STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675596	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barton Valley Rehabilitation and Healthcare Center	4501 Dudmar Dr Austin, TX 78735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 4 of 16 residents (Residents #17, #10, #1, and #63) reviewed for activities. The facility failed to ensure Residents #17, #10, #1, and #63, all of whom were completely dependent on staff, received activities that interested them. This failure placed residents at risk of depression and diminished quality of life.Findings Included:Review of the undated face sheet for Resident #17 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy, affecting all four limbs, the trunk, and often the face, causing significant muscle stiffness and motor impairment), severe intellectual disabilities, Rett syndrome (genetic disorder that typically becomes apparent after 6-18 months of age; symptoms include impairments in language and coordination, and repetitive movements), dysphagia (trouble swallowing), cognitive communication deficit (problems communicating due to cognitive impairment), protein-calorie malnutrition (lack of protein in the diet), epilepsy (seizure disorder), depressive episodes, gastrostomy status (feeding tube), and chronic pain. Review of the annual MDS assessment for Resident #17 dated 10/10/2025 reflected her cognitive impairment was so severe that she could not participate in a BIMS assessment for cognition. The staff assessment for activity preferences included listening to music and spending time outdoors. Review of the care plan for Resident #17 dated 06/06/2025 reflected the following: (Resident #17) requires one on one activities. (Resident #17) will accept and participate in 1: 1 visits such as listening to cartoon soundtracks Activity assistant will visit with me once a week. She enjoys watching cartoon movies. She likes sensory stimulation, hand massage, soft music to be played while in her room. Massage. Staff will assist me to morning stroll once a week. She likes to go outside when weather outside for fresh air permits. (Resident #17) does not like loud noises or big crowds. She likes observing when out in common areas. Review of POC documentation for Resident #17's activities from 03/17/2026 to 04/16/2026 reflected one 1:1 music/sensory visit on 03/28/2026 and no other activities of any type. Observation on 04/14/2026 at 10:21 AM revealed Resident #17 lay in her bed, peg tube disconnected. There was no music playing in the room, and her roommate's television was on a Western. Resident #17 made eye contact and made expressions (curiosity, [NAME], frustration) but could not speak. Identical circumstances (other than the peg tube being connected) were observed on the following dates and times:04/14/2026 11:48 AM04/15/2026 09:30 AM 04/15/2026 10:10 AM 04/15/2026 11:35 AM04/15/2026 01:47 PM04/15/2026 03:24 PMNeither the AA nor the AD were seen going into Resident #17's room from 04/14/2026 to 04/16/2026. Observation on 04/16/2026 at 11:35 AM revealed Resident #17 was up in a tilt-back wheelchair next to her bed. There was a western on her roommate's television, and her roommate was not in the room. She interacted non-verbally by making eye contact, making noises, and moving her face. Review of the undated face sheet for Resident #10 (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction due to embolism of right middle cerebral artery, parkinsonism, epilepsy, aphasia, and gastrotomy status. Review of the annual MDS assessment for Resident #10 dated 02/26/2026 reflected she could not participate in the BIMS assessment for cognitive function. The staff assessment for cognition indicated she was severely impaired. The staff assessment for activity preferences indicated she enjoyed listening to music. Review of POC documentation for Resident #10's activities from 03/17/2026 to 04/16/2026 reflected no activities of any type documented. Observation on 04/14/2026 at 10:08 AM revealed Resident #10 lying in her bed, connected to her peg tube. There was no music playing in the room, and the television was off. Resident #10's eyes were open. Identical circumstances were observed on the following dates and times:04/14/2026 11:11 a.m. 04/15/2026 7:06 a.m. 04/15/2026 10:10 a.m. 04/15/2026 12:10 p.m.04/16/2026 9:34 a.m. 04/16/2026 11:31 a.m. 04/16/2026 1:35 p.m. Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, anxiety, disorder, depression, and muscle weakness. Review of the admission MDS assessment for Resident #1 dated 11/18/2025 reflected a BIMS score of 07, indicating severe cognitive impairment. Her activity interests included listening to music and participating in religious activities. Review of the care plan for Resident #1 dated 11/18/2025 reflected the following: Focus(Resident #1) enjoys observing while in common areas. She uses a tilt in space wheelchair and needs assistance to and from activities. Resident participates in (facility) furry friends program. (Resident #1) has a cat. Activity director to monitor for preferencesGoal(Resident #1) will accept and verbally engage during one-to-one visits for socialization and exploration of leisure interests 1 to 2 times weekly for next 90 days.InterventionsActivity staff will post monthly calendar in my room.Staff will encourage/assist me to activities of my preference. Observation on 04/16/2026 at 11:28 AM revealed Resident #1 lay in her bed, looking out the window. There was no music playing in the room. She was observed in her bed without any activity or interaction on the following dates and times:04/14/2026 11:40 AM04/14/2026 12:58 PM04/14/2026 2:12 PM04/15/2026 9:30 AM 04/15/2026 10:13 AM 04/15/2026 11:20 AM04/15/2026 1:44 PM04/15/2026 3:30 PM04/16/2026 10:01 AM04/16/2026 11:33 AMNeither the AA nor the AD were seen going into Resident #1's room from 04/14/2026 to 04/16/2026. Review of the undated face sheet for Resident #63 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included encephalopathy, cerebral infarction, protein-calorie malnutrition, aphasia, muscle weakness, dysphagia (trouble swallowing), gastrostomy status (feeding tube), cognitive, communication deficit, adult failure to thrive, and dysarthria and anarthria. Review of the admission MDS assessment for Resident #63 dated 04/06/2026 reflected her cognitive impairment was so severe that she could not participate in a BIMS assessment for cognition. The staff assessment for activity preferences included listening to music, participating in religious activities, and spending time outdoors. Review of the care plan for Resident #63 dated 04/06/2026 reflected the following: Focus(Resident #63) is dependent on staff for activities. She does need 1:1 visits for socialization. (Resident #63) does enjoy watching tv and listening to music in her room.Goal(Resident #63) will accept and participate passively in 1:1 visits such as sensory stimulation, music and going outside forfresh air, 1-2 times weekly over next 90 days.InterventionsActivity director will provide me with in-room activities as needed and required.Staff will assist me to activities of my preference. Observation on 04/14/2026 at 10:28 AM revealed Resident #63 lying in her bed. There was no music or television on in the room. Resident #63 did not respond to efforts to communicate with her. Identical circumstances were observed on the following dates and times:04/14/2026 11:50 AM04/14/2026 1:45 PM 04/15/2026 9:10 AM 04/15/2026 10:18 AM04/15/2026 11:40 AM04/15/2026 01:40 PM04/15/2026 03:19 PM04/16/2026 10:04 AM04/16/2026 11:26 AMNeither the AA nor the AD were seen going into Resident #63's room from 04/14/2026 to 04/16/2026. During an interview on 04/15/2026 at 02:13 PM the AA stated she documented activities in the POC. She said there were three types of activities: one-on-one, group, and independent activities. She stated sometimes she did (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not have the chance to document in the POC right away, so she wrote down the activities on a piece of paper and entered them in the POC at the end of the day. She stated she always documented the activities. During observation and an interview on 04/16/2026 at 09:03 AM, the AA was walking from the common area by the Unit 1 nurse's station and checking in with residents up and down the adjacent hall. She stated she had been letting everyone know about the group activity they were having. She stated the way she usually handled inviting residents to the group activities was to let the residents and nursing staff know and ask the CNAs to help get residents to the activities. She stated the CNAs did not always have time to get residents up and assisted to activities. She stated she had been assisting residents in their wheelchairs to activities but had just undergone surgery and was not able to do so for the present time. She stated the AD sometimes helped with transporting residents to activities, but there was no back up plan for assisting residents to Unit 1 while she (the AA) was unable to help. During an interview on 04/16/2026 at 01:22 PM, the AA stated when she had invited residents to activities that morning at 9:03 AM, a few of them had refused, but she had not addressed inviting Residents #17, #10, #1, or #63. She stated she relied on the staff to get those residents out of bed in order for her to bring them to activities, and the staff did not get them out of bed. She stated she did in-room activities with Resident #17, but she could not remember exactly when. She stated the last documented activity for Resident #17 was the last activity she did. She stated she did not do activities with Resident #1, because Resident #1 did not want to do activities with her. She stated she did not know Resident #63 or Resident #10 at all. During an interview on 04/16/2026 at 2:02 PM, CNA L stated he worked on the hall where Resident #1 lived. He stated anytime the activities department had a big party, like on a major holiday, they made sure everyone got up and attended for residents who wanted to. He stated Resident #1 did not like to participate in group activities and did not enjoy most of the staff, but she loved to listen to Spanish-language music. He stated he did not think she had a radio, but her roommate might not want to listen. He stated if she had a pair of headphones, she would probably love it. He stated no staff from activities had asked him to provide feedback about how to help Resident #1 enjoy activities. During an interview on 04/16/2026 at 2:10 PM, CNA M stated he worked on the hall where Residents #17 and #63 lived. He stated he had seen the AA and the AD go in Resident #17 and Resident #63's rooms, but he did not remember when. He stated he was never asked to bring residents to activities. During an interview on 04/16/2026 on 3:13 PM, the AD stated all visits and activities should have been documented by her or the AA in the POC. She stated she scheduled one or two 1:1 visits each week with residents who needed 1:1 visits.She stated Resident #1 loved conversation with her and lit up when the AD came in for a visit. She stated she was not sure when the last visit with Resident #1 was, but Resident #1 definitely needed more activities. She stated, in general, the 1:1 visits were not being utilized thoroughly and the residents needed more. She stated the CNAs did not get residents out of bed or bring them to activities, and she did not think she had asked them to. She stated the AA was always telling her Resident #10 was asleep every time she went by the room. She stated she did not really know Resident #63. During an interview on 04/16/2026 at 4:08 PM, the ADM stated the AD was responsible along with any of the IDT. He stated the nursing staff had a role in ensuring residents could get to activities. He stated he ensured compliance by monitoring and observation, interactions with the patient, and routine rounds. He stated the potential negative impact of not receiving activities could be depression. Review of facility policy dated June 2018 and titled Activity Programs reflected: Policy StatementActivity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident.Policy Interpretation and ImplementationThe activities program is provided to support the well-being of residents and to encourage both independence and community interaction.Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. Activities are considered any endeavor, other than routine ADLs, in (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health.Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs.Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs.Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote:self-esteem;comfort;pleasure;education;creativity;success; andindependence.Activities are not necessarily limited to formal activities being provided only by activities staff. Other facility staff, volunteers, visitors, residents and family members may also provide the activities.All activities are documented in the resident's medical record.Activities participation for each resident is approved by the attending physician based on information in the resident's comprehensive assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care within 48 hours of admission for 1 of 1 residents (Resident #2) reviewed for dialysis.The facility failed to include nursing interventions for Resident #2's hemodialysis in her comprehensive care plan.This failure could put residents at risk for missed treatments, and inadequate care.Record review of Resident #2' s admission MDS assessment, dated 03/30/2026, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 was diagnosed with end-stage renal disease and was dependent on renal dialysis (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively) and hypertension (high blood pressure). The MDS did not reflect Resident #2 was receiving dialysis.Record review of Resident # 2's care plan, dated 3/30/2026, reflected Resident #2 attends dialysis Mondays, Wednesdays, and Fridays. Created by: DM, Date Initiated: 04/01/2026. Interventions addressed Resident #2's dietary needs, but there was no dialysis focus developed by a doctor or nurse to address her nursing needs and no nursing interventions were included. Record review of Resident # 2's Progress notes , dated 4/13/2026, reflected Resident # 2 was a [AGE] year-old female with past medical history including non-insulin dependent diabetes mellitus type 2, ESRD. When the resident was admitted on [DATE], records reflected the resident was Dependent on renal dialysis. Resident dependent on hemodialysis Monday, Wednesday, Friday for end-stage renal disease. Interview and observation on 04/15/2026, at 11:38 AM, revealed Resident #2 was waiting on her ride to go to dialysis, and she attended every Mondays, Wednesdays, and Fridays. She stated she had been going to these appointments for the last two years.Interview on 04/16/2026, at 11:31 AM , MDS A revealed Resident #2 would need a Care plan from a Nurse or medical professional not the Dietary manager. According to the MDS A coordinator the baseline care plan should have included the DX of Dialysis.Interview and observation on 04/16/2026, at 1:38 PM, revealed Resident #2 was sitting in her room. The resident had just finished lunch, and she stated she attended Dialysis on Mondays, Wednesdays, and Fridays and had not had any issues with the facility getting her to these appointments.Interview on 04/16/2026, at 2:56 PM, ADON A, revealed she did not know why there was not a current care plan but stated MDS A would. She stated IDT meetings are held daily to check on these types of issues. If residents do not have a care plan, sites check, etc. related to Dialysis they could be at risk for infection.Record review of facility Dialysis Management Policy, dated 03/12/2026, reflected the following:Coordination with Dialysis Providers The facility will maintain appropriate communication and coordination with the dialysis provider. If residents are transported to an outpatient dialysis center: The facility will maintain a formal agreement or contract with the dialysis provider. Care coordination will follow standard operating procedures and dialysis center protocols. Dialysis center recommendations and treatment plans will be incorporated into theresident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 2 of 8 residents (Residents #19 and 78) reviewed for nail care. The facility failed to ensure Residents #19 and 78 had clean, trimmed fingernails on 04/14/2026 and 04/15/2026. This failure placed residents at risk of skin tears and infection.Findings Included: Review of the undated face sheet for Resident #19 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included dementia with unspecified severity, muscle wasting and atrophy, age-related physical disability, persistent mood disorder, and chronic viral hepatitis C. Review of the quarterly MDS assessment for Resident #19 dated 01/16/2026 reflected a BIMS score of 09, indicating a moderate cognitive impairment. It reflected he required partial to moderate assistance with personal hygiene and had no rejection of care behaviors. Review of the care plan for Resident #19 dated 10/03/2025 reflected the following: Focus (Resident #19) has an ADL self-care performance deficit r/t Impaired balance, Limited Mobility, Pain (Bilateral knees). Goal (Resident #19) will maintain current level of function in (mobility) through the review date. Intervention BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Review of the POC (documentation system for CNAs and activities staff) for Resident #19 reflected there was no task related to nail care being documented on the current system. Review of the undated face sheet for Resident #78 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cognitive communication deficit (problems communicating due to cognitive impairment), epilepsy, schizophrenia, weakness, contracture of muscle multiple sites, cerebral palsy, lack of expected normal physiological development in childhood, paraplegia, borderline personality disorder, intermittent explosive disorder, generalized anxiety disorder, bipolar disorder, and moderate intellectual disabilities. Review of the annual MDS assessment for Resident #78 dated 07/26/2025 reflected a BIMS score of 09, indicating a moderate cognitive impairment. It reflected he was completely dependent on staff for all ADLs, including personal hygiene. Review of the care plan for Resident #78 dated 06/06/2025 reflected the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus The resident has an ADL self-care performance deficit r/t Confusion, Impaired balance, Limited Mobility, Limited ROM, Scoliosis, Paraplegia, DX CP, ID Goal The resident will improve current level of function in through the review date. Intervention BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Review of the POC (documentation system for CNAs and activities staff) for Resident #78 reflected there was no task related to nail care being documented on the current system. Observation on 04/14/2026 at 10:04 AM revealed Resident #78's fingernails were long, jagged, and dirty. During observation and interview on 04/15/2026 at 09:02 AM, Resident #19 was observed with long fingernails (1/4 inch long). He stated he liked his nails trimmed short, but he was not able to cut them himself. He stated he sometimes bit his nails to get them short, because the staff had not offered to cut his nails for him. During observation and interview on 04/15/2026 at 12:55 PM, Resident #78 was sitting in his wheelchair near the nurse's station. His fingernails were long, jagged, and dirty. He stated he wanted his fingernails cut, but they had not done it yet. He stated he did not know when someone would cut his nails. He stated the staff did not help with that. During an interview on 04/16/2026 at 3:50 PM, the DON stated the aides usually provided nail care with showers if the resident did not have diabetes. She stated nail care should have been offered every time residents were bathed. She stated she oversaw the system to ensure compliance by interacting with residents and providing nail care if she saw it was needed. She stated nail care was supposed to have been documented when it was offered, even if residents refused. She stated the potential negative outcome was residents could scratch themselves. During an interview on 04/16/2026 at 4:08 PM, the ADM stated the DON was responsible for the system ensuring nail care was offered to residents. He stated the potential negative impact on residents was diminished quality of life and possible injury. Review of facility policy dated April 2025 and titled Activities of Daily Living reflected the following: Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care); (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mobility (transfer and ambulation, including walking); elimination (toileting); dining (eating, including meals and snacks); and communication (including speech, language, and other functional communication systems).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 2 of 10 residents (Resident #99 and Resident #52)The facility failed to ensure the floor mat in Resident #99's room was beside his bed on 04/14/2026 and 04/15/2026.The facility failed to ensure the floor mat in Resident #52's room was beside his bed on 04/14/2026.This violation could place residents at risk of experiencing avoidable injuries from falls.The findings included: 1. Record review of Resident #99's admission Record, dated 04/15/2026, revealed a [AGE] year-old male admitted on [DATE]. Record review of Resident #99's Diagnosis Report, dated 04/15/2026, revealed diagnoses including multiple sclerosis (chronic disease where the immune system attacks the brain and spinal cord), type 2 diabetes mellitus (body does not produce enough insulin), COPD (a group of diseases that cause airflow blockage and breathing-related problems), unspecified protein calorie malnutrition (condition where the body is not getting enough protein and calories leading to weight loss, weakness, and poor overall health). Record review of Resident #99's Annual MDS, dated [DATE], reflected Resident #99 had a BIMS score of 14, indicating intact cognitive function. Resident #99 was dependent on staff for his self-care needs and mobility needs. Record review of Resident #99 's Care Plan, accessed 04/14/2026, reflected Resident #99 was at high risk for falls. An intervention included having call light within reach, having bed in lowest position, and having fall mat in place beside bed. During an observation on 04/14/2026 at 9:30 AM, 10:30AM, and 11:42AM, Resident #99, was observed lying in his bed with the fall mat at foot of the bed folded up between the wall and dresser. During an observation on 04/15/2026, at 1:44 PM, Resident #99 was observed lying in his bed with the fall mat at foot of the bed folded up between the wall and dresser. 2. Record review of Resident #52's admission Record, dated 04/15/2026, revealed a [AGE] year-old male admitted on [DATE]. Record review of Resident #52's Diagnosis Report, dated 04/15/2026, revealed diagnoses including type 2 diabetes (body does not produce enough insulin), COPD (a group of diseases that cause airflow blockage and breathing-related problems, Muscle wasting and atrophy (loss of muscle tissue and strength), and osteomyelitis (a bone infection). Record review of Resident #52's Annual MDS, dated [DATE], reflected Resident #52 had a BIMS score of 07, indicating he was severely cognitively impaired. Resident #52 was dependent on staff for her self-care needs and mobility needs. Record review of Resident #52's Care Plan, accessed 04/14/2026, reflected Resident #52 was at risk for falls, initiated 01/23/2026. An intervention included having fall mat in place beside the bed and call light within reach. During an observation on 04/14/2026 at 9:38 AM and 10:35 AM. Resident #52, was observed lying in his bed. Resident #52's Fall mat was on the floor, but on the other side of the room away from the bed. During an interview on 04/16/2026, at 9:30 AM, LPN D stated that when a resident with fall precautions is in their bed, the bed should be lowered, the fall mat is right next to the bed, and the call light is in place. LPN D said the resident could get hurt if they fell out of bed and the fall mat was not in place. During an interview on 04/16/2026 at 9:40 AM with CNA I stated that if the resident has a fall mat it should be placed right next to the bed when the resident is in bed. CNA I said a resident could get hurt if they fell and the fall mat was not in place. During an interview on 04/16/2026 at 10:00 AM with DON she said her expectation is that the fall mat should be placed beside the bed when the resident is in bed. DON stated that both residents are on fall precautions and it is in their care plans to have fall mat beside their bed when they are in bed. During an interview on 04/15/2026 at 2:00PM with the ADM he stated he expects all staff to place fall mats beside the resident bed when the resident is in the bed. The ADM. stated it is nursing responsibility that the orders and care plan for fall precautions are carried out. Record review of facility policy, Fall Prevention and Management Program, dated as Reviewed and Revised 03/04/2026 reflected: Policy StatementThe facility maintains an interdisciplinary fall (continued on next page)

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	675596	A. Building B. Wing	04/16/2026

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Barton Valley Rehabilitation and Healthcare Center	4501 Dudmar Dr Austin, TX 78735

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention and management program designed to identify resident-specific fall risk factors and implement individualized, least restrictive interventions that support safety while promoting mobility, independence, dignity and quality of life.Fall Prevention InterventionsInterventions may include but are not limited to .Bed in low position with bedside mat as appropriate

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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 #10) reviewed for medication administration. RN C failed to administer medications and enteral feed safely to Resident #10ˆˆby: initiating medication administration without first checking for G-tube (a tube inserted through the abdominal wall into the stomach for the administration of medication and food) placement, forcefully pushing medications and the bolus feed through a connected syringe instead of gravity, shaking syringe from side to sideˆand moving it in circular motions while it was attached to G-tube. These failures could place residents at risk of . aspirations and injuries to the stoma site.Findings include: Record review of Resident #10's face sheet, dated 04/15/2026, reflected a [AGE] year-old female initially admitted [DATE]. Resident #10 had diagnoses which included cerebral infarction due to embolism of right middle cerebral artery (a stroke caused by a clot blocking blood flow to the right side of the brain, causing sudden left-side weakness/paralysis, sensory loss, and potential behavioral changes), epilepsy unspecified, intractable, with status epilepticus (a temporary, uncontrolled surge of electrical activity in the brain that can cause convulsions, altered awareness, or behavioral changes), type 2 diabetes mellitus without complications (high blood sugar (hyperglycemia) due to insulin resistance without associated damage to nerves, eyes, kidneys, or blood vessels), aphasia (impaired ability to understand or produce speech), dysphagia oral phase (difficulty preparing food in the mouth and initiating a swallow), Gastrostomy status (presence of a functioning feeding tube (G-tube) inserted through the abdomen into the stomach for enteral nutrition, hydration, or medication administration). ˆ Record review of Resident #10's Comprehensive MDS dated [DATE] revealed, short-ˆ& long-term memory problems, severely impaired cognitive skills for daily decision making, total dependence for all ADLs, aphasia (brain damageˆthat affects the person's ability to communicate), feeding tube while a resident, received 51% or more of her intake via tube feeding and 501 ml per day or more via tube feeding. Record review of Resident #10's order summary report reflected the following: NPO diet N/A - NPO texture, NPO consistency, for Dysphagia dated 01/20/2026 Enteral Feed Order every shift Flush with 10cc H2O between medications dated 04/03/2025 Enteral Feed Order every shift Flush with 30cc H2O before and after medications dated 04/03/2025 Enteral Feed Order every shift Verify G-tube placement and check for residual dated 04/03/2025 Enteral Feed Order five times a day Administer Glucerna 1.2 Cal / 285 Cal - Flush free water 100 ML with each feeding. An observation on 04/15/26 approximately at 07:00 a.m. revealed RN C preparing medication for administration to Resident #10. She popped out: Amlodipine, Cyanocobalamin, Aspirin, Aricept, Lisinopril, Hydrochlorothiazide, Escitalopram Oxalate, Vitamin D3 2 TABs, Metoprolol, Mirapex, and placed crushed medications into individual medication cups. She poured out 10 ml of Keppra and 7 ml of Ferrous Sulfate into individual medication cups and she diluted 1 packet of Juven in the cup adding 30 ml of water. At approximately 07:09 a.m. she crushed each medication separately and returned them to their individual medication cups and at approximately 07:14 a.m. RN C entered Resident #10's room with all the medications. Resident #10 was observed to be non-verbal.ˆResidentˆdisplayed a flat face expression and some nonverbal sounds. RN C dissolved each medication with 10-15 ml of water and mixed each with the same spoon. At approximately 07:19 a.m. RN C washed her hands and put gown and gloves on. She connected syringe to Resident #10's G-tube port and poured a cup of the medication into the syringe's barrel. RN C did not check for placement of Resident #10's G-tube with auscultation (listening to sounds) or by checking residual (the amount of feed that can be withdrawn from the feeding tube that is used to determine stomach fullness) prior to administering the medications. Observation of the syringe when checked for residual by RN C revealed there was not (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any residual in the syringe. RN C stated that the residual was zero. RN C poured another cup of medication on top of the first medication; she did not flush the syringe before and after administering medications. RN C pushed medications using the syringe's plunger. After administering all crushed medications, RN C started administering enteral feeding Glucerna; she poured Glucerna directly into the syringe from the container. RN C wiggled the syringe from side to side and moved it in circular motion for Glucerna to go through. She used plunger to push Glucerna through and Glucerna went down the syringe. RN C added more Glucerna into syringe and continued to administer feeding. During an interview on 04/15/2026 at 12:24 p.m. with DON she stated she could not recall the last time she had training in administering medication through G-tube. She stated prior to administering medication or feeding via a resident's G-tube nursing staff were expected to check for resident's comfort, auscultate for bowel sound, pull back on plunger, check residual, put residual back; If there is no residual continue with the medication administration, Sometimes there is no residual. She stated that the syringe must be flushed with water before and between each medication. DON stated if medication is not going down the syringe the nursing staff can gently push the medication but not force it. DON did not answer this surveyor's question if there are consequences for a resident if the medication was forced down the tube when it encountered resistance. During an interview on 04/15/2026 at 12:34 p.m. with ADON B stated to administer medication or feeding via a resident's G-tube nursing staff must first check for placement by checking for auscultation with stereoscope and then pull back on the plunger, note the residual amount, and push the residual back in. Medication must be administered one by one and flushed before and after each medication. If there is resistance encountered during administration of medications, then nurse must check orders for amount to dilute the medication by adding liquid to the barrel, and then nurse can gradually push on a plunger. During an interview on 04/15/2026 at 2:38 p.m. with RN C she stated prior to administering medication or feeding via a resident's G-tube nursing staff were expected to do the following steps, Check for placement by auscultating and check the air, get each medication separately, give each medication with water in between, flush it again after administering all medications and give the feeding. I didn't auscultate [Resident #10] prior administering medications. She stated , if there was resistance during administration of the medications or flush was not going freely into the stomach by gravity then more water can be added, swirl the barrel to create centrifuge, give the plunger a gentle push. If the placement of the G-tube is not checked, I guess the patient could die. They'd be having medication go into the wrong area of the body. During an interview on 04/16/2026 at 1:24 p.m. the NP stated she is familiar with Resident #10 and that Resident #10 has PEG-tube. NP stated administering two medications through the syringe attached to Peg-tube without flushing the syringe after each medication is ok. She stated prior to administering medication or feeding via a resident's G-tube nurses were expected to verify placement of PEG-tube by Instilling air into a PEG-tubeˆwhile listening over the stomach with a stethoscope. She stated if there is no residual when the tube content is aspirated it is ok to continue with administering of medications. NP stated residuals are checked to make sure that the body is processing feedings and medications. If the body is not processing, there is risk for potential aspiration. Wiggling the PEG-tube with attached syringe when medication or flush water is not going through is ok, but it depends on how extensive wiggling is. Record review of the facility's undated policy titled Administering Medications through an Enteral Tubeˆwith revision date 05/2024 and reviewed dates: 01/2023, 03/2024, 06/2025, 3/3/2026 reflected: 6. Verify placement of feeding tube: a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 10. Administer each medication separately. 12. Administer medication by gravity flow: a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. 13. If administering more than one medication, flush with 15 mL water (or prescribed amount) between medications.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 1 resident (Resident # 2) reviewed for dialysis:The facility failed to ensure Resident #2 had a physician's order for hemodialysis (machine filters the blood when kidneys do not work) 3 x week on Mondays, Wednesdays, and Fridays.This failure could have placed residents on hemodialysis at risk of not receiving proper care and/or treatment.Findings Included:Record review of Resident #2' s admission MDS assessment, dated 03/30/2026, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 was diagnosed with end-stage renal disease and was dependent on renal dialysis (the final stage of chronic kidney disease where the kidneys can no longer filter waste and fluids from the blood effectively) and hypertension (high blood pressure). The MDS did not reflect Resident #2 was receiving dialysis.Record review of Resident # 2's care plan, dated 3/30/2026, reflected Resident #2 attends dialysis Mondays, Wednesdays, and Fridays. Date Initiated: 04/01/2026.Record review of Resident # 2's Progress notes , dated 4/13/2026, reflected Resident # 2 was a [AGE] year-old female with past medical history including non-insulin dependent diabetes mellitus type 2, ESRD. When the resident was admitted on [DATE], records reflected the resident was Dependent on renal dialysis. Resident dependent on hemodialysis Monday, Wednesday, Friday for end-stage renal disease. Interview and observation on 04/15/2026, at 11:38 AM, revealed Resident #2 was waiting on her ride to go to dialysis, and she attended every Mondays, Wednesdays, and Fridays. She stated she had been going to these appointments for the last two years.Record review reflected on 4/15/2026, at 7:00 PM, the facility updated the EMR to reflect Resident received dialysis 3 days a week on M-W-F at a dialysis center under the care of a nephrologist.Interview on 04/16/2026, at 11:31 AM , MDS A revealed Resident #2 would need ordersInterview and observation on 04/16/2026, at 1:38 PM, revealed Resident #2 was sitting in her room. The resident had just finished lunch, and stated she attended Dialysis on Mondays, Wednesdays, and Fridays and had not had any issues with the facility getting her to these appointments.Interview on 04/16/2026, at 1:52 PM, NP N revealed she does not treat Resident #2 for Dialysis, this was all managed through the dialysis provider; however, all orders should have been entered into the EMR and she was not aware this had not been done.Interview on 04/16/2026, at 1:58 PM, DON, revealed initially she did not catch that Resident #2 did not have Physician orders for dialysis when admitted . It was discovered she had a dialysis order a few days later.Interview on 04/16/2026, at 2:56 PM, ADON A, revealed an Inservice was started today on Dialysis documents. Interview on 04/16/2026, at 3:54 PM, DON, revealed she could not provide insight into why the orders were not entered into the system. She went on to reveal if orders are not entered properly, it could affect a resident's plan of care and their continuity.Record review of facility Dialysis Management Policy, dated 03/12/2026, reflected the following:Goals of Dialysis ManagementThe facility will collaborate with the resident's dialysis provider and attending physician to support safe and effective dialysis care.Through ongoing communication with the dialysis center, the facility will ensure coordination regarding: Dialysis treatment schedules and attendance Resident weights and fluid status monitoring Laboratory monitoring as directed by the dialysis provider Medication adjustments related to dialysis treatment Dietary recommendations and restrictions Dialysis access care and monitoring Identification and reporting of changes in the residents' conditionThe facility will promptly communicate any significant changes in the residents' status, including symptoms, access site concerns, abnormal vital signs, or other clinical concerns, to the dialysis center and physician as appropriate.Procedures Physician Orders1. Nursing staff will verify and follow physician orders related to dialysis treatment.2. Orders may include: Dialysis schedule Medications Dietary restrictions

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 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 was maintained and ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 resident (Resident #90) and 1 of 2 medication rooms observed for medications storage.ˆ The facility failed to document on Resident #90's MAR medication Tramadol (controlledˆopioid medicationˆused to manage moderate to severe chronic pain) and sign it out on the controlled medication count sheet; The controlled medication count sheet did not indicate the medication was administered or wasted. The facility failed to ensure that Medication room at the C&D nurses' station did not have expired medications in the drawer/room. These failures could place residents at risk for overdose of medication, under-dose of medication, ineffective therapeutic outcomes, and drug diversion.ˆFindings include: Record review of Resident #90's face sheet dated 04/15/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: Quadriplegia unspecified (paralysis affecting all four limbs and the torso), Major depressive disorder, recurrent, moderate (mental disorder, depressed mood or loss of pleasure or interest in activities for long periods of time), Dysphagia (difficulty swallowing), cognitive communication deficit (communication impairment stemming from underlying cognitive issues), pain, unspecified (generalized pain, acute pain, or pain not otherwise specified that lacks a clear, localized, or diagnosed cause). Record review of Resident #90's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 suggesting she was cognitively intact. Resident #90 is in Hospice care. Resident #90 has absence of spoken words. Record review of Resident #90's order summary report reflected an order dated 03/17/2026: Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 1 tablet via G-Tube three times a day for Pain related to Quadriplegia unspecified. Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as needed for Pain. Record review of Resident #90's undated care plan reflected the focus: The resident has low back pain r/t chronic physical disability and The resident is on pain medication therapy related to disease process with interventions: Administer analgesia per physician's orders. Acetaminophen-Codeine Tablet. Tramadol and Administer analgetic medications as ordered by physician. Monitor and document side effects and effectiveness every shift. Tramadol During an observation on 04/15/26 at 07:52 a.m. of the NC C&D for medication storage revealed Resident #90's controlled substance record sheet indicated remaining amount of Tramadol HCl 50 MG was 19 tablets. Further observation revealed Resident #90's blister pack contained 18 tablets of Tramadol HCl 50 MG. RN C stated that the medication was given to Resident #90 at 08:00 am and this is charted in Resident#90's MAR. At 07:54 a.m. RN C logged in to Resident #90's MAR and the medication was not charted as given. RN C stated, It is not charted. I am screwed. RN C started looking for Tramadol looking inside of each NC's C&D drawers. RN C was complaining of her ribs hurting and touching the left side of her back. RN C pulled out a white oval shaped pill from her left pocket and showed it to the surveyor stating, I found it. I forgot that I put it to my pocket. RN C placed the medication in a medication cup. She stated she will be administering Resident #90's morning medications next and started pulling out her medication from the C&D nursing cart and went to Resident #90's room around 08:21 a.m. During an interview on 04/15/2026 approximately at 8:20 a.m. with ADON B stated she does not know the reason RN C kept the narcotic medication Tramadol in her pocket. She stated that the procedure to pull out narcotic medication from the nursing cart is to verify the order, pull out the medication from the locked box in the nursing cart. Document the pulled-out medication in the narcotics book, administer the medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and then chart the given medication in resident's chart. Not giving pain medication may increase pain and affect a resident negatively. During an attempted interview on 04/15/2026 approximately at 10:20 a.m. with Resident # 90 she was calm without agitation. Resident # 90 had unclear speech. She moved her head from side to side when she was asked if she had any pain. During an interview on 04/15/2026 at 2:38 p.m. with RN C stated she was working in the facility for 6 years. RN C stated she kept Resident #90's Tramadol tablet while she was administering Resident #10's medications and enteral feeding in her room. She stated there was a 4 hour window to administer this medication and she administered the medication to Resident #90. RN C could not explain the reason she kept Tramadol in her pocket. She stated the process of administering narcotics are: Check the order, sign out the medication, give the medication, and then sign it out in the chart. She stated not administering pain medication can increase pain. During an interview on 04/16/2026 at 7:48 a.m. with ADM he stated he cannot tell the reason for the narcotic medication being inside of the nurse's pocket. He stated that to his knowledge they need to be stored safely locked. If any narcotic is pulled out by LVN or RN, the narcotic medication must be documented, it is not acceptable to place narcotics in nursing staff's pockets. When narcotic medication is pulled out for administration to residents, the nurse should write down the name of the resident and the name of the narcotic on the medication cup. There are different reasons to do so, it can be lost, not given or given to wrong residents. Narcotic medications must be counted by 2 nurses at the end of the shift. DON is responsible for any narcotic medications. Record review of the facility policy titled Medication administration with reviewed and revised dates: 03/05/2026, 06/2025, and with reviewed dates 7/8/2024, 4/1/2019 reflected: Purpose: -To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice. Record review of the facility in service titled Controlled Substancesˆdated 04/13/2026, reflected: Controlled substances are drugs that are subject to strict government control because they may cause addiction or be misused and possibly lead to death. The government's control impacts how these substances are made, used, stored, and transported. Some examples of controlled substances that we administer here include opioids, antianxiety, and hypnotics. Whenever a controlled substance is given per MD orders, you must sign it out on the narc count sheet for that medication, and you must sign it out in PCC. This is the facility's policy and a law. Don't risk your license, job and possibly going to jail. It is mandatory that controlled substances are documented correctly at all times. An observation and audit conducted on 04/16/2026 approximately at 07:26 a.m. of Medication Room located at the nurses' station C&D revealed that inside a mini fridge was expired fluticasone prop 50 mcg (Flonase); the expiration date of the medication was 02/12/2026. During an interview on 04/15/2026 around 8:20 a.m. with ADON B stated that the pharmacy consultant and DON are responsible for removing expired medications from the nursing and medications carts. Expired medication possibly can lose treatment effectiveness. During an interview on 04/16/2026 at 7:35 a.m. with MA H stated that the CMAs are not responsible for removing expired medications out of the med carts but if a resident is discharged then CNAs CMAs are responsible to remove the medications of discharged residents and place them in medication room. She stated that expired medications potentially would not work as expected for residents' treatment. During an interview on 04/16/2026 at 7:48 a.m. with ADM he stated he has been trained in medications administration; his last training in medications administration was in July of 2025. This training covered basics, like 5 rights of medications administration and the training included the proper labeling of the medication bottle. When a new bottle of medication is opened the date should be written on the cup or on the bottom of the bottle if possible. For example, today's date: 4/16/26. ADM stated he is not sure of the reason for expired medication not being removed from nurses' carts and medication rooms. The charge nurses or ADONs are responsible for checking for expired medications. Expired medications can potentially be given to the residents and may have negative effect on the residents. During an interview on 04/16/2026 at 9:17 a.m. with CPh she stated she is not responsible for removing the expired medications from the medication carts and med (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms, she can recommend removing them if she locates expired medications. Expired medication may lose its strength, it is less potent, possibly affects cleanliness. Record review of the facility undated policy titled Storage of Medications^with reviewed dates: 06/24/2025, 07/2024, reflected: 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #10 and Resident #90) of 2 residents observed for infection control. The facility failed to ensure RN C performed hand hygiene and changed gloves during administration of medications and feeding via G-Tube to Resident #10. The facility failed to ensure RN C performed hand hygiene during administration of Resident # 90's medications. This failure could place residents at risk of cross contamination and the spread of infection. Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #10 and Resident #90) of 2 residents observed for infection control. The facility failed to ensure RN C performed hand hygiene and changed gloves during administration of medications and feeding via G-Tube to Resident #10. The facility failed to ensure RN C performed hand hygiene during administration of Resident # 90's medications. This failure could place residents at risk of cross contamination and the spread of infection. Findings include: Record review of Resident #10's face sheet, dated 04/15/2026, reflected a [AGE] year-old female initially admitted [DATE]. Resident #10 had diagnoses which included cerebral infarction due to embolism of right middle cerebral artery (a stroke caused by a clot blocking blood flow to the right side of the brain, causing sudden left-side weakness/paralysis, sensory loss, and potential behavioral changes), epilepsy unspecified, intractable, with status epilepticus (a temporary, uncontrolled surge of electrical activity in the brain that can cause convulsions, altered awareness, or behavioral changes), type 2 diabetes mellitus without complications (high blood sugar (hyperglycemia) due to insulin resistance without associated damage to nerves, eyes, kidneys, or blood vessels), aphasia (impaired ability to understand or produce speech), dysphagia oral phase (difficulty preparing food in the mouth and initiating a swallow), Gastrostomy status (presence of a functioning feeding tube (G-tube) inserted through the abdomen into the stomach for enteral nutrition, hydration, or medication administration). ˆ Record review of Resident #10's Comprehensive MDS dated [DATE] reflected short-ˆ& long-term memory problems, severely impaired cognitive skills for daily decision making, total dependence for all ADLs, aphasia (brain damageˆthat affects the person's ability to communicate), feeding tube while a resident, received 51% or more of her intake via tube feeding and 501 ml per day or more via tube feeding, pressure ulcer stage 3. An observation on 04/15/26 approximately at 07:00 a.m. revealed Resident #10 had the Enhanced Barrier Precautions signs posted in English and Spanish languages on the right side of the door and PPE inside of the clear plastic drawers. At 07:00 a.m. RN C prepared medication for administration to Resident #10. At approximately 07:30 a.m. after administering all crushed medications, RN C started administering enteral feeding Glucerna; she poured Glucerna directly into the syringe from the container and spilled some of it on Resident #10's stomach. RN C picked up a paper towel from Resident #10's bedside table and wiped the spill off from Resident #10's stomach and continued administering enteral feeding without performing hand hygiene and changing her gloves. RN C wiped off a stain left from Glucerna's box on the medication table using the same paper towel she previously used to wipe off the spill on Resident #10's stomach. RN C wiped off the stain left from Glucerna's box on the medication table using the same paper towel another 2 times while she continued to administer Resident #10's feeding without performing hand hygiene and changing gloves. Record review of Resident #90's face sheet dated 04/15/2026 reflected a [AGE] year-old female with initial admission date 03/05/2025 with diagnoses that included: Quadriplegia unspecified (paralysis affecting all four limbs and the torso), Major depressive disorder, recurrent, moderate (mental disorder, depressed mood or loss of pleasure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or interest in activities for long periods of time), Dysphagia (difficulty swallowing), cognitive communication deficit (communication impairment stemming from underlying cognitive issues), pain, unspecified (generalized pain, acute pain, or pain not otherwise specified that lacks a clear, localized, or diagnosed cause). Record review of Resident #90's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 suggesting she was cognitively intact. Resident #90 is in Hospice care. Resident #90 has absence of spoken words. Record review of Resident #90's order summary report reflected; Tramadol HCl Oral Tablet 50 MG (Tramadol HCl). Give 1 tablet via G-Tube three times a day for Pain related to Quadriplegia unspecified. dated 03/17/2026 Record review of Resident #90's undated care plan reflected the focus: The resident requires tube feeding r/t diagnosis of spastic quadriplegic cerebral palsy (extreme muscle stiffness and involuntary movements in all four limbs, the trunk, and the face). date initiated 03/18/2025. The goal The resident's insertion site will be free of s/s of infection. date initiated 03/18/2025. During an observation on 04/15/26 at 07:52 a.m. RN C pulled out Resident #90's Tramadol HCl 50 MG pill from her left pocket and placed the medication in a medication cup. RN C stated she will be administering Resident #90's morning medications next and started preparing Resident #90's medications on the NC C&D without performing hand hygiene. During an interview on 04/15/2026 at 12:24 p.m. with DON she stated she was working in the facility for 3 years. She stated she has been trained in infection control. DON stated that it is expected for nurses to perform hand hygiene before and after each patient, clean area, off gloves, hand hygiene again. She stated that wiping off resident's body and then cleaning the work area with the same paper towel without performing hand hygiene and changing gloves is not acceptable. During an interview on 04/15/2026 at 12:34 p.m. with ADON B she stated that it is unacceptable if nurse is cleaning a spill from resident's body and then wiping off the medication table repeatedly with the same paper towel while continuing administering feeding via G-tube without performing hand hygiene and changing gloves. It is an infection control issue; residents can get infection. During an interview on 04/15/2026 at 2:38 p.m. with RN C she stated that during medication administration to Resident #10 she used a paper towel from the resident's bedside table to wipe off a spill from Resident #10's stomach and then used the same paper towel to clean the medication table while continuing feeding the resident via G-tube without performing hand hygiene wearing the same gloves because she was only working in that resident's room and with that one resident only. RN C stated that she did not follow appropriate infection control practice. She stated that she should have properly discarded the Tramadol pill she pulled out of her pocket and pulled a new one. She stated that nurses must perform hand hygiene before administering medications to residents. Not performing hand hygiene may cause spread of infection. During an interview on 04/16/2026 at 7:35 a.m. with MA H she stated she has been trained in infection control, it is monthly in-service training. The infection control training covered how to protect residents while providing care to the residents; putting on the proper PPE when providing direct care to the residents on precautions; performing hand hygiene, gowning up, using gloves and face masks when required. This training also covered hand hygiene procedures when administering medications to the residents; Hands must be washed if they are visibly soiled. Hand sanitizing before starting pulling out residents' medications. Before going to the residents' rooms to administer medications and after leaving the residents' rooms, Sanitize hands in and out of the residents' rooms. She stated staff can give residents infections; they can get sick if the infection control protocol is not followed. During an interview on 04/16/2026 at 7:48 a.m. ADM stated his last training in infection control was in July of 2025. The training covered hand hygiene and when to do it, use of PPE when it is required. Washing hands when they are visibly soiled. Hand hygiene before and after giving medications to residents. Not following hand hygiene protocols can potentially increase the risk of infection. Record review of the facility undated policy titled Handwashing/hand Hygiene reflected: 1. Hand hygiene is indicated: a. immediately before touching a resident: d. after touching a resident. e. after touching the resident's environment; g. immediately after glove removal. Record review of the facility policy titled Medication administration with reviewed and revised dates: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/05/2026, 06/2025, and with reviewed dates 7/8/2024, 4/1/2019 reflected: Infection Control Staff follow established infection control practices during medication administration, including: Hand hygiene Appropriate PPE use

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents for 1 of 8 residents (Resident #17) reviewed for pest control. The facility failed to ensure that Resident #17's room was free of flies on 04/16/2026. This failure placed residents at risk of infection and diminished quality of life.Findings Included:Review of the undated face sheet for Resident #17 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy, affecting all four limbs, the trunk, and often the face, causing significant muscle stiffness and motor impairment), severe intellectual disabilities, Rett syndrome (genetic disorder that typically becomes apparent after 6-18 months of age; symptoms include impairments in language and coordination, and repetitive movements), dysphagia (trouble swallowing), cognitive communication deficit (problems communicating due to cognitive impairment), protein-calorie malnutrition (lack of protein in the diet), epilepsy (seizure disorder), depressive episodes, gastrostomy status (feeding tube), and chronic pain. Review of the annual MDS assessment for Resident #17 dated 10/10/2025 reflected her cognitive impairment was so severe that she could not participate in a BIMS assessment for cognition. Review of the section on functional status reflected she was completely dependent on staff for bed mobility and personal hygiene. Review of the care plan for Resident #17 dated 10/03/2025 reflected the following: FocusResident is PASRR positive for IDD. Resident does have a custom W/C through PASRR, which she tolerates appropriately at this time. Resident requires total assistance from staff for all ADLs and mobility and is a part of the contracture management program.GoalResident will receive services that will be provided to benefit her well-being.FocusResident has alteration in ADL participation RT DX CP, ID, impaired mobility, spastic CP InterventionBED MOBILITY: The resident is totally dependent on staff for repositioning and turning in bed Q2H and as necessary. Observation on 04/16/2026 at 11:35 AM revealed Resident #17 was up in a tilt-back wheelchair next to her bed. There was a western on her roommate's television, and her roommate was not in the room. She interacted non-verbally by making eye contact, making noises, and moving her face. There was one housefly and at least seven fruit flies swarming around her and landing on her and the pillow on the bed next to her. During an interview on 04/16/2026 at 11:37 AM, ADON A stated it was the first time she had seen insects in Resident #17's room. She stated she did not know why the CNA who had visited Resident #17's room did not notice it. During an interview on 04/16/2026 at 11:45 AM, the MAINT stated he was aware they had been working on getting rid of fruit flies in the facility and had pest control coming out as needed. He stated he had not seen the flies on any residents with peg tubes and relied on the staff to report sightings like that. He stated if flies landed on a resident with a peg tube that could cause an infection. During an interview on 04/16/2026 at 11:59 AM, the service manager for the facility pest control company stated he was aware there was a fruit fly problem at the facility. He stated the facility had gone to twice monthly pest control instead of once monthly. He stated it was not a huge infestation and probably the fault of residents who did not allow staff to fully clean up their rooms. He stated the staff wrote pest sightings in the log and the technician read the log and treated those problems. He stated fruit flies were hard to control. During an interview on 04/16/2026 at 2:10 PM, CNA M stated he saw flies in the building once in a while but had never seen any in Resident #17's room. He stated he had been in her room that day but had not noticed the flies. He stated he was supposed to report the flies in the pest control book. He stated he did not know the potential negative outcome of flies being on Resident #17 and her belongings. During an interview on 04/16/2026 at 2:42 PM, ADON A stated the staff should have rounded on residents every two hours and she rounded on all the residents after lunch. She stated the procedure was for the staff to write any pest sightings in the pest control log. She stated she had spoken to CNA M who had denied seeing any flies in Resident (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#17's room when he rounded. During an interview on 04/16/2026 at 4:08 PM, the ADM stated the person responsible for ensuring there were no pests in the building was maintenance. He stated he monitored the system for compliance by doing rounds. He stated the potential negative impact of the flies being in Resident #17's room was they could land anywhere on her and cause an infection. Review of facility policy dated May 2008 and titled Pest Control reflected the following: Policy StatementOur facility shall maintain an effective pest control program.Policy Interpretation and ImplementationThis facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.