STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675637	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooldridge Place Nursing Center	7352 Wooldridge Rd Corpus Christi, TX 78414

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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 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 residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 5 of 8 (Resident #82, Resident #21 , Resident #53 , Resident #32, and Resident #1) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #82's oxygen was administered at the correct setting of 3 liters per minute on 2/24/2026 as ordered by the physician. 2. The facility failed to ensure Resident #21's oxygen was administered at the correct setting of 2 liters per minute on 2/24/2026 as ordered by the physician. 3. The facility failed to ensure Resident #53's oxygen was administered at the correct setting of 4 liters per minute on 2/24/2026 as ordered by the physician. 4. The facility failed to post an Oxygen sign indicating Resident #32 received oxygen on 2/24/2026. 5. The facility failed to ensure Resident #1's oxygen was administered at the correct setting of 2 liters per minute on 2/24/2026 as ordered by the physician. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications, a decreased quality of care, and at risk of fire hazards by not posting oxygen signs outside the residents' rooms. The findings included: Record review of Resident #82's admission record dated 2/24/2026 reflected an [AGE] year-old female with an admission date of 02/17/2026. Pertinent diagnoses included Shortness of Breath, Chronic Obstructive Pulmonary Disease (a progressive lung condition causing airflow blockage, making breathing difficult, and includes emphysema and chronic bronchitis). Record review of Resident #82's person-centered care plan, initiated date 2/17/2026 reflected Resident #82 used oxygen therapy related to respiratory illness. Intervention included: Observe for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis (excessive, abnormal sweating), Headaches, Lethargy, Confusion, Atelectasis (the partial or complete collapse of one or more lobes of the lung), Hemoptysis (coughing up blood), Cough, Pleuritic pain a sharp, stabbing, or piercing chest pain that intensifies when breathing deeply), Accessory muscle usage (the recruitment of neck, chest, and abdominal muscles to assist with breathing when primary muscles are insufficient), Skin color. Record review of Resident #82's Order Summary dated 2/24/2026, reflected Oxygen at 3 liters per minute continuously per nasal cannula every shift. Record review of Resident #82's admission MDS assessment, dated 02/17/2026 reflected in progress. During an observation of Resident #82 on 2/24/2026 at 10:12 a.m. the oxygen level on the oxygen concentration machine was at 2 Liters Per Minute via nasal cannula. Observation of Resident #82 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the resident was in bed with head of the bed slightly elevated. No signs of respiratory distress noted. During an interview on 2/24/2026 at 10:20 a.m. LVN D stated she was the nurse for Resident #82. LVN D agreed that the Oxygen setting was set at 2 Liters Per Minute. She stated the oxygen setting was supposed to be at 3 Liters Per Minute per physician orders. She stated that she checked the settings at the beginning of her shift. She was not sure who might have moved it. LVN D stated that she checked Resident #82's oxygen tubing and saturation in the mornings. LVN D stated that the negative outcome of keeping Resident# 82's oxygen setting at 2 Liters Per Minute was that the resident could go to respiratory distress, shortness of breath or hypoxia (low oxygen levels). During an interview on 2/26/2026 at 2:40 p.m. the DON, stated that the nurses assigned to that hall were responsible for checking the Oxygen settings. She stated that the nurses were to check the setting twice per shift and as needed. The DON stated they were to follow oxygen settings on physician orders. The DON stated that the negative outcome could be that the resident could have difficulty breathing and hypoxia (low oxygen levels). Record Review of the facility's Oxygen Administration policy, revised 09/30/2025, revealed Definitions Oxygen Therapy- is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. Procedure: Oxygen Administration: 1. Oxygen orders should include the specific liter flow required by the resident. General Safety Guidelines 1. Post a NO SMOKING sign on the outside of door to the residents room before starting use of oxygen. Oxygen Signage Guidelines 1. NO SMOKING sings (and/or the international symbol for no smoking), readable from a distance of 5ft, need to be posted where supplemental oxygen is in use. The findings included: Record review of Resident #21's face sheet, dated 02/26/2026, revealed a [AGE] year-old male with an admission date of 12/06/2024. Pertinent diagnosis included Diffuse Traumatic Brain Injury (severe brain injury characterized by widespread damage to the brain). Record review of Resident #21's Annual MDS assessment, dated 12/01/2025, revealed no BIMS conducted as Resident #21 was rarely or never understood. MDS Diagnoses revealed Traumatic Brain Injury. Record review of Resident #21's physician orders, started 12/06/2024, revealed an order for Oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 2 liters per minute continuously per nasal cannula. Record review of Resident #21's care plan for Oxygen therapy, initiated 12/09/2024, revealed an intervention to give medications as ordered. An observation on 02/24/2026 at 3:42 PM revealed Resident #21's oxygen concentrator was set at 1.5 liters per minute. In an interview on 02/24/2026 at 8:27 AM, the DON stated Resident #21's oxygen should be set on 2 liters per minute, or it can be titrated up to 3 to 4 liters per minute if his oxygen saturation dropped below 90%. She also stated Resident #21's oxygen concentrator settings should not be set lower than 2 liters per minute because if a residents' oxygen saturation dropped too low they could experience hypoxia, or not enough oxygen to meet the demand of the body. Record Review of the facility's Oxygen Administration policy, revised 09/30/2025, revealed Procedure: Oxygen Administration: 1. Oxygen orders should include the specific liter flow required by the resident. 3. Record review of Resident #53's face sheet, dated 02/24/2026, revealed an [AGE] year-old male with an admission date of 05/02/2025 and an initial admission date of 12/27/2024. Pertinent diagnosis included Acute and Chronic Respiratory Failure with Hypoxia (when the tissues of your body don't have enough oxygen) and Chronic Obstructive Pulmonary Disease (lung disease that causes obstructed airflow from the lungs). Record review of Resident #53's Quarterly MDS assessment, dated 02/06/2026, revealed a BIMS score of 03 indicated he had severe cognitive impairment. MDS Additional active Diagnoses revealed Dependence of Supplemental Oxygen. Record review of Resident #53's physician orders, started 05/03/2025, revealed an order for Oxygen at 4 liters per minute continuously per nasal cannula. An observation on 02/24/2026 at 11:20 a.m. revealed Resident #53's oxygen concentrator was set at 3 liters per minute. In an interview on 02/24/2026 at 11:30 a.m., LVN D stated that she was the nurse for Resident #53. She stated that she was not sure if Resident #53's oxygen was supposed to be at 3 or 4 liters per minute. LVN D stated that she checks the oxygen setting twice during her shift. If the resident goes out to therapy or out with family, she checks it again when they return. She stated that she checked the oxygen setting this morning. LVN D then logged into the computer, reviewed Resident #53's oxygen setting physician order and stated that it was supposed to be at 4 liters per minute. LVN D verified that the oxygen setting was set at 3 liters per minute. She checked Resident #53's SPO2 and it was 95%. LVN D stated the negative outcome to keeping Resident #53's oxygen setting at 3 liters per minute was that he could have altered mental status. 4. Record review of Resident #32's face sheet, dated 02/24/2026, revealed a [AGE] year-old male with an admission date of 12/30/2025. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (lung disease that causes obstructed airflow from the lungs), Primary Spontaneous Pneumothorax (the sudden onset of a collapsed lung without any apparent cause), and Congestive Heart Failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #32's Comprehensive MDS assessment, dated 01/05/2026, revealed a BIMS score of 11 indicated he had moderate cognitive impairment. Section O-Special Treatments, Procedures, and Programs indicated he was on Oxygen Therapy. Record review of Resident #32's physician orders, started 12/31/2025, revealed an order for Oxygen at 3 liters per minute continuously per nasal cannula. An observation on 02/24/2026 at 2:30 p.m. revealed Resident #32 was in his room lying on his bed. He was wearing a nasal canula and was receiving oxygen at 3 liters per minute. There was no oxygen sign posted outside of his room. In an interview on 02/24/2026 at 2:25 p.m., LVN D stated that she was the nurse for Resident #32. She stated that all the staff were responsible for posting the oxygen sign outside the residents' rooms. LVN D verified that Resident #32 did not have an oxygen sign posted outside his room. She stated that all residents who wereon oxygen regardless of needing it continuously or prn, they all need a sign. LVN D stated that it was important for posting an oxygen sign outside the resident's rooms, so no one smokes and to make everyone who went into the facility aware that there was oxygen in use inside the room. 5. Record review of Resident #1's face sheet, dated 02/24/2026, revealed a [AGE] year-old female with an admission date of 02/03/2026 and an initial admission date of 12/24/2025. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (lung disease that causes obstructed airflow from the lungs) and Congestive Heart Failure. Record review of Resident #1's MDS assessment, dated 02/06/2026, revealed a BIMS score of 14 indicated she had no cognitive impairment. Section O-Special Treatments, Procedures, and Programs indicated he was on Oxygen Therapy. Record review of Resident #1's physician orders, started 02/24/2026, revealed an order for Oxygen at 2 liters per minute continuously per nasal cannula. An observation on 02/24/2026 at 3:30 p.m. revealed Resident #1's oxygen concentrator was set at 1.5 liters per minute. In an interview on 02/24/2026 at 3:35 p.m., LVN C stated that he was the nurse for Resident #1. He stated that he checks the oxygen setting once during his shift. He stated that he checked it this morning, 2/24/2026. He stated that he was not sure if Resident #1's oxygen was supposed to be at 2 liters per minute. LVN C verified that the oxygen setting was set at 1.5 liters per minute. He checked Resident #1's SPO2 and it was 95%-97%. He then logged into the computer, reviewed Resident #1's oxygen setting physician order, and stated that it was supposed to be at 2 liters per minute. LVN C stated the negative outcome to keeping Resident #1's oxygen setting at 1.5 liters per minute was that he could desaturate (decrease amount of oxygen), become short of breath, get confused and lead to a fall. In an interview on 02/26/2026 at 8:47 a.m., the ADON stated that the floor nurses were responsible for verifying the oxygen order and the oxygen setting every shift. She stated that anybody could post the oxygen sign on the outside of the residents' room, but it was the responsibility of the admitting nurse. The ADON stated that it was important for the oxygen sign to be posted for everyone to know that there was oxygen in use in that room. She stated that she does random compliance rounds. She (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that if the oxygen setting was low then the resident could get hypoxic (the tissues of the body do not have enough oxygen). The ADON stated that the oxygen saturations were checked every shift. In an interview on 02/26/2026 at 3:22 p.m., the DON stated that it was the responsibility of the nurse who gets the order to post the oxygen sign on the outside of the resident's room. She stated that the oxygen signs were easily accessible for the nurses to get. The DON stated that compliance rounds were completed once a week by their administrative team. She stated that the oxygen sign should be posted so that people going into that room know there was oxygen in use. The DON stated that the nurses do ongoing monitoring of the oxygen setting. She stated that training was provided for oxygen administration annually at the end of the year. Record Review of the facility's Oxygen Administration policy, revised 09/30/2025, revealed Definitions Oxygen Therapy- is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. Procedure: Oxygen Administration: 1. Oxygen orders should include the specific liter flow required by the resident. General Safety Guidelines 1. Post a NO SMOKING sign on the outside of door to the residents room before starting use of oxygen. Oxygen Signage Guidelines 1. NO SMOKING signs (and/or the international symbol for no smoking), readable from a distance of 5ft, need to be posted where supplemental oxygen is in use.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident #8) reviewed for pharmacy services. The facility failed to ensure Resident #8's blood pressures were assessed prior to administering Lisinopril (a medication used to treat high blood pressure) per the prescribed order and blood pressure parameters in February of 2026. This failure could have placed residents at risk for complications and jeopardize their health and safety.The findings Included: Record review of Resident #8's face sheet, dated 02/26/2026, revealed an [AGE] year-old female with an admission date of 02/05/2026 and a discharge date of 02/25/2026. Pertinent diagnosis included Essential Primary Hypertension (high blood pressure).Record review of Resident #8's physician orders, started 02/07/2026, revealed an order for Lisinopril 40 MG, give one tablet by mouth daily for Hypertension. Hold for blood pressure less than 110/60 and/or pulse less than 60.Record review of Resident #8's care plan for hypertension, initiated 02/15/2026, revealed Resident #8 will remain free of complications related to hypertension through review, and an intervention to give anti-hypertensive medications as ordered and observe for side effects such as orthostatic hypotension (low blood pressure which could happen when standing after sitting or lying down) and increased heart rate. Record review of Resident #8's February 2026 MAR revealed Lisinopril 40 MG, give one tablet by mouth daily for Hypertension at 8:00 AM. Hold for blood pressure less than 110/60 and/or pulse less than 60. There were no blood pressures listed in the MAR to coincide (reflect or occur at the same time) with the medication. The MAR also revealed the Lisinopril was administered on all days from 02/06/2026 - 02/24/2026.Record review of Resident #8's vital signs revealed no blood pressures taken in the mornings to coincide with the blood pressure medication on the following dates: 02/05/2026, 02/06/2026, 02/07/2026, 02/08/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/14/2026, 02/15/2026, 02/16/2026, 02/17/2026, 02/18/2026, 02/19/2026, 02/21/2026, 02/22/2026, and 02/23/2026. In an interview on 02/26/2026 at 8:27 AM, the DON stated nurses should always check the blood pressure prior to administering the blood pressure medication. The DON also stated if a blood pressure was already low, and the blood pressure medication was administered, the blood pressure could have continued to drop, and the resident's blood pressure could have bottomed out, causing potential health risks for the resident such as dizziness, blurred vision, fainting, or even possibly shock. She stated she could not find any blood pressure listed in Resident #8's February MAR to coincide with the blood pressure medication, but she was able to find possibly two blood pressures listed in the February vital signs, and given the times they were taken, could possibly coincide with Resident #8's blood pressure medication. In an interview on 02/26/2026 at 2:55 PM, MA-B stated he only worked PRN, but thought he recalled Resident #8, but did not recall her blood pressure medication or any of her blood pressures. MA-B stated if Resident #8 was on a blood pressure medication he would have taken the blood pressure prior to administering the medication because he always checked blood pressures prior to blood pressure medications. He stated he may not have recorded or written down the blood pressures when he took them, or he may have recorded them at a different time which did not coincide with the blood pressure medication, but he stated he would not have administered the blood pressure medication without the blood pressure. He also stated it was important to check the blood pressure because if a resident's blood pressure dropped too low it could make them feel sick. In an interview on 02/26/2026 at 3:00 PM, LVN-C stated he recalled Resident #8 and her blood pressure medication. He stated he thought the reason there were no blood pressures to coincide with the blood pressure medication was because there was no place or line on the MAR to record the blood pressures. He stated usually with blood pressure medications on the MAR there was a place to enter the blood pressure next to where you sign off which you gave the blood pressure medication, but he did not recall there being one on Resident #8's MAR. He stated he always took the residents' blood pressure prior to administering (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood pressure medication because if the blood pressure was too low, the medication needed to be held because it could make the resident feel sick if it continued to drop. Record Review of the facility's Medications Administration policy, revised 05/05/2022, revealed Policy: The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Procedure: 2. Staff who are responsible for medication administration will adhere to the 10 rights of medication administration: f. Right Assessment: Note the resident's history and any parameters around drug administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were labeled and stored appropriately for 3 of 4 medication carts (100 Hall Nurse Med-Cart and 200/400 Hall and 300 Hall Medication Carts) reviewed for labeling and storage. 1. The facility failed to ensure the 100 Hall Nurse Med-Cart was locked and secured. 2. The OTC medications in the 200/400 Hall and 300 Hall Medication Carts did not have an open date written on the liquid and powder bottles. 3. The facility failed to ensure a (diabetic) lancet, sitting on top the unattended 200 hall medication cart, was used. These failures could have placed residents at risk of gaining access to unlocked medications which were not prescribed to them and could have caused them harm and not receiving the therapeutic effects of the medication and could place residents at risk of access or injury to a lancet. The findings included: 1.An observation on 02/26/2026 at 2:41 PM of the 100 Hall Nurse Med-Cart belonging to LVN-A parked at the nurses' station revealed an unlocked medication cart. The lock on the med-cart was popped out, and all drawers, except the narcotic drawer, were able to be accessed. An observation on 02/26/2026 at 2:42 PM of the 100 Hall Nurse Med-Cart parked at the nurses' station revealed the keys to the 100 Hall medication cart belonging to LVN-A were sitting on the 100 Hall medication cart in the binder that contained the narcotic and controlled count sheets. In an interview on 02/26/2026 at 2:42 PM, LVN-A stated the 100 Hall Nurse Med-Cart belonged to her. She stated she knew the med-cart should not be left unlocked because residents could have gotten into the med-cart and taken medications which had not belonged to them, and this could have caused them harm. She stated she had been in-serviced on this previously, but she could not recall when the in-service was. She stated the keys to the med-cart were in her pocket, but upon looking for them, she could not find them in her pocket or at the nurse's station. She then stated she remembered she had placed them inside the narcotic binder but stated they should have been in her pocket so no one could have gained access to the medication cart. Record review of the facility's Storage of Medications policy, dated 12/01/07, revealed Med-Carts are locked when unattended. Med storage keys are retained by designated staff. Controlled medication must be stored separately, double locked, permanently affixed compartments. 2. An observation on 02/25/2026 at 3:32 p.m., of the 200/400 Hall Medication Cart with LVN G, revealed the following over the counter (OTC) medications which did not have an opened date written on the bottles -Tussin Guaifenesin Oral Solution 8oz, Enulose (Lactulose Solution) 10g/15ml 473mls, Milk of Magnesium 16oz, and 2 bottles of Polyethylene Glycol 3350 Powder for solution Osmotic Laxative 8.3oz. An observation on 02/25/2026 at 3:42 p.m., of the 300 Hall Medication Cart with LVN H, revealed the following over the counter (OTC) medications which did not have an opened date written on the bottles –Mylanta Liquid 12oz and Polyethylene Glycol 3350 Powder for solution Osmotic Laxative 8.3oz. In an interview on 02/25/26 at 3:34 p.m., LVN G stated that the liquid OTCs should be labeled with an open date. She stated that the person responsible for labeling the bottles was the person who initially (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opened them. LVN G stated that they need to know when the bottle was opened, so they know when it expires. She stated that it was important for them to label the bottles with an open date to know when to get rid of them and so the resident does not get sick. In an interview on 02/25/2026 at 3:42 p.m., LVN H stated that she did not realize that the bottles did not have an open date. She stated that the person who opened the bottle was responsible for labeling it with the date. LVN H stated that this was important, so they know if it was outdated and effective. She stated that the negative outcome was that it could be spoiled, and they continue to administer it to the residents, causing them to have a side effect. In an interview on 02/26/2026 at 8:47 a.m., the ADON stated that they go off the expiration date on the MiraLAX bottle and the eyedrops. She stated that the milk of magnesium did need an open date. The ADON stated that the person who opens the bottles was responsible for labeling them with the open date. She stated that this was important, so they know when it expires, either within 30 or 90 days. The ADON stated that the negative outcome of not having an open date was that it would not be effective. In an interview on 02/26/2026 at 3:22 p.m., the DON stated that only the multidose bottles needed an open date. She stated that she was not sure if the milk of magnesium needed to be labeled with an open date because it has an expiration date. She stated they had in service on medication storage at the end of last year, 2025. 3.During an observation on 02/24/2026, at 5:52 PM, revealed on top of the 200 hall medication cart unattended, there was a diabetic lancet. During an interview on 02/24/2026 at 5:53 PM, LVN G walked up to cart. LVN G stated the (diabetic) lancet was supposed to be secured in the medication cart. LVN G stated the negative outcome could be someone could come by and grab it off the cart. During an interview on 02/26/2026 at 3:34 PM, the DON stated the lancet should be kept in the medication cart until use. She said it would be a safety issue if it were left on top the medication cart unattended and anyone could grab it. Record review of the facility's Storage of Medications policy, dated 12/01/07, revealed Med-Carts are locked when unattended. Med storage keys are retained by designated staff. Controlled medication must be stored separately, double locked, permanently affixed compartments. Record review of the facility's Storage and Expiration Dating of Medications and Biologicals, revised date 6/30/2025, revealed 11. Facility should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration dated once opened or opened. 11.1 Facility staff may record the calculated expiration date based on date opened on the primary medication container.

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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 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 observations, interviews, and record reviews, 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 sanitation. The facility failed to properly label and date open, shelf stable food.The facility failed to dispose of expired shelf stable and refrigerated food.The facility failed to ensure boxes containing jugs of water were not on the floor.The facility failed to clean the filters on the ice machine.The facility failed to sweep, mop, and clean the floors and counters in the kitchen. The facility failed to ensure the refrigerators, as well as the trays inside the refrigerators, were clean. The facility failed to ensure the juice dispenser was clean. The facility failed to ensure the utensil drawer was clean. The facility failed to ensure under the sink and dishwasher were clean.These failures could have placed residents at risk of foodborne illnesses, as well as placed staff at risk for falls and injuriesThe findings included:Observations and initial tour of the kitchen on 02/24/2026 at 8:26 AM revealed the filters on the ice machine to be extremely dirty with thick build-up noted. the outsides of refrigerators were dirty and had spill lines down them. Inside of a refrigerator there was a large container of thick, yellow, substance with a use by date of 02/21/2026. There were trays inside the refrigerator which were dirty with particles and drips of old food on them. There were large containers of condiments sitting on the trays which were covered in a build-up of a sticky substance. The juice dispenser had a sticky build-up on and around the nozzles, as well as sticky build-up on the stainless backsplash of the juice dispenser. The floors in the kitchen had dirt, food, and grime built up on them with molded vegetables, silverware, and other trash under the shelves and counters. The counters and sinks were dirty with build-up and food particles. There were opened and unlabeled packages of bread, cereal, cookies, chips and peanut butter. The drawer which held the clean spoons and utensils was dirty with old food particles and splatters. Under the sink and dishwasher there was built up grime, dirt, as well as a black substance. There were boxes containing jugs of water stored on the floor in the kitchen storage room. The pans being utilized in the kitchen were scraped to the point of the Teflon scraped off, as well as burned to the point of black chips breaking off. In an interview on 02/24/2026 at 08:29 AM, the Food Services Director stated the filters, floors, counters, walls, equipment and sinks were cleaned daily, and she was not sure how all the dirt, grime, and particles had built up on the floor in one day. She also stated the juice machine was supposed to be cleaned daily as well, but she could tell it had not been cleaned. She stated if things were not cleaned and disinfected appropriately mold could grow and end up in the residents' drinks or food, and this could make them sick. She also stated if food was not dated or discarded appropriately it could make the residents sick as well. The Food Services Director stated she knew there was not supposed to be anything stored on the floor because it was a hazard, and they were in the process of disposing of the boxes full of water jugs but had not finished disposing of them yet. The Food Services Director also stated she knew the kitchen staff were not supposed to cook with pans which had burned stuff breaking off or were scraped so badly the Teflon was coming off because it could end up in the residents' food and make them sick. In an interview on 02/26/2026 at 8:45 AM, the cook stated the kitchen staff should not be cooking on pans which were extremely burned, or the Teflon was scraping off because it could end up in the residents' food and make them sick. Record review of the facility's Food Safety Policy, revised 04/26/2023, revealed Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Procedure: 1. Food is stored at a minimum of six inches off the floor. 2. Pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary container with a tight-fitting lid. The container is labeled with the name of the contents and date (when item is transferred to the new container). Use by Date is noted on the label or product when applicable. Cold Food Storage: Leftovers are dated properly and discarded after 72 hours unless otherwise indicated. Dry Storage: 2. (continued on next page)

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	675637	A. Building B. Wing	02/26/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Opened packages of food are resealed tightly to prevent contamination of the food item and use by date will be used when applicable. 5. Shelves have a cleanable surface; Food Service/Meal Service: 1. Foods are prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact with prepared foods.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interviews, observations and record review, the facility failed to ensure the resident had the right to personal privacy during medical treatment for 3 (Resident #15, Resident #82, and Resident #21) of 5 Residents reviewed for Privacy. The facility failed to ensure MA E closed the door or the curtain during medication administration for Resident #15 and Resident #82 on 02/25/2026. The facility failed to ensure LVN F closed the door, the curtain or the blinds during medication administration via gastrostomy tube for Resident #21 on 02/25/2026. These failures could place the residents at risk of not having their personal privacy maintained during medical treatment.The Findings included: During an observation on 02/25/2026 at 6:49 a.m., MA E kept the door and the curtain open while checking Resident #15's blood pressure. She then proceeded to administer his medications. During an observation on 02/25/2026 at 7:06 a.m., MA E kept the door and the curtain open while checking Resident #82's blood pressure. She then proceeded to administer his medications. During an observation on 02/25/2026 at 1:27 p.m. LVN F kept the door, the curtain, and the blinds open while administering medications via G-tube (a soft, flexible tube into the stomach to deliver liquid nutrition, fluids, and medications directly to the digestive tract). In an interview on 02/25/2026 at 7:12 a.m., MA E stated that she was supposed to close the door and the curtain before checking the blood pressures and administering medications to both Resident #15 and Resident#82. She stated that she forgot to do it. MA E stated that closing the door and the curtain was important to provide the residents with privacy.In an interview on 02/25/2026 at 1:35 a.m., LVN F stated that she forgot to close the door, the curtain and the blinds while administering medications to Resident #21. She stated that she got sidetracked looking for the soap to wash her hands with. LVN F stated that she should have closed the curtain and the door because you never knew who would walk in while she was providing care. She stated that she should have provided the resident with privacy. LVN F stated that she had been trained in resident dignity and privacy less than a month ago.In an interview on 02/26/2026 at 8:47 a.m., the ADON stated that staff should close the door, pull the curtain, and close the blinds to provide privacy when administering medications. She stated that the staff had been trained. The ADON stated that this was important because this was the patient's home, and they should provide dignity and privacy.In an interview on 02/26/2026 at 3:22 p.m., the DON stated that MA E and LVN F should have closed the door, the curtain, and the blinds prior to administering medications to residents. She stated that the staff should provide privacy when providing care. The DON stated that staff were trained annually and as needed. She stated that it was important for staff to provide privacy because that was a resident's right.Record review of the facility's policy, Resident Rights review date 11/24/2025, revealed At the time of admission, a resident is afforded certain rights while residing in a Long-Term Care Facility. The facility and its associated have the responsibility to ensuring the rights are always upheld the resident is in their care. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promote maintenance or enhancement of his or her quality of life .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the residents ' discharge notice, including the reason for transfer or discharge, prior to discharge, to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 2 residents (Resident #3) reviewed for notifying the LTC Ombudsman of the residents ' discharge. Resident #3 was discharged home on [DATE] without a notice to the LTC state ombudsman. These failures could place residents at risk of not knowing their rights and receiving the services of the state LTC Ombudsman.Findings were: 1. Record review of Resident #3 ' s admission record dated 02/26/26 with an admission date 1/26/26 revealed Resident #3 was a [AGE] year-old male with diagnoses of Acute Respiratory Failure with Hypoxia (lungs cannot supply oxygen to blood), Type 2 Diabetes Mellitus without Complications (high blood sugar levels), Chronic Obstructive Pulmonary Disease (lung disease that causes obstructed airflow from lungs), Essential (Primary) Hypertension (high blood pressure), Muscle Weakness (Generalized). Record review of Resident #3 ' s latest MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognition. Record review of Resident #3 ' s order summary revealed discharge home with medications on 2/5/26. Home health for patient, occupational skilled nursing follow up with primary care physician. Record review of Resident #3 ' s electronic medical record from 02/5/26 to 02/26/26 revealed no evidence of notice given to the LTC Ombudsman pertaining to Resident #3 ' s discharge home. During an interview on 02/26/26 at 9:00 a.m. the SSD stated she was not in charge of notifying ombudsman whenever a resident is discharged from the facility. She said that the BOM was in charge of notifying the Ombudsman. During an interview on 02/26/26 at 9:05 a.m. the state LTC Ombudsman representative for the facility stated she had not received any discharge notices. During an interview on 02/26/26 at 9:15 a.m. BOM said she was not aware that she needed to notify the Ombudsman when a resident was discharged from the facility. She said that she only notified the Ombudsman when there was a thirty day notification for the resident to leave the facility. Record review of the facility's policy titled Discharge Process and Bed Holds, date revised: 12/1/2025 revealed; The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

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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 provide 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 (Resident #82) of 4 residents reviewed for medications.The facility failed to administer Carvedilol for Resident #82 per physician's order on 02/25/2026. This failure could place the residents at risk of not receiving therapeutic doses of their medication. Findings include Record review of Resident #82's admission record dated 2/24/2026 reflected an [AGE] year-old female with an admission date of 02/17/2026. Pertinent diagnoses included Essential Hypertension (high blood pressure), Hypertensive Heart Disease (a constellation of changes affecting the left ventricle, left atrium, and coronary arteries resulting from chronic elevation of blood pressure), and Cardiac Pacemaker. Record review of Resident #82's person-centered care plan, initiated date 2/17/2026 reflected Resident #82 has hypertension. Intervention included administer medications as ordered. Record review of Resident #82's Order Summary dated 2/24/2026, reflected Carvedilol 12.5mg oral tablet give 1 tablet by mouth two times a day for HTN. Hold if SBP less than 100 or pulse less than 60. Give with snack or meals to avoid rapid drop in BP. Record review of Resident #82's admission MDS assessment, dated 02/17/2026 reflected in progress. An observation on 02/25/2026 at 7:07 a.m., revealed MA E checked Resident #82's blood pressure and reading was 107/63 pulse 63. She grabbed a plastic pouch and said she would destroy Carvedilol and the other two blood pressure medications properly. In an interview on 02/25/2026 at 7:20 a.m, MA E stated that she was not going to administer Carvedilol because it was out of parameters along with two other blood pressure medications for Resident #82. Surveyor had her review physician's order for these medications. MA E verified Carvedilol was supposed to be given because it was within parameters. She stated that she thought that all of the medications had the same parameters. MA E stated that the negative outcome of not administering the Carvedilol would be that Resident #82's blood pressure can get too high and cause her to feel dizzy. In an interview on 02/26/2026 at 3:22 p.m., the DON stated that all three blood pressure medications were supposed to have the same parameters. She stated that MA E should have administered the blood pressure medication that was within parameters. The DON stated that the negative outcome of not receiving the medication as per physician orders could cause Resident #82s blood pressure to be raised. Record Review of the facility's Medications Administration policy, revised 05/05/2022, revealed Policy: The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Procedure: 2. Staff who are responsible for medication administration will adhere to the 10 rights of medication administration: f. Right Assessment: Note the resident's history and any parameters around drug administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #21 and Resident #87) of 5 residents reviewed for infection control practices, in that: 1. The facility failed to ensure LVN F followed enhanced barrier precautions while administering medications via gastrostomy for Resident #21. 2. CNA I failed to remove contaminated gloves after catheter care prior placing clean brief on Resident #87 on 02/25/2026. This failure could place residents at risk for healthcare associated cross contamination and infections. 2. Record review of Resident #87's face sheet dated 2/26/26 revealed an [AGE] year-old female admitted originally on 2/17/26. Her diagnoses included, pressure ulcer of sacral region, stage 4 (a severe, medical emergency involving full-thickness tissue loss with directly palpable or visible bone, tendon, or muscle), muscle weakness. Record review of Resident #87's Comprehensive Care Plan initiated 02/18/2026 revealed, Focus: [Resident #87] has an indwelling catheter due to sacral wound. Interventions: [Resident #87] needs enhanced barrier precautions. Record review of Resident #87's MDS dated [DATE] reflected it was in progress. During an observation on 02/25/2026 at 10:50 AM, CNA I entered Resident #87's room after knocking. CNA I began with washing hands for 30 seconds, gloved up, and prepared table of needed supplies. CNA I continued by raising bed and then discarded gloves. After discarding the gloves, CNA I continued with applying hand sanitizer and she did apply new gloves. CNA I proceeded with catheter care and proceeded placed a new brief on resident, using same pair of gloves, catheter care, and applied new brief. During an interview on 02/25/2026 at 11:00 AM with CNA I stated that they should have changed those gloves after cleaning the foley catheter, for the reason to minimize contraction of infection. CNA I stated they should have washed hands/use hand sanitizer and changed gloves, before, during, and after care to minimize chance of infection. CNA I stated that resident could get an infection because she did not changed gloves when changing from one area to another area. During an interview on 02/26/26 at 3:05 PM with the DON, The DON stated that after perineum care, hand hygiene should have been performed prior to moving to the second part of applying the new brief. The DON stressed the importance of infection prevention and stated that personnel were educated and observed by her performing specific care during checkoffs, before being allowed to work on the floor independently. DON stated this practice could put Resident #87 at risk for infection. Record review of policy titled Transmission-based Precautions and Isolation Procedures revealed: the facility will implement and utilize transmission-based precautions to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. Findings include: 1.Record review of Resident #21's face sheet, dated 02/26/2026, revealed a [AGE] year-old male (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with an admission date of 12/06/2024. Pertinent diagnoses included Gastrostomy Status (opening in the stomach to insert a tube for nutritional support), Dysphagia (difficulty swallowing), Type 2 Diabetes Mellitus, Spastic Quadriplegic Cerebral Palsy (early brain damage, resulting in extreme stiffness in all four limbs, the trunk, and the face). Record review of Resident #21's Annual MDS assessment, dated 12/01/2025, revealed no BIMS conducted as Resident #21 was rarely or never understood. Further review revealed nutritional status was feeding tube (PEG). Record review of Resident #21's physician orders, started 11/10/2025, revealed an order for Enhanced Barrier Precautions Diagnosis: G-tube every shift. Record review of Resident #21's Care Plan for the resident requiring tube feeding r/t Dysphagia. Enhanced Barrier Precautions, initiated 12/09/2024, revealed an intervention of Enhanced barrier precautions. During an observation on 02/25/2026 at 1:35 p.m., LVN F donned gloves but did not wear a PPE gown when she administered medications via G-tube for Resident #21. In an interview on 2/25/26 at 1:40 p.m., LVN F stated that she was supposed to put on a gown along with the gloves when she entered Resident #21's room, but she forgot. She stated that EBP was indicated for residents who have gastrostomy tubes, foley catheters, wounds, or who have an infection. She stated that EBP requires the use of a gown and gloves during contact with patient care. LVN F stated that it was important to wear the required PPE when providing care to EBP patients to prevent the spread of infection and to protect themselves. In an interview on 02/26/2026 at 8:47 a.m., the ADON stated that EBP was to be used on high contact care for patients with G-tubes, foley catheters, and trachs. She stated that EBP requires the use of a gown and gloves during contact with patient care. The ADON stated that it was important if the nurse were to get splashed on her when checking the residual. She stated that it was protecting patients from any bacteria. The ADON stated that it was also important to prevent infection from one patient to the other. In an interview on 02/26/2026 at 3:22 p.m., the DON stated that EBP patients were identified as anyone who has a foley catheter, a G-tube, IV's, and wounds because they have a portal for infection. She stated that the staff needed to wear gowns and gloves. The DON stated that PPE for EBP was for patients' protection, so they are not exposing germs to them. Record review of policy titled Transmission-based Precautions and Isolation Procedures, revised date 12/23/2025 revealed: the facility will implement and utilize transmission-based precautions to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. 5. Enhanced Barrier Precautions Refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .