STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675633	A. Building B. Wing	04/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Lake Rehabilitation and Wellness Center	1201 Holland Lake Dr Weatherford, TX 76086

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 5 of 7 residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5) reviewed for care plans. 1. The facility failed to ensure the staff implemented the comprehensive care plan goals and interventions for Resident #1. 2. The facility failed to ensure the comprehensive care plan for Resident #2, Resident #3, Resident #4 and Resident #5 described the resident's goals for admission and desired outcomes. 3. The facility failed to ensure the comprehensive care plans for Resident #2, Resident #3, Resident #4 and Resident #5 described the resident's preference and potential for future discharge. 4. The facility failed to ensure the comprehensive care plans for Resident #2, Resident #3, Resident #4 and Resident #5 documented a desire to return to the community was assessed. These failures could place residents at risk of inadequate care and services resulting in physical harm or psychosocial harm.Findings include: Record review of Resident #1's face sheet, reviewed on 4/11/2026, revealed an [AGE] year-old male with an admission date of 01/07/2026. Resident #1 had diagnoses which included: type 2 diabetes (body does not use insulin and sugar builds up in the blood), fracture of lower end of right femur (break in lower thigh bone above knee), hypertension (high blood pressure), disorder of kidney and ureter (blockage where kidney and ureter meet and may cause kidney to swell and eventually stop working), leukemia (cancer of blood-forming tissues, including bone marrow and lymphatic system), atrial fibrillation (irregular and often very rapid heart rhythm), muscle wasting and atrophy (reduction in muscle thinning and mass). Record review of Resident #1's comprehensive care plan, dated 1/29/2026, revealed Resident #1 had potential for signs and symptoms and complications related to hypertension. The comprehensive care plan intervention for this focus was to give anti-hypertensive meds as ordered. Observe for side effects such as orthostatic hypotension, and increased heart rate. Record review of Resident #1's Physician Orders, dated 01/26/2026, revealed AmLODIPine Besylate tablet 10 MG to give 1 tablet by mouth one time a day for HTN. Hold for SBP less than 110. The Physician Orders further revealed Metoprolol Tartrate Oral Tablet 100MG to give 1 tablet by mouth two times a day for HTN. Hold for HR less than 55 and/or SBP less than 100. Record review of Resident #1's MAR, reviewed on 4/12/2026, revealed on 4/07/2026, Resident #1's blood pressure reading was 109/52 and HR of 53. RN administered AmLODIPine Besylate and Motoprolol despite the hold parameters in the physician orders for both medications. In an interview on 4/12/2026 at 11:34 a.m. with RN, she revealed she did provide the HTN medications to Resident #1 on 4/7/2026, because she utilized her nursing judgement instead of following the physician orders. RN stated Resident #1's blood pressure was borderline, and he was about to get up for therapy. She stated to get this resident up was a workout for him and therapy would also get his blood pressure and HR up. The RN stated her fear was his blood pressure would skyrocket during therapy. The RN stated she should have contacted the doctor before administering the medication. She also stated (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's blood pressure and heart rate were good and back up later per documentation, so nothing bad happened to Resident #1. Record review of Resident #2's face sheet, reviewed on 4/11/2026, revealed a [AGE] year-old female with an admission date of 12/06/2025. Resident #2 had diagnoses which included: metabolic encephalopathy (brain dysfunction due to an underlying condition), hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side (partial weakness and motor impairment on one side often due to brain damage), cerebral infarction (stroke caused by blockage in an artery supplying blood to the brain resulting in tissue death due to lack of oxygen), narcolepsy without cataplexy (sudden and temporary muscle weakness usually triggered by strong emotions), depression (persistent sadness interfering with daily life). Record review of Resident #2's comprehensive care plan record, dated 2/12/2026, revealed no evidence of documented discharge plans or discharge assessments. In an attempted interview on 4/10/2026 at 3:45 p.m. with Resident #2, she did not answer questions and was uninterviewable. Record review of Resident #3's face sheet, reviewed on 4/11/2026, revealed a [AGE] year-old female with an admission date of 01/16/2026. Resident #3 had diagnoses which included: type 2 diabetes (body does not use insulin and sugar builds up in the blood), spinal stenosis (space inside backbone too small), bipolar disorder (extreme mood swings), emphysema resulting from a procedure (air gets into tissues under the skin). Record review of Resident #3's comprehensive care plan record, dated 3/16/2026, revealed no evidence of documented discharge plans or discharge assessments. In an interview on 4/10/26 at 6:15 p.m. with Resident #3, she stated staff make sure she is taken care of. Resident #3 stated she finally realized she cannot live on my own. Record review of Resident #4's face sheet, reviewed on 4/11/2026, revealed a [AGE] year-old female with an admission date of 03/01/2023. Resident #4 had diagnoses which included: atrial fibrillation (irregular and often very rapid heart rhythm), unspecified dementia (loss of memory, language problem-solving and other thinking abilities affecting daily life), depression (persistent sadness interfering with daily life), atherosclerotic heart disease of native coronary artery (hardening of artery from gradual plaque buildup), cognitive communication deficit (problem with communication due to a disruption in cognitive processes). Record review of Resident #4's comprehensive care plan record, dated 04/09/2026, revealed no evidence of documented discharge plans or discharge assessment. In an interview on 4/10/2026 at 1:06 p.m. with Resident #4, she revealed she was cared for by staff and had no concerns. She stated she was not sure if she would stay at the facility but had no plans to leave currently. Record review of Resident #5's face sheet, reviewed on 4/11/2026, revealed a [AGE] year-old male with an admission date of 01/28/2025. Resident #5 had diagnoses which included: major depressive disorder (persistent low mood and loss of interest in activities), type 2 diabetes (body does not use insulin and sugar builds up in the blood), nontraumatic subdural hemorrhage (type of bleeding in the head when blood collects under outer layer of tissue closest to the skull between brain and skull), acquired absence of right and left foot, hemiplegia and hemiparesis following cerebral infarction (weakness on one of the body due to lack of blood flow to the brain). Record review of Resident #5's comprehensive care plan record, dated 03/11/2026, revealed no evidence of documented discharge plans or discharge assessments. In an interview on 4/10/2026 at 4:10 p.m. with Resident #5, he stated staff took care of his needs and he had no concerns. In an interview on 04/12/2026 at 11:13 a.m. with the ADON, she stated the SW, DON, activities, dietary, and therapy all met to set up the care plan and goals of if the resident would go home or if they would set up more skilled days or not. The ADON stated she believed they all had a part in documenting discharge plans for the residents. She stated a negative effect of the discharge plan not documented on the care plan could be the residents not being followed up with properly. In an interview on 4/12/2026 at 12:12 p.m. with the DON, she stated the SW was responsible for documenting discharge planning in the care plan. In an interview on 4/12/2026 at 12:38 p.m. with the SW, she stated she was the person responsible for documenting discharge planning in the care plan. The SW stated she was aware discharge information was supposed to be in the care plan. She stated she felt it was in the care plan under (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychosocial well-being due to long-term care placement. The SW stated she did not document if the resident planned to stay at the facility, but it was documented elsewhere. The SW further stated if it was not in the care plan, she had not gotten to it yet. In an interview on 4/12/2026 at 2:11 p.m. with the ADM, she stated she did not feel there were any negative effects from the discharge planning not being in the care plan because staff always looked at discharge planning and addressed it. Record review of the Comprehensive Care Planning policy, dated December 2016, reflected 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. 8. The comprehensive, person-centered care plan will: a.c. Describe services That would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d.f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desired.

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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 interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 7 resident's (Resident #1) reviewed for pharmaceutical services. The facility failed to ensure staff followed physician orders in administering Resident #1's medication. This failure could place residents at risk of physical harm and inadequate care and services.Findings include: Record review of Resident #1's face sheet, dated 4/11/2026, revealed an [AGE] year-old male with an admission date of 01/07/2026. Resident #1 had diagnoses which included: type 2 diabetes (body does not use insulin and sugar builds up in the blood), fracture of lower end of right femur (break in lower thigh above knee), hypertension (high blood pressure), disorder of kidney and ureter (blockage where kidney and ureter meet and may cause kidney to swell and eventually stop working), leukemia (cancer of blood-forming tissues, including bone marrow and lymphatic system), atrial fibrillation (irregular and often very rapid heart rhythm), muscle wasting and atrophy (reduction in muscle thinning and mass). Record review of Resident #1's Physician Orders, dated 1/26/2026, revealed AmLODIPine Besylate tablet 10 MG to give 1 tablet by mouth one time a day for HTN. Hold for SBP less than 110. The Physician Orders further revealed Metoprolol Tartrate Oral Tablet 100MG to give 1 tablet by mouth two times a day for HTN. Hold for HR less than 55 and/or SBP less than 100. Record review of Resident #1's MAR, reviewed on 4/12/2026, revealed on 4/07/2026, Resident #1's blood pressure was 109/52 and HR was 53. RN administered AmLODIPine Besylate and Metoprolol despite hold parameters in the physician orders for both medications. In an interview on 4/10/2026 at 7:08 p.m. with Resident #1, he stated he believed he got his medications correctly and experienced no issues with his medications. Resident #1 stated the only concern he had was he got cold. In an interview on 4/12/2026 at 11:34 a.m. with RN, she revealed she was trained in medication administration. The RN stated she did provide the HTN medications to Resident #1 on 4/7/2026, because she utilized her nursing judgement instead of following the physician orders. The RN stated Resident #1's blood pressure was borderline, and he was about to get up for therapy. She stated to get this resident up was a workout for him and therapy would also get his blood pressure and HR up. The RN stated her fear was his blood pressure would skyrocket during therapy. The RN stated she should have contacted the doctor before administering the medication. In an interview on 4/11/2026 at 1:38 p.m. with LVN, she stated too much blood pressure medication could make a person dizzy or non-responsive and not enough could also make them dizzy as it depended on the patient. In an interview on 4/12/2026 at 11:13 a.m. with the ADON, she stated all nurses were trained in medication administration. The ADON stated she was not aware the RN provided HTN medications outside of physician order parameters to Resident #1. She stated this could cause dizziness and hypotension episodes such as not being able to stand up, faint, or have a fall. The ADON stated other negative effects could be that the patient may not feel good and it could make them feel cold. In an interview on 4/12/2026 at 12:12 p.m. with the DON, she stated she was not aware the RN provided medications outside of parameters for Resident #1. The DON stated parameters were there for a reason and the nurses were not to make that judgment call and the RN should have contacted the doctor and documented the conversation. The DON stated the negative effect could have been Resident #1's blood pressure could have dropped. The DON did not provide further effects on blood pressure dropping. In an interview on 4/12/2026 at 2:11 p.m. with the ADM, she stated she could not say if there would be a negative effect of the RN providing the medication to Resident #1 and not following parameters because that was a medical question. The ADM stated they would educate staff to make sure they follow parameters in the future. Record review of Administering Medications policy, dated December 2012, revealed Medications shall be administered in a safe and timely manner, and as (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed.3. Medications must be administered in accordance with the orders, including any required time frames.