS Coordinator stated she did not know why there were no annual and quarterly meetings held in 2025. The MDS Coordinator stated it was important that documentation was received after every visit for continuity of care, and to ensure the residents received services their entitled too. During a telephone interview on 07/02/26 at 2:23 p.m., the Director of IDD Service stated the habilitation coordinator that was responsible for ensuring quarterly meetings were held was no longer (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the company. The Director of IDD Service stated the nursing facility was responsible for conducting the annual/initial meetings and LIDDA was responsible for conducting the quarterly meetings. The Director of IDD Service stated when the facility became aware that there were no quarterly meetings, they should have notified LIDDA. The Director of IDD Service stated she could not state why the quarterly meetings were not held. The Director of IDD Service stated it was important to ensure meetings were held to ensure the residents' needs were met. During an interview on 07/02/26 at 4:08 p.m., the DON stated she could not recall the exact services Resident #5, should be receiving but she expected some type of documentation to be provided after every visit to show the Habilitation Coordinator was in the building. The DON stated she remembered having trouble with the provider's number during the change of ownership in 2025, but she was not familiar with all the PASRR information and the frequency of meetings. The DON stated she did attend the quarterly and annual meetings. The DON stated the previous MDS Coordinator was responsible for ensuring meetings were held in 2025. The DON stated it was important to ensure documentation was provided during each monthly visit and meetings were held quarterly/annually as required to ensure needs were being met. During an interview on 07/02/26 at 4:40 p.m., the Administrator stated she did not know how often the habilitation coordinator came to the facility. The Administrator stated there was not a system in place to monitor the MDS Coordinator oversight of needs. The Administrator stated the MDS Coordinator was responsible for ensuring quarterly and annual meetings were held. The MDS Coordinator stated she did not know why the meetings were not held. The Administrator stated it was important to ensure documentation was provided, and meetings were held annually and quarterly for continuity of care for their services. Record review of the facility's policy titled Preadmission Screening and Resident Review, revised 06/02/26, reflected. The services to be provide by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination, and the evaluation report should be addressed in the plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs, for 3 of 4 (Resident #12, Resident #3, and Resident #2) residents reviewed for comprehensive resident centered care plan .1.The facility failed to care plan medication for Resident #12 on 04/23/26 which included Eszopiclone (for insomnia), Lexapro (for depression), and Mirtazapine (for appetite and depression).2. The facility failed to care plan medication for Resident #3's on 06/01/26 which included Zolpidem (medication for insomnia).3. The facility did not ensure Resident #2 was measured for diabetic shoes and diabetic insoles per the physician order.These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs.The findings included:1.Record review of Resident #12's face sheet, dated 07/02/26, reflected Resident #12 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental ability that interferes with daily life), anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), malnutrition (your body isn't getting enough calories or the right balance of nutrients to stay healthy), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life).Record review of Resident #12's admission MDS assessment, dated 04/27/26, reflected Resident #12 made herself understood, and was understood by others. Resident #12's BIMS score was an 11 which indicated she had a moderate cognitive impairment. The MDS indicated she received an antidepressant and hypnotic medication during the 7-day look-back period.Record review of Resident #12's comprehensive care plan, dated 04/23/26, did not indicate medication of Eszopiclone for insomnia(hypnotic), Lexapro, and Mirtazapine for depression.Record review of Resident #12?s physician orders dated 04/23/26 indicated Eszopiclone Oral Tablet 2 MG (Eszopiclone), give 1 tablet by mouth at bedtime related to insomnia.Record review of Resident #12?s physician orders dated 04/23/26 indicated Lexapro Oral Tablet 20 MG (Escitalopram Oxalate), give 1 tablet by mouth one time a day related to depression.Record review of Resident #12?s physician orders dated 04/23/26 indicated Mirtazapine Oral Tablet 15 MG (Remeron), give 1 tablet by mouth at bedtime related to protein-calorie malnutrition. Record review of Resident #12 ?s medication administration record dated 06/01/26 through 06/30/26 revealed Resident #12 received: Eszopiclone Oral Tablet 2 MG (Eszopiclone), give 1 tablet by mouth at bedtime related to insomnia , Lexapro Oral Tablet 20 MG (Escitalopram Oxalate), give 1 tablet by mouth one time a day related to depression, and Mirtazapine Oral Tablet 15 MG (Remeron), give 1 tablet by mouth at bedtime related to protein-calorie malnutrition.2. Record review of Resident #3's face sheet, dated 07/02/26 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included Post-traumatic stress disorder also known as PTSD (is a mental health condition triggered by experiencing or witnessing a terrifying event), depression (sadness), and stroke.Record review of Resident #3's admission MDS assessment, dated 06/08/26, indicated Resident #3 understood and was understood by others. Resident #3's BIMS score was 08, which indicated his cognition was severely impaired. The MDS indicated Resident #3 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated she received hypnotic medication during the 7-day look-back period.Record review of Resident #3?s physician orders dated 06/01/26 indicated Zolpidem Tartrate Tablet 5 MG Give 1 tablet by mouth at bedtime related to insomnia. Record review of Resident #12's comprehensive care plan, dated 04/23/26, did not indicate medication of Zolpidem.During an observation and interview on 07/01/26 at 4:22 p.m., the MDS Coordinator said they worked on care plans as a team, but she was ultimately responsible. She looked (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in Resident #12's medical records and did not see a care plan for her Eszopiclone (for insomnia), Lexapro (for depression), or Mirtazapine (for appetite and depression). She looked at Resident #3's care plan and did not see Zolpidem care planned. She said it was an oversight as to why she missed care planning those medications for Resident #12 and Resident #3. She said care plans were done so the staff would know how to care for the residents. She said the risk could have been that the staff would not know she was on the medication and for what to monitor.During an interview on 07/02/26 at 4:31 p.m., the DON said care plans were a team effort with the IDT. She said she and the MDS Coordinator were the overseers. She said they were made aware of any new orders or changes in the morning meetings and the electronic health records dashboard. She said care plans were done to direct and guide care of the residents. She said if care plans were not done properly, care could be missed.During an interview on 07/02/26 at 4:44 p.m., the Administrator said all disciplines should work together to complete a resident's care plan, but the MDS Coordinator was the overseer. She said care plans were the blueprint of residents' care. She said it was used so staff would know the care the residents needed.Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 06/05/25, indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. #13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 3 of 4 residents (Residents #12, Resident #27 and Resident #9) reviewed for quality of care. 1.The facility failed to ensure Resident #12's oxygen was set at 2 liters per nasal cannula as ordered on 04/23/26. 2. The facility failed to ensure Resident #27's oxygen concentrator filter was clean. 3.The facility failed to ensure Resident #27's oxygen tubing and water bottle were changed and dated. 4. The facility failed to ensure Resident #9's oxygen tubing was changed when it was dirty. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Findings included: 1.Record review of Resident #12's face sheet, dated 07/02/26, reflected Resident #12 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included shortness of breath (feeling that you can't get enough air into your lungs), dementia (a decline in mental ability that interferes with daily life), anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #12's admission MDS assessment, dated 04/27/26, reflected Resident #12 made herself understood, and was understood by others. Resident #12 BIMs score was an 11 which indicated she had a moderate cognitive impairment. The MDS indicated Resident #12 received oxygen during the 7-day look back period. Record review of Resident #12's comprehensive care plan dated 05/04/26 indicated Resident #12 had oxygen. The intervention was to apply oxygen at 2 liters via nasal cannula and may titrate up to 4 liters. Record review of Resident #12's physician orders dated 04/23/26 indicated an order for Oxygen at 2 liters per minute via nasal cannula continuously. May titrate up to 4 liters to keep oxygen saturations above 90% every shift. During an observation and interview on 06/29/26 at 12:27 p.m., Resident #12 was up in her chair with no oxygen. No distress noted. Resident #12 said she was wearing oxygen but was not sure when or why they stopped applying it. During an interview on 07/01/26 at 11:24 a.m., LVN H said she was Resident #12 nurse. She said Resident #12 did not wear oxygen. She looked at her physician orders and saw she had an order for oxygen at 2 liters continuously. She said she misread the order as may apply oxygen if oxygen saturations fall below 90%. She said she would apply oxygen and call the physician. She checked her oxygen saturations, and it was at 91%. She said failure to apply oxygen as ordered could lead to respiratory issues. During an interview on 07/02/26 at 5:02 p.m., the DON said the nurses were responsible for ensuring oxygen orders were being followed. She said the clinical nurses were the overseers of oxygen. She (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said failure to apply oxygen as ordered could lead to low oxygen levels which could cause respiratory distress. During an interview on 07/02/26 at 5:50 p.m., the Administrator said if a resident had an order for oxygen, it should be applied. She said the nurses were responsible for ensuring the oxygen was set at the ordered rate, and the DON was the overseers. She said failure to apply oxygen could lead to difficulty breathing. 2. Record review of Resident #27's face sheet dated 7/2/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (decline in memory and thinking skills that interferes with daily life), chronic obstructive pulmonary disease (progressive lung condition that causes difficulty breathing due to damage to the airways), general anxiety (persistent, excessive worrying about everyday matters like health, finances, or family), and shortness of breath. Record review of Resident #27's quarterly MDS assessment dated [DATE] indicated she could make herself understood and she understood others. The MDS also indicated she had a BIMS score of 13 which meant she was cognitively intact. The MDS also indicated she was independent with toileting, dressing, bed mobility, and transfers, and she required set assistance with eating. The MDS also indicated Resident #27 required oxygen therapy while she was a resident. Record review of Resident #27's comprehensive care plan revised 06/24/2026 indicated she had oxygen therapy related to her diagnosis of chronic obstructive pulmonary disease with interventions in place to change oxygen tubing as needed and nebulizer tubing every week. Record review of Resident #27's order summary report dated as of 7/1/26 indicated she had an order for: 1. O2 at 2 liters per minute via nasal cannula. May titrate to 3-4 liters per minute to keep O2 sats >94% as needed for shortness of breath or O2 sats below 90%room air with a start date of 02/02/26 and no end date. 2. Change nebulizer treatment tubing Q week every night shifts every Sunday with a start date of 04/19/26 and no end date. 3. Change O2 tubing as needed with a start date of 04/17/26 and no end date. During an observation and interview on 06/29/26 at 11:06 a.m., Resident #27 was sitting on the side of her bed with oxygen on set at 3 liters per minute. Resident #27 said she wore her oxygen when she was in her room and used a small oxygen machine when she left her room. The oxygen concentrator filter was gray in color and dirty, and the tubing and empty water bottle was dated 5/24/26 as well as her nebulizer mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/30/26 at 9:07 a.m., Resident #27 was sitting on her bed with oxygen on set at 3 liters per minute. She continued to have the same empty water bottle dated 5/24/26 and dirty gray filter on her oxygen concentrator. Resident #27 said the staff usually changed it, but it had not been changed that she could recall. During an observation on 07/01/26 at 11:45 a.m., Resident #27 was sitting in her room and her oxygen concentrator continued to have tubing and empty water bottle dated 5/24/26 and Resident #27 said oh I thought the nurse changed it. Resident #27 said she did not realize it had not been changed and did not want to use a dirty line and filter. Resident #27 said the graveyard shift normally changed it out every and was unsure what had happened for them not changing the oxygen tubing. During an observation and interview on 07/02/26 at 2:35 p.m. with LVN K, Resident #27's nasal canula continued to be dated 05/24/25, a new water bottle was in place dated 6/29/26, and oxygen concentrator filter still gray and dirty. LVN K said some of the oxygen nasal cannulas, water bottles, and respiratory masks were changed on the 2 PM-10 PM shift and some were changed out on the 10 PM to 6 AM so she was unsure of who was responsible. LVN K said the oxygen filter and tubing needed to be changed and the oxygen concentrator filter was dirty. LVN K said the failure placed Resident #27 at risk for infection and LVN K said she would clean the filter and replace the tubing. During an interview on 07/02/26 at 2:51 p.m., the ADON said the nebulizer should be changed out weekly and the oxygen should be changed out when compromised (if it falls on the floor, dirty, or water coming through tubing). The ADON said the oxygen concentrator filters should be changed and cleaned weekly. The ADON said she would have expected Resident #27's tubing and water bottle, dated 5/24/26, to be changed out by 07/02/26, but the oxygen tubing should not have been dated. The ADON said the failure placed Resident #27 at risk for respiratory infection or pneumonia. During an interview on 07/02/26 at 5:11 P.M., the DON said maintenance was responsible for cleaning oxygen concentrator filters, but the nurses could and should clean the oxygen concentrator filters. The DON said the oxygen tubing did not have to be changed out. The DON said the nebulizer mask and tubing should be changed every week. The DON said the failure of the dirty oxygen concentrator filter, and old nebulizer mask placed a risk of for compromising the function of the oxygen concentrator and placed Resident #27 at risk for respiratory infection. During an interview on 07/02/26 at 5:41 p.m., the Administrator said her expectation was for the cleanliness of the oxygen concentrator and tubing to be checked and cleaned as needed. The Administrator said she was unsure about a certain day for the change of the tubing or the filters. The Administrator said the DON was responsible for ensuring the oxygen concentrator tubing and filter were changed and cleaned. The Administrator said the failure placed a risk for Resident #27 breathing in dirty germs. 3. Record review of Resident #9's face sheet dated 07/02/2026 revealed a [AGE] year-old female admitted [DATE] with diagnoses which included COPD (Chronic Obstructive Pulmonary Disease, a progressive, irreversible lung disease that restricts airflow and makes breathing difficult), seizures (sudden, uncontrolled bursts of electrical activity in that brain that affects movement and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consciousness), dysphagia (difficulty swallowing), hypotension (abnormally low blood pressure), major depressive disorder (a mental health condition characterized by a persistent feeling of sadness and loss of interest in normally enjoyable activities). Record review of Resident #9's Quarterly MDS dated [DATE] revealed Resident #9 had unclear speech, was usually understood by others and usually understood what was said to her with a BIMS score of 8 which indicated moderate cognitive impairment. The MDS indicated Resident #9 required a wheelchair for mobility, set-up assistance with eating, moderate assistance in upper body dressing, transfers, and bed mobility, total assistance in toileting and lower body dressing. Record review of Resident #9's physician order dated 08/29/25 indicated O2 at 2 to 4 liters per nasal cannula to maintain PO2 greater than 90% every shift related to Chronic Obstructive Pulmonary Disease, unspecified (J44.9). Resident #9's physicians' orders accessed 06/30/2026 did not reveal an active order to change oxygen tubing as needed. On 07/01/26, the oxygen order was updated to reflect, Change oxygen tubing prn as needed. Record review of Resident #9's care plan with target completion date of 7/1/26 revealed a focus area of COPD and interventions to include Oxygen at 2 to 4 liters per nasal cannula to maintain PO2 (partial pressure of oxygen levels in the blood) greater than 90% with no parameters to monitor or change oxygen tubing. Record review of Resident #9's June MAR revealed an order that read, Change O2 tubing prn as needed dated 05/01/26 and the oxygen tubing was changed on 06/01/26. Observation and attempted interview of Resident #9 on 06/29/26 in the dining room at 1:12 p.m. revealed the resident received oxygen at 2.5 liters per nasal cannula and the oxygen tubing attached to the oxygen concentrator was laying on the floor, and the tubing had a piece of tape that was brown and curled up at the edges and dated 06/22/26. Additional observation of Resident #9 on 07/02/26 at 2:30 p.m. while the resident was in bed revealed the resident received oxygen at 2.5 liters per nasal cannula and the tubing was lying on the floor and observed brown dust in the pattern of wheel markings on the tubing. The oxygen tubing was dated with a piece of tape that was curled up at the edges and dated 06/22/2026. Resident #9 presented with difficult speech and was unable to state when the tubing was last changed or how often it was changed. During an interview on 07/01/26 at 7:50 a.m., LVN H stated that she was not sure who is responsible for monitoring and changing the oxygen tubing. The LVN H stated that everywhere she has worked, the oxygen tubing and masks are changed weekly on the night shift. LVN H stated that the care plan should reflect the use of oxygen and appropriate interventions to ensure adequate infection control. During an interview on 07/02/26 at 10:20 a.m., LVN B stated that the oxygen tubing is changed weekly, when it is dirty, or observed to be hanging on the ground. LVN B stated the staff would date the tubing by putting a piece of tape on the tubing with the date. LVN B stated that residents who are on continuous oxygen should have the tubing changed more frequently, and that the nurse should document when the tubing is changed. LVN B could not recall when she last changed the tubing for Resident #9. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/02/26 at 12;44 p.m., LVN K stated that the oxygen tubing should be changed weekly to prevent condensation build up in the tubing and respiratory distress. LVN K did not know which nurse was assigned to change the tubing. During an interview on 07/02/26 at 3:00 p.m., the DON stated she had been advised, per corporate nursing, to not date the oxygen tubing. She stated that she advised her staff to change the tubing when it is visibly soiled. The DON stated that it is her responsibility to ensure residents have clean oxygen tubing and that the tubing is monitored and changed as needed when visibly soiled. The DON stated that risks to the residents is illness related to inhaling harmful bacteria or mold. The DON stated she would review the current policy with the corporate nurse and complete spot checks to ensure oxygen tubing is clean. During an interview on 07/02/26 at 4:08 p.m., the Administrator stated that nursing staff are ultimately responsible for ensuring the resident oxygen equipment is clean and serviceable. The Administrator stated the residents are at risk for respiratory infection due to unclean tubing. Record review of the facility's policy titled Oxygen Administration and Oxygen Safety, reviewed 03/03/2026, revealed Steps in the Procedure, 11. Cannula / Mask need changed if it malfunctions or becomes visibly contaminated. The Centers for disease Control and Prevention recommends oxygen concentrators be maintained according to the manufacturer's instructions, with special attention to the air intake filters to prevent contamination and ensure safe oxygen delivery. The air intake filter should be inspected and cleaned 1-2 times per week and replaced every 6-12 months or sooner if visibly clogged. The facility policy does not provide guidance for the cleaning of the oxygen concentrator filter.

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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. Based on observation, interview, and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 medication storage area (The Facility Medication Room) reviewed for pharmacy services. The facility failed to keep a record of receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. This failure could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included:During an observation and interview on 07/01/2026 at 08:56 AM, the following medications were observed in the facility medication room underneath a counter in a locked cabinet, that all nurses had a key to, awaiting to be disposed:*Pregabalin 25mg- 24 tablets*Lorazepam 0.5mg- 2 tablets*Tramadol 50mg- 16 tablets * Lorazepam 0.5mg- 56 tablets*Fentanyl 50mcg- 4 patches*Morphine 100mg/5ml -20.75 milliliters*Morphine 100mg/5ml -30 milliliters LVN B said the controlled medications had been under the cabinet for about a week that she could remember. LVN B said all narcotics that were discontinued were supposed to be taken to the DON Immediately to be logged and locked in the DON's office. LVN B said the failure placed a risk for the nurses nor the DON being able to account for the narcotic medications that were discontinued. LVN B said no one counted the medications once they were placed in the medication room in the locked cabinet. LVN B said the cabinet was missing a count sheet for the 30ml bottle of Morphine. She found the count sheet in the narcotic count sheet book folded. During an observation and interview on 07/01/2026 9:20 AM, the DON said her locked area for discontinued narcotic medications was in the ADON's office, and she was the only one who had keys. The DON said she meant to get the discontinued narcotic medications on Monday 06/29/2026, but she forgot. During an observation and interview on 07/01/2026 at 9:26 AM, the DON said her expectation was for the nurses to bring the discontinued medications to her immediately after the medications were removed from the medication cart so that she could reconcile the medications and lock the medications in her double locked area in the ADON office immediately. The DON said she normally checked with the nurses on Monday, Wednesday, and Friday mornings to ensure the narcotic medications were reconciled properly. The DON said the failure placed a risk for drug diversion. During an interview on 07/02/2026 at 5:46 PM, the Administrator said when the narcotic medications were discontinued and removed from the medication cart, they should be taken to the DON immediately. The Administrator said the DON was responsible for making sure there were no controlled medications stored in the medication room. The Administrator said the failure placed a risk for the medications not being discarded properly and the DON not having an account for the controlled medication and how many there were. Record review of the facility's policy, revised 06/24/2026, Controlled Substance: Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.1. Only authorized licensed nursing and/or pharmacy personnel have access 10 Schedule 11 controlled substances maintained on premises.13. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. 14. Accountability records for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal), as reviewed 1.The facility failed to ensure [NAME] E followed the recipe for preparing mechanical diets for Resident #2 on 06/29/26.2.The facility failed to ensure Dietary Manager C followed the recipe by using the correct scoop size when for preparing pinto beans and sausage for the puree lunch on 06/30/26.These failures could place residents at risk for choking, weight loss, not having their nutritional needs met, and a decreased quality of life. 1. Record review of Resident #2's face sheet, dated 07/02/26, reflected Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included morbid (a chronic disease characterized by a body mass index of 40 or higher accompanied by severe weight-related health complications) (severe) obesity due to excess calories and unspecified protein-calorie malnutrition. Record review of Resident #2's quarterly MDS assessment, dated 04/03/26, reflected Resident #2 made himself understood, and understood others. Resident #2's BIMS score was 9, which reflected his cognition was moderately impaired. Resident #2 required setup or clean-up assistance with eating. Record review of Resident #2's comprehensive care plan, revised on 04/08/26, reflected Resident #2 had an ADL self-care performance deficit related to generalized weakness. The care plan interventions included required setup or clean-up assistance with eating. Record review of Resident #2's physician order dated 04/22/26, reflected: Regular diet Mechanical soft texture, and thin consistency, related to dysphagia. During an observation on 06/29/26 at 12:20 p.m., Resident #2 was sitting at the table and had a mechanical diet which consisted of stuffed bell peppers, and okra. He did not have gravy on his meats.During an interview on 06/29/26 at 12:23 p.m., [NAME] E said Resident #2 should have had gravy on his mechanical bell pepper. During an interview and observation on 06/29/26 at 12:30 p.m., Dietary Manager C said Resident #2 should have had gravy on his mechanical bell pepper. She looked at the policy, and it indicated mech soft meats should have some type of liquid consistency on it.During an interview on 06/29/26 at 12:58 p.m., [NAME] E said she was not sure where the menu was for lunch or what scoop size she should use. She said she had been the cook about a month and no one, even the dietitian, had said anything to her about the scoop size. She said she used a large spoon for the puree and the green scoop for the regular and mech soft. She said she did not know the scoop size of either spoon. She said she just served whatever scoop she had.During an interview on 06/29/26 at 12:59 p.m., Dietary Manager C said she was not sure where the extended menus were. She said she was not sure of the serving size that should have been served for the regular, mech soft or puree lunch served which consisted of stuffed bell pepper and okra. Dietary Manager C called a sister facility or the dietitian and was told the scoop size should have been 4 oz for the mech soft of bell pepper and okra. She said the regular should have received 1 stuffed bell pepper and 4 ounces of okra.During an interview and observation on 06/29/26 at 1:17 p.m., [NAME] E and the surveyor took the correct size scoop which was a 4 ounce and measured the mech soft bell pepper and compared it to the utensils used and it measured 3 ounces. The okra was measured and it measured 4 ounces, which was the correct serving size. She said not serving the correct size could lead to weight loss2. During an observation on 06/30/26 at 12:12 p.m., the Dietary Manager gave 2 scoops of pinto beans and sausage combination using a 4-ounce scoop for 2 residents who required a puree diet.During an interview on 06/30/26 at 12:56 p.m., Dietary manager C said she gave 2 scoops of pinto beans and sausage using the 4-ounce scoop. She said she was supposed to give 6 ounces The surveyor asked about the dietary spreadsheet to verify the serving size and the Dietary Manager could not locate the spreadsheet.During an interview on 07/02/26 at 9:21 a.m., the Registered Dietitian said the correct serving size should be used with all meals. She said kitchen staff should be using the spread sheet (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when serving to ensure they were following the recipe and serving size. The Registered Dietitian said the spreadsheet indicated what size serving of pinto beans and sausage was supposed to be used. She said the spread sheet also indicated that mechanical diets required gravy on their meat. The Registered Dietitian said she had made a visit on 06/26/26 at the facility and the staff were not using the menu spreadsheet and she did a verbal educated with Dietary Manager C. The Registered Dietitian said the Dietary Manager was responsible for ensuring the cooks and Dietary Manager followed the menu serving size. The registered Dietitian said mechanical diets required some type of liquid on their meats such as gravy to help with swallowing. The Registered Dietitian said it was important to follow the recipe and serve the correct serving size to ensure the residents did not have any swallowing or weight loss issues. During an interview on 07/01/26 at 1:29 p.m., Dietary Manager F said the Dietary Manager C was supposed to serve 6 ounces of pinto beans and sausage for the lunch menu on 06/30/26. He presented the dietary spread sheet, and it revealed 6 ounces of pinto beans and sausage were supposed to be served to the puree residents. He said if Dietary Manager C served 2 scoops of 4- ounces, she did not serve enough. Dietary Manager F said all mech soft should have some type of liquid added to their meats. He said it was part of the menu. Dietary Manager F said not following the serving size or providing enough protein could cause weight loss. He said if the mech soft did not have some type of liquid such gravy it could cause swallowing or choking problems.During an interview on 07/02/26 at 5:05 p.m., the DON said she expected the dietary staff to use the correct serving size so residents could receive the correct portions. She said if mechanical soft diets required some type of gravy or sauce on their food, she expected it to be on the food. The DON said failure to use the correct serving size placed residents at risk for not receiving the nutrition intended. She said failure to have gravy or sauce on mechanical soft diets could cause choking or swallowing issues. The DON said the Dietary Manager was responsible for following the recipe and ensuring the correct serving size and was being used to serve the residents' meals. During an interview on 07/02/26 at 5:52 p.m., the Administrator said she expected the dietary staff to read the menu and use the correct serving size. She said if the menu called for gravy or sauce on residents who required a mechanical soft diet then she expected it to be on the trays. The Administrator said the Dietary Manager was responsible for ensuring the correct serving size was being used when serving the meals. The Administrator said failure to serve the correct serving size or food that required gravy could affect the resident's overall health and well-being.Record review of the facility's policy titled, Menu Planning, revised 08/2017, indicated, Policy: Menu shall be preplanned to include a variety of foods that are nutritionally adequate, attractively prepared, and appetizing. Procedure: The Dietary Manager is responsible for using approved standardized menus to meet the resident nutritional needs and to sustain product consistency and portion control.Record review of the facility's policy titled, Food and Nutrition Services, revised 06/23/25, indicated, Policy Statement: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. #7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. The food appears palatable and attractive, and it is served at a safe and appetizing temperature.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 4 of 18 residents (Resident #28, and 3 anonymous) and 1 of 1 lunch meals reviewed for palatability. The facility failed to provide palatable food served at an appetizing temperature or taste for Resident #28, and 3 anonymous residents, who complained the food served was mushy, cold, and hard.The dietary staff failed to provide food that was palatable for the lunch meal observed on 06/30/26.These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included:During an interview on 06/30/26 at 11:28 a.m., Resident #28 said the vegetables were mushy and the food was cold.During an observation and interview on 06/30/26 at 1:30 p.m., the DON and six surveyors sampled a lunch tray. The sample tray consisted of Pinto beans with sausage, rice, and mixed vegetables. The DON said the sampled regular and puree diet did not meet her expectations with flavor or temperature. She said the Pinto beans with sausage and mixed vegetables could be warmer, and the rice and mixed vegetables were bland. She sampled the puree Pinto beans with sausage and rice, and mixed vegetables and said they were cold. During a confidential resident group meeting 3 residents stated the food was cooked hard. They said they could tell when the Dietary Manager cooked.During an interview on 06/30/26 at 4:36 p.m., Dietary Manager C said she had not had complaints about food but had only been employed for about 3 weeks. She said if the residents did not like the food, they may not eat it, which could cause weight loss.During an interview on 07/02/26 at 9:06 a.m., the Dietitian said she was not aware of any food concerns. She said she did talk to residents when she visited the facility. She said if residents did not like the food it could potentially cause weight loss.During an interview on 07/02/26 at 5:05 p.m., the DON said she expected the temperature to be within parameters and taste should be palatably. She said it was the Dietary Manager's responsibility to ensure the food was palatable. She said if the residents thought the food was too cold, bland, or hard they may not consume enough which could lead to weight loss.During an interview on 07/02/26 at 5:52 p.m., the Administrator said she expected the food to be palatable. She said the Dietary Manager was responsible for ensuring the food served was palatable and served at an appetizing temperature. She said failure to serve palatable food could cause weight loss. Record review of the facility's policy titled, Food Preparation and Service, revised 03/05/26, indicated, Policy: Food and nutrition service employees prepare and serve food in a manner that complies with food handling practices. #4 Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food Service/Distribution: #4 Food and nutrition service staff, including nursing service personnel, wash hands before serving food to residents. #6 Bare hand contact with food is prohibited. Gloves are worn when handling food directly and change between tasks. #7. Food and nutrition service staff wear hair nets (hair net, hat, restraints, etc.) so that hair does not contact food.Record review of the facility's policy titled, Menu Planning, revised 08/2017, indicated, Policy: Menu shall be preplanned to include a variety of foods that are nutritionally adequate, attractively prepared, and appetizing. Procedure: The Dietary Manager is responsible for using approved standardized menus to meet the resident nutritional needs and to sustain product consistency and portion control.Record review of the facility's policy titled, Food and Nutrition Services, revised 06/23/25, indicated, Policy Statement: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. #7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. The food appears palatable and attractive, and it is served at a safe and appetizing temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services. The facility did not ensure:1. Food items were labeled and dated.2. Hair restraints were worn correctly. 3. Hand washing was always performed. 4. The floors, bowls, saucers, pots/pans, and stove were cleaned.5. The microwave was clean and free of food debrisThese failures could place residents at risk for foodborne illness.Findings included: During the initial tour observation and interview with the Dietary Manager on 06/29/26 beginning at 10:35 a.m., revealed the following: 1.1 container of melons and 2 juice containers were undated in the refrigerator. 2. Dietary aide L and Dietary Manager C had hair sticking out of their hairnets.3. [NAME] F and Dietary aide N came into the kitchen and did not wash their hands, and no pedal trash can was next to the sink.4. Dirty bowls and saucers were stacked in the clean area but were dirty, pots/pans and stove were dirty with black buildup, and floors in the storage room were dirty and had an ice cream cup and a prefilled juice cup under the bottom shelves.5. The microwave was dirty and had food in it.During an observation on 06/29/26 at 10:35 a.m., Dietary Aide N and the Dietary Manager C hairnets were not covering their entire head. There was loose hair sticking out. During an observation and interview on 06/30/26 at 12:56 p.m., Dietary Aide N said she should have all her hair in the hair net. She said she did not know it was sticking out. Dietary aide L fixed her hairnet. She said all her hair should be completely covered with the hairnet to prevent food from getting into the food. Dietary Aide N said she did go out of the kitchen and returned without washing her hands. She said she knew she was supposed to wash her hand to prevent cross contamination.During an interview on 06/30/26 at 1:36 p.m., Dietary Manger C said hairnet should be worn while in the kitchen. She said all hair should be always covered. She said her hair should be in a hairnet to prevent food from getting into food. She said staff should be washing their hands when they enter the kitchen. She said she took the pedal trash can outside to clean it and had not brought it back inside. She said she knew they should have had the pedal trash can next to the sink to prevent cross contamination.During an interview on 06/30/26 at 3:56 p.m., [NAME] F said all staff were responsible for dating food products. [NAME] F said hair nets should always be worn while in the kitchen and covered the entire head without loose hair sticking out. [NAME] F said she should have washed her hands when she entered the kitchen and as needed between different work areas while in the kitchen. She said these failures could potentially put residents at risk for foodborne illness and cross contamination. During an interview on 07/01/26 at 8:54 a.m., Dietary Manager D said handwashing should be done every time staff leave or enter the kitchen, between every task, and after washing dishes. He said this was done for sanitization and to prevent the spread of germs. He said hairnet should be worn in the kitchen and should not have any hair out the hairnet to prevent hair from getting into the food. He said staff should have a foot pedal trash can to dispose of trash without having to lift the lid to prevent contamination. He said dirty dishes should not be stored with clean dishes, the microwave should be clean, and the floors should be clean and without debris. Dietary Manager D said the kitchen and staff should be clean to prevent foodborne illness and cross contamination.During a telephone interview on 07/02/26 at 9:23 a.m., the Dietitian said the kitchen should be clean and organized. She said staff should be sweeping and mopping each shift and as needed The Dietitian said the dirty dishes should not be stored with clean dishes and the microwave should be cleaned after each use. She said pot/pans and the stove should not have black buildup on them. She said this could prevent the food from cooking evenly. The Dietician said staff who entered the kitchen should wash their hands and use a step trash can to discard their paper towels. She said they should have a step lid to prevent contamination. She said whoever put the food or items up in the refrigerator was responsible for dating them. She said this was done to prevent residents from eating or receiving expired food or items. The Dietician said (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hair nets should always be worn while in the kitchen and covered the entire head without loose hair sticking out. The Dietician said these failures could potentially put residents at risk for foodborne illness and cross contamination.During an interview on 07/02/26 at 5:05 p.m., the DON said cleanliness was important in the kitchen, so the staff were not spreading germs or contaminating anything. The DON said the Dietary Manager was responsible for making sure the kitchen was cleaned appropriately. The DON said all food should be dated by the date received. The DON said hair nets should be worn while in the kitchen and covering the entire head without loose hair sticking out. The DON said dirty dishes should not be stored with clean dishes. The DON said these failures could potentially put residents at risk for cross contamination and food borne illness. During an interview on 07/02/26 at 5:50 p.m., the Administrator said she expected staff to wash their hands when entering the kitchen and in between as needed, food to be dated, and hair nets to be worn without loose hair sticking out. The Administrator said she expected the kitchen to always be clean. She said clean bowls and dishes should be stored with clean dishes. She said pots/pans and the stove should not have black buildup on them. The Administrator said they should have a pedal trash can to prevent cross contamination. The Administrator said the Dietary Manager was responsible for monitoring and overseeing the kitchen. The Administrator said these failures could potentially put residents at risk for cross contamination, and food borne illness. Record review of the facility's policy titled, Food Preparation and Service, revised 03/05/26, indicated, Policy: Food and nutrition service employees prepare and serve food in a manner that complies with food handling practices. #4 Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food Service/Distribution: #4 Food and nutrition service staff, including nursing service personnel, wash hands before serving food to residents. #6 Bare hand contact with food is prohibited. Gloves are worn when handling food directly and change between tasks. #7. Food and nutrition service staff wear hair nets (hair net, hat, restraints, etc.) so that hair does not contact food.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption for 2 of 2 residents (Resident #19 and Resident #37) reviewed in that: The personal refrigerators of Resident #19 and Resident #37 revealed temperatures were outside of the recommended guidelines and Resident #37 did not have a thermometer in his freezer. This failure could place residents at risk of foodborne illness due to consuming spoiled foods. The finding included: Record review of Resident #19's face sheet dated 07/02/2026 revealed an [AGE] year-old male admitted [DATE] and readmitted [DATE]. His diagnoses included Schizoaffective disorder bipolar type (a chronic mental health condition that combines the severe, reality-distorting symptoms such as hallucinations and delusions with mood swings of mania and depression), Benign Prostatic Hyperplasia (non-cancerous enlargement of the prostate gland), and protein calorie malnutrition (a severe condition caused by the inadequate intake of protein, calories or both). Record review of Resident #19's Comprehensive MDS dated [DATE] revealed adequate speech, hearing and communication skills and a BIMS Score of 11 which indicated moderate cognitive impairment with fluctuating inattention and disorganized thinking. The MDS indicated Resident #19 required the use of a walker for mobility, was independent in eating, toileting, dressing, bed mobility and transfers and required setup assistance with bathing. Record review of Resident #19's care plan with target completion date of 08/25/2026 revealed a focus area of Obsessive-Compulsive Disorder (a mental health condition characterized by uncontrollable, recurring thoughts and repetitive behaviors) that indicated Resident #19 will save food for 203 days and then say it is too hard. Interventions do not indicate that the personal refrigerator was monitored for expired foods, dated foods or temperatures within acceptable parameters. Record review of physician's orders revealed a regular diet with no restrictions. During an interview with Resident #19 and observation of personal refrigerator on 06/29/2026 at 11:10 a.m., Resident #19 stated that the girl checks my refrigerator every day. Observation of the personal refrigerator revealed that the refrigerator was clean, contained 3 unsealed and undated clear cups with approximately 4 ounces of milk, 7 closed bottles of grape juice with manufactures expiration of June 2028 and thermometer gauge revealed 50 degrees. Interview and observation with Resident #19 on 07/01/2026 at 10:15 a.m. revealed 2 undated and unsealed clear cups containing approximately 4 ounces of milk, 6 closed bottles of grape juice with manufactures expiration of June 2028 and thermometer gauge at 52 degrees. Resident #19 pointed to the cups of milk and stated, these will be gone by tonight. Interview and observation with Resident #19 on 07/02/2026 at 10:10 a.m., Resident #19 stated, I think she already checked my refrigerator today. Observation of refrigerator contents revealed 2 unsealed and undated clear cups with approximately 4 ounces of milk, 5 bottles of grape juice with manufactures expiration of June 2029 and thermometer gauge revealed 50 degrees. Record review of the temperature log for Resident #19's personal refrigerator from 05/01/2026 - 05/31/2026 revealed temperatures outside of recommended parameters ranging from 42-52 degrees for 20 days, 11 days with no temperature documented. The temperature log was completed by the Activity Director. Record review of the temperature log for Resident #19's personal refrigerator from 06/01/2026 - 06/30/2026 revealed temperatures outside of recommended parameters ranging from 41-53 degrees for 18 days, acceptable parameters ranging from 38-41 degrees for 4 days and 9 days with no temperature documented. The temperature log was completed by the Activity Director. Record review of Resident #37's face sheet dated 07/02/2026 revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE]. His diagnoses included multiple sclerosis (an autoimmune disease that affects the central nervous system, leading to damage of the nerve fibers), paraplegia (paralysis of the legs and lower body), atrial fibrillation (irregular heart rhythm), major depressive disorder (a mental health condition characterized by (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	persistent feelings of sadness, loss of interest that intrudes upon daily life), hypertension (high blood pressure) and neurogenic bowel (a condition in which nerve problems prevent normal bladder control, affecting the ability to store or release urine properly). Record review of Resident #37's Quarterly MDS dated [DATE] revealed adequate speech, hearing and communication skills and a BIMS Score of 12 indicating moderate cognitive impairment. The MDS indicated Resident #37 had upper and lower extremity impairment and required the use of a wheelchair for mobility, was dependent in eating, toileting, bathing, dressing, bed mobility and transfers. Record review of Resident #37's care plan with target completion date of 07/01/2026 revealed no preference for personal food items or use of personal refrigerator. Record review of Resident 337's physician's orders revealed a regular diet with double portions. During an observation of room [ROOM NUMBER]A, observation of refrigerator #1 on 06/29/2026 at 11:18 a.m. revealed a box of corn dogs (unopened with manufactures expiration date of May 2028), a box of tacos (opened with 4 tacos remaining with a manufactures expiration date of August 2028) and refrigerator items that included condiments of miracle whip, mustard and jelly with current manufactures expiration dates. The freezer in refrigerator #1 did not have a thermometer. The thermometer gauge in refrigerator #1 revealed 51 degrees. Observation of refrigerator #2 revealed contents to include a store-bought cake with expiration date that was illegible and a thermometer gauge revealed 62 degrees. Observation and interview on 07/01/2026 at 10:42 a.m. revealed the same food items in refrigerator #1 and refrigerator #2. Refrigerator #1 temperature gauge revealed 60 degrees and refrigerator #2 temperature gauge revealed 52 degrees. Resident #37 stated that both refrigerators belonged to him, that his family provided the food items and that he had never been ill because of spoiled food items. Record review of the temperature log for Resident #37's personal refrigerator from 05/01/2026 - 05/31/2026 revealed temperatures outside of recommended parameters ranging from 42-52 degrees for 9 days, acceptable parameters ranging from 36-41 degrees for 11 days, and 11 days with no temperature documented. Record review of the temperature log for Resident #37's personal refrigerator from 06/01/2026 - 06/30/2026 revealed temperatures of 32-42 degrees for 22 days and 8 days with no temperature documented. The temperature log for Resident #37 reflected only one refrigerator although there were two refrigerators in his room and did not reflect the temperature log for the freezer. The temperature log was completed by the Activity Director. During an interview on 07/01/2026 at 8:07 a.m., the Activity Director stated that she checks the personal refrigerators every day for cleanliness and temperature check and that she checks to ensure the temperature gauge range was between 32-40 degrees. The Activity Director stated she checks some of the food for dates and will ask the resident when the food was received if there was no date and throw it away if it was too long. She stated she was not aware of any resident getting sick because their food was spoiled. The Activity Director could not say why she did not report the temperatures obtained were outside of the recommended parameters. During an interview on 07/01/2026 at 9:05 a.m., CNA G stated that she was not sure who monitored the residents' personal refrigerators and that she was not aware of any time when the residents were sick because of spoiled food. During an interview on 07/01/2026 at 9:10 a.m., CNA L stated that the Activity Director checks the refrigerators for expiration dates of food items and that she did not know what a recommended temperature for the refrigerator was. During an interview on 07/02/2026 at 10:20 a.m., LVN B stated that the night shift nurse and the Activity Director check the refrigerators for acceptable temperatures. LVN B stated she was not sure what an acceptable temperature for the refrigerator or freezer was and that risks to residents would be food poisoning if the food was not properly stored. During an interview on 07/02/2026 at 3:00 p.m., the DON stated that the Activity Director was responsible for ensuring and logging the temperature logs of the resident's personal refrigerators. The DON stated the risk for of not following the policy guidelines for acceptable temperatures would be the residents could consume spoiled food items. During an interview on 07/02/2026 at 4:08 p.m., the Administrator stated that she expected the facility staff to follow the recommended temperature guidelines as designated in the personal refrigerator policy. The (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator stated the risk would be residents consuming spoiled food items that could make them ill. The Administrator stated she was not aware that the personal refrigerator temperature logs did not reflect acceptable parameters or that one of the freezers did not have a thermometer and that she would review the policy with the Activity Director. Record review of the facility Personal Refrigerator Policy, reviewed 03/03/2026, revealed Temperature Control, the refrigerator compartment should be maintained at temperature of 35-41 degrees, and the freezer compartment should be maintained at zero degrees or less; and Cold Food Storage revealed food products should be stored by Commonly Used Dates such as Sell by and Best Buy. The refrigerator policy does not reflect the need to date or label items that are not stored in the original container. Additionally, the refrigerator policy revealed that the housekeeping staff can assist the resident or family member by inspecting the refrigerators at least weekly and assist with the removal of outdated food items and cleanliness.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 18 residents (Resident #2) reviewed for foot care. The facility did not ensure Resident #2 was measured for diabetic shoes and diabetic insoles per the physician order. This failure could result in residents developing fungal infections or other podiatric problems. Findings included: Record review of Resident #2's face sheet, dated 07/02/26, reflected Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar) Record review of Resident #2's quarterly MDS assessment, dated 04/03/26, reflected Resident #2 made himself understood, and understood others. Resident #2's BIMS score was 9, which reflected his cognition was moderately impaired. Record review of Resident #2 comprehensive care plan, revised on 04/08/26, reflected Resident #2 had diabetes mellitus. The care plan interventions included: check all of body for breaks in skin and treat promptly as ordered by the doctor. Record review of Resident #2's order summary report, dated 06/09/26, reflected: physical therapy to measure, order, and dispense diabetic shoes, three pairs of heat molded/custom molded diabetic insoles. During an interview on 06/30/26 at 8:29 a.m., Resident #2 stated he did not recall someone from therapy talking to him about diabetic shoes. During an interview on 07/01/26 at 9:35 a.m., LVN B stated the podiatrist (a medical professional who helped with problems that affect the feet or lower legs) had come to the facility on [DATE] to see Resident #2 and wrote an order for physical therapy to measure and order diabetic shoes and insoles. LVN B stated she gave the order to the Director of Rehabilitation on 06/09/26. LVN B stated the ADON was responsible for following up on the order to ensure the order was followed through. LVN B stated it was important that Resident #2 was measured for diabetic shoes to prevent open areas. During an interview on 07/01/26 at 10:52 a.m., the Director of Rehab stated there was a miscommunication between her and the podiatrist. The Director of Rehab stated LVN B had notified her around 06/17/26 that there was a new order for a physical therapy eval for diabetic shoes. The Director of Rehab stated she should have called the podiatrist office right away to collaborate on how to go about getting the custom fit diabetic shoes. The Director of Rehab stated she was not aware the resident had not been seen until the state surveyor intervention. The Director of Rehab stated it was important Resident #2 was measured for diabetic shoes to protect his feet from any chances of skin tears. During an interview on 07/01/26 at 11:00 a.m., the ADON stated the podiatrist completed the order form and gave it to her on 06/09/26. The ADON stated she gave the order to LVN B, and LVN B gave it to the Director of Rehab. The ADON stated her, LVN B, and the Director of Rehab discussed on 06/09/26, that therapy did not evaluate residents for diabetic shoes. The ADON stated the Director of Rehab should have reached out to the podiatrist office to see what the next was. The ADON stated she should have followed up to see what needed to be done to get Resident #2 to be evaluated for diabetic shoes. The ADON stated it was important Resident #2 was measured for diabetic shoes to prevent foot ulcers. During an interview on 07/02/26 at 4:08 p.m., the DON stated the Director of Rehab should have contacted the podiatrist office and found a solution, and the ADON should have followed up with the Director of Rehab since she had the original order. The DON stated she monitored orders by clinical morning meeting, and from her understanding, the podiatrist was contacted and they were waiting for further instruction. The DON stated it was important Resident #2 was measured for diabetic shoes to prevent any foot problems. During an interview on 07/02/26 at 4:40 p.m., the Administrator stated she expected orders to be followed. The Administrator stated therapy was responsible for ensuring Resident #3 received diabetic shoes. The Administrator stated if the Director of Rehab was unable to do the evaluation, he/she should have (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified the podiatrist office to see what steps should have been taken. The Administrator stated there was no system for monitoring therapy eval to ensure orders were being followed through. The Administrator stated it was important Resident #2 was measured for diabetic shoes to prevent open sores. During an interview on 07/02/26 at 6:04 p.m., the DON stated there was not a policy and procedure regarding following physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to ensure the environment was as free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents for 2 of 2 halls (east hall and west hall) reviewed for quality of care. The facility failed to ensure the shelves located on the east hall and west hall were free from rough edges. These failures could place residents at risk of accidents that could result in injury or harm.Findings included: During an observation on 06/30/2026 at 11:15 AM, the east hall had shelving attached directly to the hall wall that had jagged, rough edges. During an observation on 06/30/2026 at 11:22 AM, the west hall had shelving attached directly to the hall wall that had jagged, rough edges. During an interview on 06/30/2026 at 11:28 AM, the Maintenance Supervisor said he was aware that the shelves on the east and west halls had jagged, rough edges, but it was because he did not have time to sand the edges of the shelves. The Maintenance Supervisor said he placed the shelves on the east and west halls, and had planned to place doors on the outside of the shelves. The Maintenance Supervisor said he had been busy doing other things around the facility, but the Administrator did instruct him to remove the shelves after the surveyor's intervention until he was able to sand the shelves. The Maintenance Supervisor said the failure placed a risk for staff, residents, and visitors to get skin tears. During an interview on 07/01/2026 at 5:19 PM, the ADON said she was aware that the shelving on east and west wings were painted and replaced but she did not realize the edges were rough and jagged. The ADON said the failure of replacing the shelving without sanding the edges could have caused skin tears for staff, visitors, or residents. During an interview on 07/02/2026 at 5:03 PM the DON said she was made aware after the surveyors found the shelves on the east and west halls and she noted the shelves had jagged rough edges on them. The DON said she immediately went and reported the problem to the Administrator. The DON said she was unsure how long the shelves on the east and west wings had been replaced, but the failure placed a risk for residents and staff to get splinters as well as skin tears or cuts. The DON said the Maintenance Supervisor was responsible for ensuring the shelves were sanded prior to painting so that there were no sharp or splintered edges on either shelf. During an interview on 07/02/2026 at 5:36 PM, the Administrator said the areas on the east and west halls were cubby holes (open storage areas in the wall) where the facility was looking to store resident items. The Administrator said she expected the shelves on the east and west halls to be sanded prior to painting and then covered. The Administrator said the Maintenance Supervisor had steps left to sand the shelves jagged, rough edges down, and then to place doors over the storage area. The Administrator said the failure placed a risk for staff, visitors, and residents to acquire cuts or scratches. Record review of the undated facility policy Safety Guidelines indicated Policy: Staff shall follow procedures to ensure safe working environment while performing maintenance-related tasks.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #4) reviewed for quality of care. The facility failed to ensure Resident #4's physician's order for his enteral feedings (a form of nutrition that is delivered into the digestive system as a liquid form via the feeding tube) indicated the strength of the enteral feed and the specific administration method.This failure could affect residents receiving enteral nutrition and hydration and place them at risk of dehydration, weakness and malnutrition.Findings included:Record review of Resident #4's face sheet, dated 07/02/26, reflected Resident #4 was a [AGE] year old male, admitted to the facility on [DATE] with diagnose which included gastrostomy status (the presence of a surgically placed feeding tube through the abdomen), unspecified protein-calorie malnutrition and sequelae of protein-calorie malnutrition (long-term physical complications resulting from severe past malnutrition). Record review of Resident #4's significant change in status MDS assessment, dated 06/03/26, reflected Resident #4 rarely/never made himself understood, and sometimes understood others. The assessment did not address Resident #4's BIMS score but reflected he had long term and short-term memory problems. Resident #4 had a feeding tube and had not had any weight loss/gain of 5% or more in the last month or 10% or more in the last 6 months. Record review of Resident #4's comprehensive care plan, revised 05/11/26, reflected Resident#4 required tube feeding related to dysphagia (difficulty swallowing). The care plan interventions indicated the administration of tube feeding per physician orders. The order changed on 6/19/2026 to Isosource (nutrition supplement) 1.5 cal, 300 mL four times daily (providing 425 kcals and 20.4 g of protein per feeding), with a revision to the care plan on 06/30/2026 and water flushes per MD order. Record review of Resident #4's physician order summary report, dated 06/30/26 reflected an active physician order for enteral feed four times a day; give IsoSource 300ml 4 times a day via g-tube. This order omitted the required formula strength of Isosource and the specific administration method (bolus or pump). Record review of the hospice physician orders dated 6/19/2026 revealed a more specific directive: Isosource 1.5; 4 x day. The facility failed to transcribe the 1.5 strength or clarify the delivery method onto the current eMAR. During an interview on 6/30/2026 at 11:04 a.m., the MDS Coordinator stated nursing staff had been administering Isosource 1.5 cal bolus feeding via g-tube. During an interview and record review on 07/02/26 at 9:35 a.m., after reviewing Resident #4's electronic medical record, LVN B stated the order was missing the strength and administration method. LVN B stated the DON was responsible for ensuring the strength and administration method was in the order when she put the order in and the nurses that provided care to him were also responsible. LVN B stated the order should have specified 1.5 Cal for the strength and bolus for the administration method. LVN B stated it was important the five rights were followed through to prevent harm to the residents, medication error as well as aspiration. During an interview on 06/30/26 at 4:25 p.m., after reviewing Resident #4's electronic medical record, the DON stated the order was missing the strength and administration method. The DON stated when she updated the original order to add the nurse could use another brand if the Isosource was not available she specifically remembered adding the strength of 1.5 Cal, but could not recall if she added the administration method. The DON stated she reviewed the orders in clinical morning meetings, but could not recall specifics. The DON stated it was important the strength and administration methods were noted in the order to prevent potential adverse effects. During an interview on 07/02/26 at 4:40 p.m., the Administrator stated she expected strength and administration method to be stated on the order. The Administrator stated the person that put in the order was responsible. The Administrator stated the DON, or designee, was responsible for monitoring and overseeing physician orders to ensure (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accuracy. The Administrator stated she was not clinical, and did not know what could happen medically. Record review of the facility's policy Enteral Nutrition reviewed 03/03/2026, reflected . Adequate nutritional support through enteral nutrition is provided to residents as ordered . 11. The Nurse confirms that orders for enteral nutrition are complete. Complete orders include: the enteral nutrition product; Administration method (continuous, bolus, intermittent) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 1 of 18 residents (Resident #28) reviewed for storage and labeling of medications and 1 of 2 (East Hall nurse) medication carts reviewed for storage of medications. 1. The facility did not ensure Resident #28's Triamcinolone Acetonide cream (corticosteroid used to reduce inflammation, redness, and itching) was properly secured.2. The facility failed to ensure LVN M locked the east hall nurse's cart when left unattended in the hallway. These failures could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications. Findings included: 1. Record review of Resident #28's face sheet, dated 07/02/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #28's annual MDS assessment, dated 06/17/26, reflected Resident #28's made himself understood, and understood others. Resident #28's BIMS score was 11, which reflected his cognition was moderately impaired. Record review of Resident #28's comprehensive care plan, initiated 02/26/26, reflected Resident #28 had discoloration to his bilateral lower extremities. The care plan interventions included: monitor for breaks in the skin and report to MD if noted and monitor for edema and increased redness. Record review of Resident #28's order summary report, dated 07/02/26, reflected there was no order for Triamcinolone Acetonide cream 0.5%. During an interview and observation on 06/29/26 at 11:38 a.m., a tube that was labeled Triamcinolone Acetonide cream 0.5%, was observed on Resident #28's bedside table. Resident #28 stated a nurse gave him the cream to put on his legs for the rash. Resident #28 was unable to recall the nurse's name. During an interview and observation on 07/02/26 at 9:28 a.m., the Triamcinolone Acetonide 0.5% was observed on Resident #28's bedside table with CNA G. CNA G stated during her rounds, she did not see the cream on his bedside table. CNA G stated all staff were responsible for ensuring items were stored properly and securely. CNA G stated creams should be stored in the medication cart. CNA G stated it was important to ensure medications were not left on the bedside table for residents' safety. During an interview and observation on 07/02/26 at 9:35 a.m., LVN B stated she did not see the cream on Resident #28's bedside table. LVN B stated Resident #28 could not apply the cream to his legs. LVN B stated all staff were responsible for ensuring medications were not stored at bedside. After reviewing Resident #28's electronic medical records, LVN B stated Resident #28 did not have an order for the cream and she did not know who gave it to him. LVN B stated an order must be obtained first, and the medication should be stored in the treatment cart. LVN B stated it was important to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure medications were not left on the bedside table for residents' safety. During an interview on 07/02/26 at 4:08 a.m., the DON stated she did not know where Resident #28 got the cream from, because he did not have an order for the cream. The DON stated she expected medications to be stored on the medication cart. The DON stated nursing staff were responsible for ensuring medications were not stored at bedside by observing during rounds. The DON stated she was responsible for monitoring and overseeing by entering random residents' rooms and making observations. The DON stated it was important to ensure medications were not on the bedside table for residents' safety. During an interview on 07/02/26 at 4:40 p.m., the Administrator stated she expected an order for the cream. The Administrator stated medications should be locked/secured on the medication cart. The Administrator stated nursing staff should be ensuring medications were not left at bedside. The Administrator stated she monitored medications at bedside by random spot checks. The Administrator stated it was important to ensure medications were not left at bedside for resident safety. 2. During an observation and interview on 06/30/2026 at 11:45 AM, LVN M gathered supplies to check a resident's blood sugar, closed the east hall nurse's cart while it was facing the room, but left cart open in the hallway with the privacy curtain in the resident's room pulled where she could not see the cart. LVN M returned to the east hall nurse's cart and gathered items for insulin administration and closed the east hall while it was facing the room, but left the east hall nurse's cart open in the hallway with the privacy curtain in the resident's room pulled where she could not see the east hall nurse's cart while administering insulin. LVN M said she understood that she could leave her nurse cart open if it was facing toward the resident's door. LVN M said she left the nurse carts open her entire career that way, but she said she understood the risk of a resident or staff getting into the east hall nurse cart with it being unlocked. During an interview on 07/02/2026 at 5:14 PM, the DON said her expectation was for the nurses' and medication carts to always be locked when the cart was unattended and not in view. The DON said the nurses or medication aides were responsible for ensuring the carts were locked if unattended. The DON said the failure placed a risk for residents getting into the carts and getting medications. During an interview 07/02/2026 at 5:44 PM, the Administrator said her expectation was anytime the nurse stepped away from the cart, the nurse should be locking the nurses' and medication carts. The Administrator said the failure placed a risk for residents getting into the cart and accessing medications. Record review of the facility's policy, dated 06/24/2025, Storage of Medications: Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that accommodated resident allergies, intolerances, and preferences for 2 of 2 residents (Residents #2 and #28) reviewed for food preferences and the accommodation of resident's meal choices. 1. The facility failed to ensure Resident #2's preference for large portions was honored on 06/29/26 and 06/30/26. 2. The facility did not ensure Resident #28's preference for over easy eggs was honored on 06/29/26 and 06/30/26. These failures could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings include: 1. Record review of Resident #2's face sheet, dated 07/02/26, reflected Resident #2 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included morbid (a chronic disease characterized by a body mass index of 40 or higher accompanied by severe weight-related health complications) (severe) obesity due to excess calories and unspecified protein-calorie malnutrition. Record review of Resident #2's quarterly MDS assessment, dated 04/03/26, reflected Resident #2 made himself understood, and understood others. Resident #2's BIMS score was 9, which reflected his cognition was moderately impaired. Resident #2 required setup or clean-up assistance with eating. Record review of Resident #2 comprehensive care plan, revised on 04/08/26, reflected Resident #2 had an ADL self-care performance deficit related to generalized weakness. The care plan interventions included required setup or clean-up assistance with eating. Record review of Resident #2's order summary report, dated 06/30/26, reflected: give large portions of food for every meal per resident with a start date 09/22/23. Record review of Resident #2's lunch meal ticket dated 06/29/26 did not reflect large portions. During an observation on 06/29/26 at 12:50 p.m., Resident #2 received one serving of ground stuff bell pepper, and one serving of fried okra. During an interview on 06/30/26 at 8:29 a.m., Resident #2 stated he wanted to have large portions with every meal. During an observation and interview on 06/30/26 at 1:22 p.m., Resident #2 received one serving of pinto beans, chopped sausage, steamed rice and capri vegetable blend. The DON stated by the look of Resident #2's servings looked average. After reviewing Resident #2's lunch meal ticket the DON stated he did not have to have large portions. During an interview and record review on 07/02/26 at 9:35 a.m., LVN B stated she was responsible for ensuring Resident #2 received large portions with his lunch meal on 06/30/26. LVN B stated she unaware Resident #2 preferred large portions. After reviewing Resident #2's electronic medical records, LVN B stated he should be receiving large portions with every meal. LVN B stated she usually goes with what was on the ticket and compared it to the tray. LVN B stated it was important for their food preferences to be honored because it was their right and prevent weight loss. During an interview on 07/02/26 at 11:00 a.m., the ADON stated she was responsible for ensuring Resident #2 received large portions with his lunch meal on 06/29/26. The ADON stated she compared the ticket with the tray and if large portions were not on there, she would not have known. The ADON stated it was important for their food preferences to be honored because it was their right. 2. Record review of Resident #28's face sheet, dated 07/02/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and morbid (a chronic disease characterized by a body mass index of 40 or higher accompanied by severe weight-related health complications) (severe) obesity due to excess calories. Record review of Resident #28's annual MDS assessment, dated 06/17/26, reflected Resident #28 made himself understood, and understood others. Resident #28's BIMS score was 11, which reflected his cognition was moderately impaired. Record review of Resident #28's comprehensive care plan, revised 03/20/26, reflected Resident #28 had an ADL self-care performance deficit related to impaired balance and limited mobility. The care plan interventions included required setup or clean-up assistance with eating. Record review of Resident (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#28's order summary report, dated 07/02/26, reflected there was no order for Resident #28 dislikes. During an interview on 06/29/26 at 11:38 a.m., Resident #28 stated he was told by the dietary staff that he could not have over easy eggs. Resident #28 stated the eggs were fried so hard, he could cut with a butter knife.During an interview on 06/30/26 at 9:00 a.m., Resident #28 stated I wish you seen my eggs this morning. Resident #28 stated those eggs were fried so hard you could have knocked someone out with them. During an interview on 06/30/26 at 3:37 p.m., Dietary Manager C stated she told her cooks to cook the eggs hard to prevent salmonella (foodborne illness) poisoning. Dietary Manager C stated she did have complaints and they just told the residents they could not do runny eggs. The Dietary Manager stated she was not aware that eggs could be runny if the eggs were pasteurized (raw eggs that have been gently heated their shells to a specific temperature to destroy harmful bacteria). During a telephone interview on 07/02/26 at 8:56 a.m., The Dietician stated Dietary Manager C had never mentioned not being able to cook over easy eggs. The Dietician stated to her knowledge she had never heard a resident preferred over easy eggs. The Dietician stated if the facility had pasteurized eggs over easy eggs could be provided. The Dietician stated Resident #2's entire plate should be large portions per his request. The Dietician stated Resident #2's meal tickets should reflect large portions. The Dietician stated the Dietary Manager was responsible for ensuring the meal tickets reflect the order. The Dietician stated it was important for residents' preference to be followed to meet the residents' needs.During an interview on 07/02/26 at 10:03 a.m., [NAME] E stated she was cooking Resident #28's eggs like he preferred until Dietary Manager C told her to fry the eggs hard. [NAME] E stated Resident #28 complained about his eggs and when she told Dietary Manager C, she would tell her to fry them extra hard on purpose so he would not come back. [NAME] E stated she was aware that eggs could be made over easy if the eggs were pasteurized. [NAME] E stated Dietary Manager C was responsible for ensuring the meal tickets state residents' preferences. [NAME] E stated she was unaware Resident #2 was supposed to receive large portions with every meal. [NAME] E stated it was important for residents' food preferences were followed to prevent the potential of weight loss. During an interview on 07/02/26 at 10:36 a.m., Dietary Manager D stated over easy eggs could be prepared if the eggs were pasteurized. Dietary Manager D stated Dietary Manager C was responsible for ensuring the tickets reflected residents' preference. Dietary Manager D stated that when she received the order from the nurse she should go into the system to make the change to reflect on the meal ticket. Dietary Manager D stated Resident #2 should have received one and half serving of protein, vegetables and starch. Dietary Manager D stated it was important for residents' food preferences to be honored because it was their right. An attempted telephone interview on 07/02/26 at 10:55 a.m. with [NAME] F, the cook that prepared breakfast and lunch on 06/30/26, voicemail left. During an interview on 07/02/26 at 4:08 p.m., the DON stated she expected food preferences to be followed. The DON stated after she reviewed Resident #2's orders he should have received large portions with every meal. The DON stated she was unaware Resident #28 was told that he could not have over easy eggs. The DON stated if the eggs were pasteurized over easy eggs could be prepared. The DON stated the Dietary Manager was responsible for ensuring the residents' preferences reflected on the ticket. The DON stated it was important for their food preferences to be followed to prevent weight loss. During an interview on 07/02/26 at 4:40 p.m., the Administrator stated she expected food preferences to be followed. The Dietary Manager stated she expected Resident #2 to receive large portion with every meal. The Administrator stated after education with corporate she in serviced the Dietary Manager and cooks that eggs could be cooked in the preference of Resident #28. The Administrator stated there was no system to monitor and oversee meal service. The Administrator stated it was important for residents' food preferences to be followed because it was their right. Record review of the facility's policy titled Food and Nutrition Service Menus revised 06/23/25 reflected. Each resident is provided with a nourishing, palatable, well-balanced diet that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 7. Food and nutrition services staff will inspect food (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trays to ensure that the correct meal is provided to each resident. 7 (a) if an incorrect meal is provided to a resident, or a meal. nursing staff will report it to the Food Service Manager so that a new food tray can be issued.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to maintain medical records in accordance with the accepted professional standards and practices that are complete and accurately documented for 2 of 2 (Resident #9 and Resident #24) residents reviewed for documentation. Resident #9 and Resident #24's electronic medical record did not contain complete and accurate documentation that reflected that the resident or the responsible party were informed of and attended or declined to attend the quarterly care conference meeting. This failure could result in the residents' records not accurately documenting participation in the plan of care.The findings included: Record review of Resident #9's face sheet dated 07/02/2026 revealed a [AGE] year-old female admitted on [DATE]. Her diagnoses included COPD (Chronic Obstructive Pulmonary Disease, a progressive, irreversible lung disease that restricts airflow and makes breathing difficult), seizures (sudden, uncontrolled bursts of electrical activity in that brain that affects movement and consciousness), dysphagia (difficulty swallowing), hypotension (abnormally low blood pressure), major depressive disorder (a mental health condition characterized by a persistent feeling of sadness and loss of interest in normally enjoyable activities). The face sheet indicated that Resident #9's family member was her Responsible Party. Record review of Resident #9's Quarterly MDS dated [DATE] revealed Resident #9 had unclear speech, was usually understood by others and usually understood what was said to her with a BIMS score of 8 which indicated moderate cognitive impairment. The MDS indicated Resident #9 required a wheelchair for mobility, set-up assistance with eating, moderate assistance in upper body dressing, transfers, and bed mobility, and total assistance in toileting and lower body dressing. Record review of Resident #9's care plan with target completion date of 07/1/26 revealed a focus area that reflected impaired cognitive function, dementia or impaired thought processes related to history of traumatic brain injury initiated 09/21/2021 and a psychosocial well-being focus potential related to social isolation initiated 06/03/2025 with interventions that included to provide opportunities for the resident and family to participate in care. Review of the Care Conference & DC Case Management Evaluations for Resident #9 dated 07/03/2025, 10/15/2025 and 06/24/2026 revealed the conferences were conducted in person and attended by therapy, nursing staff, the activity department and the social worker. Section 1c. Care Plan Conference Attendees did not indicate that the resident or responsible party attended the care plan conference, refused to attend the care plan conference, were invited and were a no show for the care plan conference, refused to attend the conference or was too ill to attend the care plan conference. No Care Conference & DC Management Evaluation was available for January 2026 or March 2026. Attempted interview with Resident #9 on 06/29/26 at 11:48 a.m. was unsuccessful due to speech communication deficits as well as cognitive comprehension deficits. Attempted interview with Resident #9's family member who was identified as the responsible party on 06/29/2026 at 6:44 p.m. was unsuccessful. Message was left for responsible party with no return contact during survey. Record review of Resident #24's face sheet dated 06/20/2026 revealed an [AGE] year-old female admitted [DATE] and readmitted [DATE]. Her diagnoses included atrial fibrillation (irregular heart rhythm), heart failure (a chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypertension (high blood pressure), hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone leading to a slowdown of metabolism), hyperlipidemia (high levels of fat in the blood), dementia (a decline in cognitive function severe enough to interfere with daily life), major depressive disorder (a mental health condition characterized by persistent feelings of sadness and loss of interest that impacts daily life). The face sheet indicated that Resident #24's family member was her Responsible Party, Power of Attorney for Care and Finances and Emergency Contact #1. Record review of Resident #24's Quarterly MDS dates 05/14/2026 revealed no vision, hearing or communications deficits and a BIMS Score of 15 which (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated intact cognition. The MDS indicated Resident #24 required the use of a wheelchair for mobility, setup assistance in eating, supervision with upper body dressing, moderate assistance with lower body dressing, and bed mobility, maximum assistance with transfers and total assistance in toileting and bathing. Record review of Resident #24's care plan with target completion date of 04/22/2026 identified focus areas of falls with intervention to educate the resident or family about safety reminders; a focus area of altered cardiovascular status with interventions to provide disease management teaching to resident or family; discharge planning with intervention to evaluate and discuss with resident or family; and activity involvement with interventions to invite and encourage family to attend events to support participation. Record review of the Care Conference & DC Case Management Evaluations for Resident #24 dated 08/25/2025, 11/12/2025, 02/11/2026, 04/15/2026 revealed the conferences were conducted in person and attended by members of the nursing, therapy, activity and social services staff. Section 1c. Care Plan Conference Attendees did not indicate that the resident or responsible party attended the care plan conference, refused to attend the care plan conference, were invited and were a no show for the care plan conference, refused to attend the conference or was too ill to attend the care plan conference. During an interview on 07/01/2026 at 7:14 a.m., Resident #24 stated that she was aware of the care plan meetings but could not recall if she was invited of the meeting every 90 days. Resident #24 stated she chose not to attend the meeting because in the past, a lot is talked about, but nothing happens. Resident #24 did not provide any specific concern that had not been addressed. Resident #24 stated that she did not know if her family member was informed of and invited to the care plan meeting. An attempted interview with Resident #24's family member on 07/01/2026 at 9:00 a.m. and 07/06/2026 at 3:25 p.m. were unsuccessful and voice mail had not been returned. During an interview of 07/01/2026 at 7:50 a.m., LVN H stated that she personally invites the resident to the Care Plan meeting and that she sends an invitation to the responsible party. LVN H stated she does not place a copy of the invitation as validation they were sent in the EMR. LVN H stated that she was responsible for completing the Care Conference & DC Case Management Evaluation forms and acknowledged that she failed to indicate that the resident or responsible party had been informed of the meeting, attended the meeting or refused to attend the meeting. LVN H stated she did not document resident or family participation and that the evaluation did not accurately reflect the meeting attendance. During an interview on 07/01/2026 at 8:07 a.m., the Activity Director stated she only completes the activity section of the Care Conference & DC Case Management Evaluation form and has nothing to do with inviting the resident or family. During an interview on 07/02/2026 at 3:00 p.m., the DON stated that she expects the Care Conference & DC Case Management Evaluation form to be completed in its entirety and that the presence or absence of the resident or the responsible party was indicated on the form. The DON stated she expects all the team members to assist with the form completion, that the MDS Nurse has been assigned the task of inviting the resident or responsible party and that she will monitor the care plan meetings sporadically to ensure the form is completed. The DON stated that failure to accurately document on the designated form could result in inadequate documentation that does not reflect the resident or family who were invited to participate in the plan of care. During an interview on 07/06/2026 at 4:08 p.m., the Administrator stated that accurate documentation was important to ensure all steps taken by staff members were captured. The Administrator stated that she will spot check the Care Conference & DC Case Management Evaluation form based on the care plan schedule to ensure the form was properly completed. The Administrator stated that risks of inaccurate documentation does not directly affect the residents, but cold overall reflect on the competency of the staff. A request for facility policy on accuracy of documentation was requested on 07/02/2026 at 2:00 p.m. The DON stated they did not have a policy for documentation.

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	675471	A. Building B. Wing	07/02/2026

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North Star Ranch Rehabilitation and Healthcare Cen	709 W Fifth St Bonham, TX 75418

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 3 residents (Resident #12, and Resident #27) reviewed for hospice services.1.The facility failed to maintain Resident #12's hospice binder containing information related to hospice services provided for the resident such as the most recent medication profile, last two months of IDG also known as Interdisciplinary Group meetings (a regular, collaborative team review of a patient's care meetings), or updated recertification form.2.The facility failed to ensure Resident #27's Hospice binder included an up to date and accurate medication profile.These failures could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included: 1. Record review of Resident #12's face sheet, dated 07/02/26, reflected Resident #12 was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (a decline in mental ability that interferes with daily life), anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #12's admission MDS assessment, dated 04/27/26, reflected Resident #12 made herself understood, and was understood by others. Resident #12 BIMs score was an 11 which indicated she had a moderate cognitive impairment. The MDS indicated Resident #12 was on hospice services. Record review of Resident #12's comprehensive care plan revised 04/23/26 indicated Resident #12 had a terminal prognosis and was on hospice services. The intervention was to work cooperatively with the hospice team to ensure the residents' spiritual, emotional, intellectual, physical, and social needs were met, and for the nursing staff to provide maximum comfort for the resident. Record review of Resident #12's physician orders dated 04/23/26 indicated an order for {name} hospice. Record review of Resident #12's physician orders dated 05/22/26 indicated an order for Fentanyl Transdermal Patch 72 Hour 12 MCG/HR (Fentanyl) Apply 1 patch transdermal every 72 hours related to pain. Record review of Resident #12's physician orders dated 06/10/26 indicated an order for Zyprexa Oral Tablet 7.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime related to schizoaffective disorder. Record review of Resident #12's hospice binder on 07/02/26 at 11:09 a.m., revealed it did not have the last medication profile (last updated 05/05/26), the last two months of IDG (Interdisciplinary Group) meetings or updated recertification form. The last recertification was dated (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/19/26-06/19/26. Record review of Resident #12's hospice binder on 07/02/26 at 11:09 a.m., did not reveal an order for Fentanyl Transdermal Patch or Zyprexa. During a phone interview on 07/01/26 at 3:48 p.m., the hospice RN K said the binders at the facility should contain any supporting notes or documentation needed for Resident #12. She said the binder should at least have the face sheet, election form, code status, certification of terminal illness, plan of care, and medications. She said they meet every two weeks on Friday for the IDG meetings and said the documentation should be updated at least the following week after the IDG meetings. She looked at the office's records and said Resident #12's last IDG meeting was 06/26/26 and prior meeting was 06/12/26 and had not been delivered to the facility. She said she was responsible for bringing over any updated information after the meetings on the following week. She said she did not have a reason why she had not brought the updated information, except she had forgotten. She said she would bring her recertification which started on 06/18/26 and would end on 08/16/26. She said the recertification should also be in the facility's chart the week of the termination of the recertification period. She said she would bring over the information to the facility and place it in the resident's binder. She said it was important to have the binders at the facility updated to help the facility know the care and services they were providing. During an interview on 07/02/26 at 10:39 a.m., LVN H said she was not sure of all the information that needed to be included in the hospice binder. She said she thought the hospice binder should include the name of the hospice, diagnosis, face sheet, and code status. She said management was responsible for ensuring the hospice binders were updated. She said any information the hospice company had for Resident #12 should be at the facility for effective communication because their care was combined. During an interview on 07/02/26 at 5:02 p.m., the DON said she expected the hospice binders to be updated on all material required in the book. She said the recertification and IDG meetings should be in the folder. She said hospice should correlate with the facility nurses to see about any medication changes. She said she the ADON was responsible for ensuring the hospice binder was updated. She said the risk of the binders not being updated was not knowing all of Resident #12's plan of care. During an interview on 07/02/26 at 5:50 p.m., the Administrator said any information the hospice had should be updated in the facility's hospice binder. She said she expected the recertification and IDG meeting to be in the facility's binder. She said the DON was responsible for ensuring all hospice documents were up to date. She said the binder should be updated for effective communication between hospice and the facility for the care of the residents. 2. Record review of Resident #27's face sheet dated 7/2/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE]. Her diagnoses included dementia (decline in memory and thinking skills that interferes with daily life), chronic obstructive pulmonary disease (progressive lung condition that causes difficulty breathing due to damage to the airways), general anxiety (persistent, excessive worrying about everyday matters like health, finances, or family), and shortness of breath. Record review of Resident #27's quarterly MDS assessment dated [DATE] indicated she could make herself understood and she understood others. The MDS also indicated she had a BIMS score of 13 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which meant she was cognitively intact. The MDS also indicated she was independent with toileting, dressing, bed mobility, and transfers, and she required set assistance with eating. The MDS also indicated Resident #27 required oxygen therapy while she was a resident. The MDS also indicated she received hospice care while she was a resident. Record review of Resident #27's comprehensive care plan dated 12/31/25 indicated she had a terminal diagnosis of chronic obstructive pulmonary disease and was admitted to hospice care with interventions in place to work cooperatively with hospice team to ensure the Resident 27's spiritual, emotional, intellectual, physical and social needs were met. Record review of Resident #27's hospice binder on 06/30/26 indicated Resident #27's medication profile, last completed 3/30/26, did not match the facility orders. Record review of Resident #27's hospice medication profile dated 3/30/26 indicated Resident #27 had an order for: 1)Zoloft 25mg tab -Oral 1 tablet at bedtime for insomnia 2)Cyclobenzaprine 10 Mg tablet - Oral 1 tablet 2 times daily muscle spasms The hospice medication profile did not indicate Zoloft 50mg tablet or a as needed dose for cyclobenzaprine 10mg tablet. Record review of Resident #27's order summary report dated as of 07/01/26 indicated Resident had an order for: 1) Cyclobenzaprine HCl Oral Tablet 10 MG (Cyclobenzaprine HCl) Give 1 tablet by mouth every 24 hours as needed for Leg Cramps Cyclobenzaprine 10 mg PRN every 24 hours for leg cramps with a start date of 06/20/2026 and no end date. 2)Cyclobenzaprine HCl Tablet 10 MG Give 1 tablet by mouth two times a day related to pain in unspecified joint May cause dizziness, drowsiness with a start date of 02/15/2026 and no end date. 3) Sertraline HCl Tablet (Zoloft) 50 MG Give 1 tablet by mouth at bedtime for Depression related to generalized anxiety disorder with a start date of 04/15/26and no end date. During an interview on 07/02/26 at 11:30 a.m., the hospice receptionist said she would have Resident #27's RN case manager return a call to discuss the information about the Resident #27's medication profile but no return called was received. During an interview on 07/02/26 at 2:54 p.m., the ADON said the hospice company should have provided an updated medication profile. The ADON said the IDG meeting with medications should have matched the orders the facility had ordered. The ADON said herself and the DON were responsible and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the failure placed Resident #27 at risk for medication errors. During an interview on 07/02/26 at 5:05 p.m., the DON said her expectation was for the hospice nurse to communicate with the facility nurse to ensure there were no new orders for each visit to ensure the IDG meeting paperwork and the hospice medication profile matched the facility orders. The DON said the ADON was responsible for checking the hospice binders and ensuring the hospice binders were up to date and accurate. The DON said the failure placed a risk for medication errors. During an interview on 07/02/26 at 5:39 p.m., the Administrator said her expectation was for the hospice to have the same orders as the facility to ensure proper continuity of care. The ADON and DON were responsible for ensuring the hospice books up to date. The Administrator said the failure placed a risk for ineffective communication for Resident #27's orders. During an interview on 07/02/26 at 6:04 PM the DON said the facility did not have a hospice policy.