STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675664	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Springs Nursing & Rehab	1200 Jackson St N Sulphur Springs, TX 75482

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure resident had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. for 1 of 21 (Residents #60) residents reviewed for psychoactive medications. The facility failed to ensure Resident #60 had signed a psychotropic consent for Remeron (antidepressant medication). This failure could place residents at risk for receiving unnecessary antipsychotic medications without informed consent. Findings included: Record review of Resident #60's face sheet, dated 09/10/25, indicated a [AGE] year-old male who was his own responsible party was re-admitted to the facility on [DATE] with the diagnoses which included dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, language, attention, and problem-solving, severe enough to interfere with daily life), stroke, and high blood pressure. Record review of Resident #60's significant change in MDS assessment, dated 07/28/25, indicated Resident #60 rarely understood and was rarely understood by others. Resident #60 had severe daily decision-making skills. The MDS indicated Resident #60 required assistance with toileting, bed mobility, dressing, and transfers. Resident #60 had 7 days of antidepressant medication during the look-back period. Record review of the comprehensive care plan, dated 07/31/25, indicated Resident #60 required antidepressant medication due to a diagnosis of depression. The intervention of the care plan indicated staff would give medication as ordered and educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. Record review of Resident #60's physician's orders, dated 09/08/25, indicated the resident had an order for Remeron (Mirtazapine) Oral Tablet 15 MG. Give 1 tablet by mouth at bedtime for dementia. Record review for Resident #60's medication administration record, dated 09/10/25, indicated he received Remeron as ordered over the last 2 nights (09/08/25 and 09/09/25). Record review for Resident #60's consent for use of psychotropic medication, Remeron, revealed that it was not found in his chart. During an interview on 09/10/25 at 5:23 p.m., RN D said she was the charge nurse for Resident #60. She said psychoactive consents should be obtained for all psychotropic medications before being given. RN D said she did not fill out the psychotropic consent form in the computer for Resident #60 because she forgot. She said it was important to get consents to show that we educated the family about the reason for the medication. During an interview on 09/10/2025 5:31 p.m., Resident #60 was not aware of his medication, but knew his appetite was not good. During an interview on 09/10/2025 at 5:35 p.m., the ADON said the charge nurse who took an order for psychotropic medication should have gotten the consent, and she should have followed up the next day. She said she had not printed the order summary report over the last 2 days because the state surveyors were in the building and she had not had time. She said it was important to obtain consent before medication was given. During an interview on 09/10/25 at 5:50 p.m., the DON said consents should be signed before administering any psychoactive medication. The DON said one reason consents were obtained was to inform the family about the risks and benefits before receiving medications. The DON said the charge nurse who received the order was responsible for obtaining consents, and the ADONs were the overseers. The DON said it was the state guidelines to obtain consents, and failure to obtain consents could cause the resident or families not to have all the information about the medication or a choice about the resident's care. During an interview on 09/10/25 at 6:11 p.m., the Administrator said she expected the DON or nurse management to ensure the consent forms were filled out for psychotropic medications. The Administrator said consents should be obtained to inform residents and families of risks and/or benefits of medication or a choice to decline it. Record review of the facility's policy titled Psychotherapeutic Drug management updated 01/2025, indicated Purpose: I. To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. II. To help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, promote resident safety and security, and enhance the resident's ability to interact positively with his/her environment. Procedure: X. Nurse responsibility: G. The Licensed Nurse will not administer the psychotherapeutic medication until an informed consent form has been obtained and documented by the Attending Physician from the resident and/or surrogate decision maker, unless it is an emergency situation .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the right to formulate an advanced directive was provided for 1 of 26 residents (Residents #13) reviewed for advanced directives. The facility did not ensure Resident #13 had a physician's order in his chart for DNR. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #13's face sheet, dated [DATE], reflected Resident #13 was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions). Record review of Resident #13's admission MDS assessment, dated [DATE], reflected Resident #13 usually made himself understood, and usually understood others. Resident #13's BIMS score was 12, which reflected his cognition was moderately impaired. Record review of Resident #13's undated comprehensive care plan, reflected Resident #13 had an order for DNR. The care plan interventions specified, in absence of b/p, pulse, respiration, CPR will not be initiated. Record review of Resident #13's physician order report, dated [DATE], reflected an active physician's order for code status: DNR with an order date [DATE]. Record review of Resident #13's OOH-DNR form reflected Resident #13 had an active DNR since [DATE]. During an interview on [DATE] at 3:33 p.m., the ADON stated the nurse that readmitted Resident #13 was responsible for putting in the DNR. The ADON stated Resident #13 came in at the end of one shift and that nurse started the orders and the 2nd shift nurse completed the orders. The ADON stated she was responsible for monitoring and overseeing all orders were put in correctly after a resident was admitted to the facility by reviewing the orders after each admission/readmission. When asked why there was not a physician order for Resident #13 advance directive status, the ADON stated, it was just missed. The ADON stated it was important an order for DNR was placed in the residents' electronic medical records to respect the resident's wishes. During an interview on [DATE] at 5:05 p.m., the DON stated she expected a DNR order to be in PCC when a resident admitted to the facility or if the status changed. The DON stated charge nurses were responsible for inputting code status upon admission. The DON stated the ADON was responsible for monitoring by reviewing the orders against the discharged orders after every admission. The DON stated it was important an order was placed in the resident's chart to ensure his wishes was respected. During an interview on [DATE] at 6:40 p.m., the Administrator stated she expected a DNR order to be placed in PCC upon admission. The Administrator stated the charge nurse was responsible for ensuring that the order was input into the resident's chart after he was readmitted to the facility. The Administrator stated the ADON was responsible for monitoring and overseeing orders when a resident admit to the facility. The Administrator stated it was important to ensure an order was placed in PCC to ensure the resident wishes was respected. Record review of the facility's policy Do Not Resuscitate Orders and the Withholding or Withdrawal of Life Support and Life Sustaining Treatment, revised on 08/2020, reflected. to ensure that the facility abides by state and federal law as well as resident preferences regarding withdrawal of life support and life sustaining treatment and orders not to resuscitate. D. ii. All documents concerning decision-makers consulted by the facility and the attending physician will be in the resident's medical record.

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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 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 26 (Resident 32) residents reviewed for comprehensive person-centered care plans. The facility failed to ensure Resident #32's comprehensive care plan addressed she received an IV antibiotic via her central line. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: Record review of Resident #32's face sheet dated 09/10/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included partial intestinal obstruction (bowel obstruction), diabetes type 2 (a group of diseases that result in too much sugar in the blood), and atrial fibrillation (irregular heart rhythm). Record review of Resident #32's admission MDS assessment dated [DATE], indicated she was usually understood and usually understood others. Resident #32 had a BIMS score of 15, which indicated her cognition was intact. Resident #32 had received IV medications and had an IV access. Record review of Resident #32's comprehensive care plan dated 08/28/25 indicated Resident #32 had an actual skin impairment related to left chest central catheter. The care plan interventions indicated to access/record/monitor wound healing at least weekly. The care plan did not address Resident #32 received IV antibiotics via her central line. Record review of Resident #32's orders summary report with order date range of 08/20/25-09/10/25, indicated the following orders:*meropenem (antibiotic used to treat bacterial infections of the skin, stomach and meninges) intravenous solution 2 GM intravenously three times a day for 20 days with an order date of 08/20/25. Record review of Resident #32's Nurse Administration Record dated 09/01/25-09/30/25, indicated Meropenem 2 GM was administered intravenously three times a day at 9:00 AM, 3:00 PM, and 11:00 PM. During an observation and interview on 09/08/25 at 10:31 AM, Resident #32 was in her bed. The IV pump was on with meropenem infusing to Resident #32's central catheter at 100 ml/hr. Resident #32 said she had been on IV antibiotics since she admitted to the facility due to recent abdominal surgery. During an interview on 09/10/25 at 4:14 PM, the Regional MDS Coordinator said the DON and ADON were responsible for the acute care plans. She said not having Resident #32's IV medications care planned did not affect her, because the resident still received her IV antibiotic by following the physician orders. During an interview on 09/10/25 at 4:19 PM, the DON said she was not responsible for the care plans. She said the MDS Coordinator was responsible for updating the care plans. She said she expected the care plans to be updated because it was part of the resident's care. The DON said she was unsure of the risks for the IV medications not being care planned. During an interview on 09/10/25 at 4:35 PM, the ADON said she could have sworn she had updated Resident #32's care plan to reflect the IV medications she was receiving. The ADON reviewed Resident #32's care plan and said she could not find it. The ADON said the DON and herself were responsible for ensuring the antibiotics were care planned. The ADON said failure to care plan Resident #32's IV antibiotic would place her a risk for not receiving the care she needed. She said someone who looked at the care plan would not be aware to monitor for side effects. During an interview on 09/10/25 at 4:45 PM, the Administrator said she expected Resident #32's IV medications to be care planned because it was part of her care. She said since the IV medication was not care planned, the staff would not be aware of Resident #32 required an IV antibiotic. The Administrator said nursing was responsible for ensuring the care plans were updated. Record review of the facility's policy Care Planning revised October 24, 2022, indicated . To ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. Each resident's comprehensive care plan will describe the following: A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who was unable to conduct activities of daily living received the necessary services to maintain grooming, personal, and oral hygiene were provided for 1 of 6 residents (Resident #1) reviewed for ADL care. The facility failed to ensure Resident #1 was showered or bed bathed during the dates of 09/01/25 through 09/10/25. This failure could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity. Findings included: Record review of Resident #1's face sheet, dated 09/10/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included obesity, depression (sadness), diabetes, and Chronic obstructive pulmonary disease, also known as COPD (a group of lung diseases that cause airflow obstruction and breathing problems). Record review of Resident #1's quarterly MDS assessment, dated 08/20/25, indicated Resident #1 understood and was understood by others. Her BIMs score was a 15, which indicated she was cognitively intact. The MDS indicated she required total assistance for showering, dressing, and transferring. The MDS indicated she was always incontinent of bowel and bladder. Record review of the care plan dated 07/21/25 indicated Resident #1 had an ADL self-care performance deficit. The interventions were for staff to assist with bathing. Record review of Resident #1's point of care history dated 09/01/25-09/10/25, did not indicate Resident #1 was bathed on the following dates:09/01/25, 09/02/25, 09/03/25, 09/04/25, 09/05/25, 09/06,25, 09/07/25, 09/08/25, 09/09/25, or 09/10/25. During an interview on 09/08/25 11:26 p.m., Resident #1 said she was not getting her showers three times a week. She said she had not had a shower or bed bath in about 2 weeks. She said she was supposed to be showered/bed bathed on the day shift. She said she was scheduled to have her showers on Monday and Friday and her bed baths on Wednesdays. She said they did not offer her a shower on Monday (09/01/25) or a bed bath on Wednesday (09/03/25). She said they told her something was wrong with the shower on Friday (09/05/25), but they did not even offer a bed bath. She said she felt dirty and wanted a shower. She said today (09/08/25) was her shower day but had not been offered a shower yet. During an interview on 09/09/25 at 3:58 p.m., Resident #1 was in bed and said she did not receive her shower yesterday (09/08/25) or even offered a bed bath. During an interview on 09/10/25 at 1:37 p.m., CNA G said she was assigned to Resident #1 on Monday (09/08/25) but did not shower or bed bathe her. She said the shower room was out of order, so she just wiped Resident #1 off and changed her gown. During an interview on 09/10/25 at 1:48 p.m., CNA L said she was the shower aide, but had not given Resident #1 a shower in about 2 weeks. She said the aides were supposed to bring Resident #1 to her, and they did not, so she did not shower her. She said she did not ask the aides why Resident #1 was not coming to get a shower. During an interview on 09/10/25 at 4:19 p.m., Resident #1 was in bed and said she did not receive her shower today (09/10/25) or even offered a bed bath. During an interview on 09/10/25 at 4:36 p.m., RN K said she was Resident #1's evening nurse (2 pm-10 pm). She said showers should be given according to the shower schedule. She said Resident #1 was a day shift bath but had not heard of her refusing her baths in the past. She said she was usually compliant with her showers and bed baths. She said residents should receive their baths for hygiene purposes. During an interview on 09/10/25 at 5:50 p.m., the DON said she expected showers to be given according to the shower schedule. She said she was unaware that Resident #1 missed showers. She said if a resident refused his/her shower(s), then the charge nurse was supposed to talk with the resident and see why they were refusing and document it in his/her chart. She said showers should be given for cleanliness and prevention of skin breakdown or infection. During an interview on 09/10/25 at 6:11 p.m., the Administrator said she expected the residents to receive their baths and expected the staff to document if they did not receive them. The Administrator said the aides were supposed to give the baths, and the charge nurse was responsible for ensuring the showers were completed. She said showers were given to prevent skin breakdown and maintain hygiene. She said she had staff to give Resident #1 a shower/bed bath today (09/10/25) after surveyor intervention. Record review of the facility's policy titled, Showering a Resident, undated, indicated, Purpose: A shower bath is given to the resident to provide cleanliness, comfort, and to prevent body odors. Policy: Residents are offered a shower at a minimum of once weekly and given per the residents' request.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments for 1 of 26 residents (Resident #51). The facility failed to ensure Resident #11 had his ketorolac eye drops by 08/31/25 to ensure he had his surgery on 09/02/25. This failure placed resident at risk of a delay in treatments for the residents' conditions. Findings included: Record review of Resident #51's face sheet dated 09/10/25 indicated he was a[AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of legal blindness, unspecified cataract, need for assistance with personal care, Parkinsonism (clinical syndrome characterized by tremor, slow heart rates, and postural instability), and heart failure. Record review of Resident #51's admission MDS assessment dated [DATE] indicated he was able to make himself understood and able to understand others. The MDS also indicate he had a BIMS score of 14 which meant his cognition was intact. The MDS also indicated he required moderate assistance from staff for toileting, bathing, dressing, and transfers, and he was independent with eating. Record review of Resident #51's care plan dated 03/26/25 indicated he was legally blind as defined in the USA and had cataracts with the goal to maintain optimal quality of life within limitation imposed by visual function and interventions to identify/record factors affecting visual function, monitor/document/report to Medical Doctor signs and symptoms of acute eye problems. Record review of Resident #51's order summary report dated 09/10/25 that included orders that were active, completed, and discontinued indicated he had and order for:1) Ketorolac Tromethamine Ophthalmic Solution 0.4 % Instill 1 drop in right eye four times a day for preventative that was discontinued but was dated 09/01/2025 with a start date of 09/01/2025. Record review of Resident #11's prescription from the ophthalmologist office visit dated 07/24/25 indicated:1) Ketorolac 0. 5% eye drops Dispense:5 (five) milliliter Instill drop by ophthalmic route 4 times every day into the left eye starting 2 days before surgery (09/02/25), (which meant he should have started the eye drops on 08/31/25) Record review of Resident #11's progress notes dated 09/01/25 at 8:56 PM indicated the ketorolac was not received from the pharmacy. Record review of Resident #11's progress notes dated 09/02/25 at 10:02 AM indicated his cataract surgery would be rescheduled per charge nurse. During an interview on 09/09/25 at 11:12 AM the Social Worker said she charted Resident #11's surgery was rescheduled on 09/02/25 because LVN B told her the appointment was rescheduled. She said she did not assist in scheduling the appointments for Resident #11's cataract surgery. During an interview on 09/09/25 at 11:15 AM, LVN B said she input Resident #11's order on 09/01/25 and attempted to order it from the pharmacy, but the pharmacy was out of the medication and had to order it, and it came the next day. She said since Resident #11 did not get his eye drops in time, the surgery was rescheduled to 09/30/25. LVN B said the facility had the ketorolac eye drops in the facility to ensure Resident #11 would get them on time. She said she should have input the order when she received it but guessed she forgot to chart the medication order and input the order in the computer when she received the order. LVN B said she would have to find paperwork because she could not remember the exact day since it had been a while. LVN B said she had to go give medications and would let the surveyor know when she found more information. During an interview on 09/09/25 at 11:46 AM the facility pharmacist said the pharmacy received the order for Resident #11's Ketorolac on 09/01/25 at 11:43 AM and they did not have the medication at on hand. The pharmacist said the pharmacy ordered the medication and se to the pharmacy on 09/02/25 morning run. The pharmacist said if the facility had the facility sent the order at an earlier date the pharmacy would have sent the medication earlier. During an interview on 09/10/2025 at 4:51 PM the ADON said LVN B did not input the ketorolac order when she received the order from the ophthalmologist and thought she could get the ketorolac in the facility in time. The ADON said LVN B got the order in the computer the day before the surgery on 09/01/25 and when she ordered the ketorolac, it did not come in. The ADON said she called the pharmacy to check on the ketorolac and the pharmacy told her the ketorolac was on back order and they did not receive the medication until 9/2/25. The ADON said the failure placed a risk id for Resident #11 having worsening eyesight or psychological effects. During an interview on 09/10/2025 at 6:04 PM the DON said she was not aware of when the medication ketorolac was supposed to be started for Resident #11's eye surgery until 09/10/25. The DON said LVN B should have placed the order in the computer when she received it from the ophthalmologist to prevent it from being missed. The DON said LVN could have set the start date to begin in

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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 observation, interview, and record review, the facility failed to ensure the residents environment remained free of accident hazards for 1 of 26 residents (Residents #11) reviewed for accident hazards. The facility failed to ensure a safe environment to prevent accidents and hazards for Residents #11 by not ensuring 3 razors (1 razor that did not have a cover over the blades and 2 razors in the open package) in his drawer were stored securely. This failure could place residents at risk for injuries. Findings included: Record review of Resident #11's face sheet dated 09/10/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses legal blindness, high blood pressure, malignant neoplasm of the prostate (prostate cancer), and depression. Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated he usually understood others and usually made himself understood. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he required total assistance with toileting, transfers, bathing, and bed mobility and required setup assistance for eating and hygiene. Record review of Resident #11's undated care plan indicated he had impaired visual function related to cataracts, poor vision, and macular degeneration and ADL self-care performance deficit with interventions of dependent staff participation in toileting, transfers, bed mobility, bathing, and personal hygiene. During an interview and observation on 09/08/25 at 3:05 PM, Resident #11 said the facility removed items from the residents' rooms in the facility and then returned items back to them. Resident #11 told surveyor to look in his drawer. Resident #11 had 3 razors (1 razor that did not have a cover over the blades and 2 razors in the open package). He said the staff shaved him when needed. During an interview on 09/10/2025 at 4:58 PM, the ADON said Resident #11 should not have had the razors in his room. She said the failure placed a risk for someone getting the razors and cutting themselves. She stated the facility does have wanders that goes all over the facility and open doors. During an interview on 09/10/2025 at 6:08 PM, Tthe DON said Resident #11 should not have had the razors in his room. The DON said the failure placed a risk for other residents getting the razors out of the drawers and cutting themselves, and the risk for Resident #11 using the wrong items related to him being blind. She said Resident #11 could have reached in drawer and cut himself. During an interview on 09/10/2025 at 6:23 PM, the Administrator said Resident #11 should not have had the razors in his drawers. She said the razors were hazardous items and placed a risk for Resident #11 cutting his hands. The Administrator said the department heads were responsible for monitoring each residents' room daily. She said the CNAs should have removed the razors after care. Record review of the facility's policy Resident Rooms and Environment revised 08/2020 indicated:PurposeTo provide residents with a safe, clean, comfortable and homelike environment.PolicyThe Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. This shall include ensuring that residents can receive care and services safely and that the physical layout of the Facility maximizes resident independence and does not pose a safety risk.

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	675664	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Springs Nursing & Rehab	1200 Jackson St N Sulphur Springs, TX 75482

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 2 residents reviewed for nutritional status (Resident #12). The facility failed to ensure Resident #12's enteral feeding (a form of nutrition that is delivered into the digestive system as a liquid form via the feeding tube) was administered as ordered by the physician on 09/08/25. This failure could place residents at risk for malnourishment, illness, skin breakdown, and decreased quality of life.Findings included: Record review of Resident #12's face sheet dated 09/10/25, indicated a [AGE] year-old male who readmitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing) and gastrostomy status (surgical opening in stomach to provide nutrition and medications). Record review of Resident #12's quarterly MDS assessment dated [DATE], indicated usually understood and usually understood others. Resident #12 had short and long-term memory problems. The MDS assessment did not indicate Resident #12 had a weight loss or weight gain of 5% or more in the last month or 10% or more in the last 6 months. Resident #12 had a feeding tube. Record review of Resident #12's comprehensive care plan dated 01/13/23, indicated Resident #12 had a NPO diet and had a peg tube for feeding and medication purposes. The care plan interventions included the nurse to administer feeding as ordered. Record review of Resident #12's order summary report dated 09/10/25, indicated the following orders:*Enteral Feed Order every shift, Jevity 1.5 or equivalent (ie isosource 1.5) at 78 ml/hr for at least 20 hours daily with a start date of 07/03/25. Record review of Resident #12's nurse administration record dated 09/01/25-09/30/25, indicated Resident #12's enteral feeding nutrition was removed in the morning at 11:00 AM. The record indicated it had been completed daily. The nurse administration record did not indicate the time Resident #12's feeding needed to be restarted. During an observation on 09/08/25 at 11:10 AM, Resident #12 was sitting up in his wheelchair in his room. Resident #12's enteral feeding pump was off. During an observation and interview on 09/08/25 at 4:20 PM, Resident #12's enteral feeding pump continued to be off. LVN A said Resident #12's pump could be off for 4 hours. LVN A said she was not aware Resident #12's feeding was turned off and LVN B did not relay it in report. She said if LVN B told her to check Resident #12's machine, she would have checked it. LVN A said the nurses were responsible for ensuring Resident #12's feeding was turned on within the timeframe. LVN A said by not administering his enteral feeding as ordered, Resident #12 was at risk for weight loss. During an interview on 09/10/25 at 11:45 AM, LVN B said Resident #12's enteral feeding pump could be off for 4 hours. LVN B said they turned the pump off for incontinent care and showers. LVN B said Resident #12 sometimes removed the feeding himself. LVN B said on 09/08/25, she did not relay in report to LVN A that Resident #12's feeding was off. She said she usually set an alarm on her phone to turn Resident #12's pump back on, but she did not set one on 09/08/25 since she had been busy. She said Resident #12 was at risk for not receiving his nutrition for the day since he had been left off for an hour more than the ordered amount. LVN B said she was responsible to ensure Resident #12's feeding was restarted as per physician orders. During an interview on 09/10/25 at 1:25 PM, the Registered Dietician said depending on the care being provided to Resident #12, the feeding could have exceeded the time frame of 4 hours. She said Resident #12's feeding being off for an extra hour was not going to affect him. She said nursing was responsible for ensuring Resident #12's feeding was being administered as ordered. During an interview on 09/10/25 at 4:19 PM, the DON said Resident #12 had an order to turn off the feeding at 11:00 AM and there was not an order to turn it back on. She said Resident #12's feeding order was for 20 hours a day and had a 4 hour down time for ADL care. The DON said the nurses were responsible for ensuring Resident #12's feeding was not off for a prolonged time. She said if happened often, Resident #12 was at risk for weight loss. During an interview on 09/10/25 at 4:45 PM, the Administrator said she expected the nurses to follow the physician orders. The Administrator said failure to provide the enteral feedings as ordered could cause Resident #12 to have weight loss. Record review of the facility's policy Tube Feeding/TPN/PPN revised 09/24/24, indicated . To ensure that the facility meets the nutritional guidelines and residents' nutritional requirements per physician orders.

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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 - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 6 residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1 had a physician's order for oxygen. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care.Findings included: Record review of Resident #1's face sheet, dated 09/10/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included shortness of breath also known as SOB, (feeling of difficulty breathing or not being able to get enough air), obesity, depression (sadness), diabetes, and Chronic obstructive pulmonary disease, also known as COPD (a group of lung diseases that cause airflow obstruction and breathing problems. Record review of Resident #1's quarterly MDS assessment, dated 08/20/25, indicated Resident #1 understood and was understood by others. Her BIMS score was a 15, which indicated her cognition was intact. The MDS indicated she required total assistance for showering, dressing, grooming, and transferring, and was set up for eating. The MDS indicated she wore oxygen during the 7-day look-back period. Record review of Resident#1's care plan dated 07/21/25 indicated she required oxygen for shortness of breath and COPD. The staff interventions were to give oxygen as ordered by the physician. Record review of Resident #1 ‘s physician orders dated 09/09/25 did not indicate any oxygen orders. Record review of Resident #1 ‘s physician orders dated 09/10/25, after the surveyor intervention, indicated oxygen at 3 liters per minute via nasal canula every shift for shortness of breath. During an observation on 09/08/25 at 11:39 a.m., Resident #1 was in her room wearing oxygen at 2 liters per minute via nasal cannula. She said she had been wearing oxygen for a while (unknown time) and needed it to help her breathe. During an observation on 09/10/25 at 4:09 p.m., Resident #1 was in her room wearing oxygen at 2 liters per minute via nasal cannula. RN H came in and verified she was on oxygen at 2 liters per minute via nasal canula. During an interview on 09/10/25 at 4:11 p.m., RN H went to look at Resident #1's physician's order and said she did not see an order, but knew Resident #1 wore oxygen. She said Resident #1 went to the hospital, and maybe the oxygen order fell off. She said it was important to have an order as part of her care, and having oxygen too low or not at all could cause respiratory issues. During an interview on 09/10/25 at 5:50 p.m., the DON said the charge nurses were responsible for placing orders in the computer when they received a new order. She said she did not know why Resident #1 did not have oxygen orders. She said the ADON was the overseer for ensuring the orders were placed in the electronic records. She said it was important to have orders in the system and follow them to prevent respiratory issues. During an interview on 09/10/25 6:11 p.m., the Administrator said nurse managers were the overseers of orders. She said oxygen should not be applied without an order. She said that without a written order, staff would not know the correct oxygen rate. She said failure to have an oxygen order or follow the oxygen order could cause respiratory issues. Record review of the facility's policy titled, Oxygen Administration, revised June 2020, indicated, Purpose: To prevent or reverse hypoxemia and provide oxygen to the tissues. Policy: #1 initiation of oxygen, A. A physician's order is required to initiate oxygen therapy, except in an emergency. The order shall include: #1 oxygen flow, # 2 Method of administration (e.g., nasal canula), # 3 Usage of therapy (continuous or PRN), and #5 Indication for use .

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, 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 1 of 6 residents (Resident #42) reviewed for pharmacy services. The facility failed to ensure Resident #42 did not have duplicate orders for his potassium. This failure could place the residents at risk of not receiving the intended therapeutic benefits of prescribed medications.Findings included: Record review of Resident #42's face sheet dated 09/10/25, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included dementia (memory loss) and hypertension (high blood pressure). Record review of Resident #42's annual MDS assessment dated [DATE], indicated he was usually understood and usually understood others. Resident #42 had a BIMS score of 15, which indicated his cognition was intact. Record review of Resident #42's comprehensive care plan revised on 06/24/24 indicated Resident #42 had GERD (acid reflux) and diverticulosis (condition in which small, bulging pouches develop in the digestive tract). The care plan interventions indicated to administer medications as ordered. Record review of Resident #42's order summary report date 09/10/25, indicated the following orders:*Potassium Chloride ER 20 MEQ give one tablet by mouth in the morning for BLE edema with a start date of 07/18/25.*Potassium Chloride ER 20 MEQ give one tablet by mouth one time a day for supplement with a start date of 07/31/25.*Potassium chloride ER 20 MEQ give one tablet by mouth in the afternoon for supplement with a start date of 07/30/25. Record review of Resident #42's medication administration record dated 09/01/25-09/30/25 indicated Resident #42 had received one tablet of potassium 20meq daily at 09:00 AM, 09:00 AM, and 2:00 PM. During an observation on 09/09/25 at 8:33 AM, MA C administered Resident #42 the following medications:*amlodipine 5mg- 1 tablet*famotidine 20mg- 1 tablet*multivitamin with minerals- 1 tablet*furosemide 80mg- 1 tablet*Folic acid 1mg- 1 tablet*sertraline 50mg- 1 tablet*thiamine 100mg- 1 tablet*Potassium chloride 20MEQ- 1 tablet During an interview on 09/10/25 at 12:13 PM, MA C reviewed Resident #42's MAR and said she did not realize Resident #42 had 2 orders for potassium 20 MEQ. She said it was a duplicate order. She said since she had been signing off for both potassium orders at 09:00 AM; it looked like a medication error. She said during the medication administration observed, she only administered one tablet of potassium to Resident #42. She said by having duplicate orders, Resident #42 was at risk for receiving double the medication. MA C said she was responsible for administering medications as ordered, and if a discrepancy was noted to notify the nurse. During an interview on 09/10/25 at 2:44 PM, RN D said when Resident #42 lasix was increased to twice a day, his order for his potassium was also increased. RN D said she failed to discontinue Resident #42's previous potassium order. She said she had been having trouble inputting the orders that in the midst of things she forgot to discontinue the order. RN D said failure to ensure Resident #42 did not have duplicate orders placed him at risk for receiving an extra dose of potassium which could cause cardiac issues. During an interview on 09/10/25 4:19 PM, the DON said she expected the nurse to have reviewed the Resident #42's orders prior to implementing a new order to ensure there were no duplicate orders. The DON said the medication aide was responsible for looking at the orders during medication administration. She said although one tablet was given, the MA still signed off as she had administered 2 tablets of potassium. The DON said since Resident #42 had duplicate potassium orders, it placed him at risk for an increased potassium level. The DON said the ADON clarified new orders the next day and was unsure how Resident #42's potassium order was missed. During an interview on 09/10/25 at 4:35 PM, the ADON said she when she came in the morning, she printed off any new orders and reviewed them. She said she was unsure of how Resident #42's order was missed. She said Resident #42 having duplicate potassium orders placed him at risk for overdosing on potassium. During an interview on 09/10/25 at 4:45 PM, the Administrator said she expected the person administering the medication was responsible for alerting the nurse of the duplicate orders. The Administrator said she expected the nurse to have looked at Resident #42's orders prior to initiating a new order to ensure there were no duplicate orders. The Administrator said Resident #42 was at risk for receiving an extra dose of potassium. Record review of the facility's policy Physician Orders revised on 06/2020, indicated . Purpose: This will ensure that all physician orders are complete and accurate. Record review of the facility's undated policy Medication Administration indicated . Purpose: To provide practice standards for safe administration of medications for residents in the facility IV. The licensed nurse must know the following about any medication

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 5 medication carts (100-200 halls nurse's cart) and 3 of 8 residents (Residents #21, #11, and #39) reviewed for pharmacy services. 1. The facility failed to ensure RN D secured the 100-200 hall nurse's cart when she left it unattended on 09/09/25. 2. The facility failed to ensure RN D properly secured Resident #21's insulin pen when she left it on top of the 100-200 hall nurse's cart on 09/09/25. 3. The facility failed to ensure Resident #11 did not have wound cleanser in his bedside drawer. 4. Medication aide failed to ensure Resident #39 took her morning medications prior leaving her room and not leaving the medications behind on 09/10/25. These failures could place residents at risk for not receiving drugs and biologicals as needed and a drug diversion. Findings include: 1. During an observation and interview on 09/09/25 at 11:04 AM, RN D entered a resident’s room to answer her call light. RN D left the 100-200 nurse’s cart unlocked with Resident #21’s insulin pen on top of the cart. RN D came out of the resident’s room and said she should not have left the cart unlocked and the insulin pen on top. She said the resident was a high fall risk and made her nervous, so she tried to answer her call light timely. She said she was responsible for ensuring the cart was locked when left unattended and medications secured. RN D said by leaving the cart unlocked and the insulin pen on top of the cart, someone could have taken medications from inside the cart or taken the insulin pen. During an interview on 09/10/25 at 4:19 PM, the DON said she expected the medication cart to be locked when not in view of the nurse. The DON said she expected medications to be always secured. The DON said by leaving the medication cart and the insulin pen unsecured, someone could have taken medications. The DON said the person in charge of the medication cart was responsible for ensuring the medication cart and medications were properly secured when not in view. During an interview on 04/10/25 at 4:45 PM, the Administrator said she expected the medication carts to be locked when the staff stepped away from them. The Administrator said she expected medications to be properly secured. The Administrator said a resident could have gained access to the medications by not properly securing the mediation cart or insulin pen. The Administrator said the nurse providing the medications was responsible for ensuring the cart was locked when left unattended and ensuring medications were properly secured. 2. Record review of Resident #11’s face sheet dated 09/10/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of legal blindness, high blood pressure, malignant neoplasm of the prostate (prostate cancer), and depression. Record review of Resident #11’s quarterly MDS assessment dated [DATE] indicated he usually understood others and usually made himself understood. The MDS also indicated he had a BIMS score of 15 which meant his cognition was intact. The MDS also indicated he required total assistance with toileting, transfers, bathing, and bed mobility and required setup assistance for eating and hygiene. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11’s undated care plan indicated he had impaired visual function related to cataracts, poor vision, and macular degeneration and ADL self-care performance deficit with interventions of dependent staff participation in toileting, transfers, bed mobility, bathing, and personal hygiene. During an interview and observation on 09/08/25 at 3:05 PM, Resident #11 said the facility removed items from the residents’ rooms in the facility and then returned the items back to them. Resident #11 told the surveyor to look in his drawer. Resident #11 observed a bottle of wound cleanser in his drawer. During an interview on 09/10/2025 at 4:58 PM the ADON said Resident #11 should not have had the wound cleanser in his room. She said the failure placed a risk for the wound cleanser being ingested because the facility had wanderers that went all over the facility and opened other resident doors. During an interview on 09/10/2025 at 6:08 PM, the DON said Resident #11 should not have had the wound cleanser in his room. The DON said the failure placed a risk for Resident #11 using the wrong items related to him being blind. During an interview on 09/10/2025 at 6:23 PM, the Administrator said the wound cleanser should be stored in the nurse carts or medication rooms. She said the wound cleanser should not be in the resident rooms. The Administrator said wound care items should be removed by the nurse when they were done with the treatments. She said the failure could place a risk for residents ingesting the wound cleanser. The Administrator said management staff and floor staff should monitor resident rooms for items that should not be in the rooms. 3) Record review of Resident #39’s face sheet dated 09/10/25 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (disease in which the body has trouble controlling blood sugar), schizoaffective disorder (disease with a combination of schizophrenia and mood disorders), anxiety, high blood pressure, and major depression. Record review of Resident #39’s quarterly MDS dated [DATE] indicated she could usually understand others and usually made herself understood. The MDS also indicated she had a BIMS score of 14 which meant her cognition was intact. The MDS also indicated she required moderate assistance with toileting and bathing, supervision with dressing, bed mobility, and transfers, and she was independent with eating. Record review of Resident #39’s care plan dated 01/31/25 indicated she was taking an antipsychotic medication related to her diagnosis schizoaffective disorder, medication for diagnosis of depression, and high blood pressure with interventions in place to administer medications as ordered. During an observation and interview on 09/10/25 at 8:21 AM, Resident #39 was sitting in her wheelchair beside her bed and had a full medicine cup of medication on her completed breakfast tray. Resident #39 said the medication aide did not normally leave her medications. She thanked the surveyor for pointing them out because she did not realize they were on her breakfast tray. Resident #39 started swallowing the medications quicky and said, “Thank you”. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/25 at 8:23 AM, Medication Aide T was standing in the hall next to Resident #39’s room. Medication Aide T stated she was in a hurry and left the medications in the room for Resident #39 to take. She said she did not normally do that, but she was running behind. Medication Aide T said the failure placed a risk for other residents getting the medication and taking it. During an interview on 09/10/2025 at 4:49 PM, the ADON said she expected the medication aides to administer the medications, ensure the medications were swallowed, and for the empty cups to be brought out of the room and thrown away. The ADON said the medication aide had been checked off for medication administration and the ADON was responsible for ensuring the medication aides were competent. The ADON said the failure placed a risk for other residents coming in and taking Resident #39’s medications, overdose, or even death. During an interview on 09/10/2025 at 6:02 PM, the DON said her expectation was for the nurses and medication aides to not to ever set medicine down and leave it in residents’ rooms. The DON said her and the ADON were responsible for ensuring the nurses and medication aides were competent with medication check administration. The DON said the failure placed a risk for Resident #39 not taking the medication, and could have sub therapeutic levels of medications or other residents could have taken and been allergic or overdose. During an interview on 09/10/2025 at 6:21 PM, the Administrator said she expected the medication aides to stay with the resident until they completely take the medications. The Administrator said the DON and ADON were responsible for ensuring the medication aides were competent. The Administrator said the failure placed a risk for Resident #39 missing the medication or risk for other residents ingesting. Record review of the facility’s policy” Medication-Administration with no revision date indicated: Purpose To provide practice standards for safe administration of medications for residents in the Facility. Policy I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner, or as consistent with state law. II. No medication will be used for any resident other than the resident for whom it was prescribed. Ill. Medications must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law…VIII. Medications will not be left at the bedside.” Record review of the facility’s policy “Storage of medications revised 08-2020 indicated: (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications… Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access…3. All medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label…5. Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area. 6. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. ”

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	675664	A. Building B. Wing	09/10/2025

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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	675664	A. Building B. Wing	09/10/2025

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 23 (Resident #11) residents and 1 of 3 meals (lunch) reviewed for palatability. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #11, who complained the food was cold and not good. The dietary staff failed to provide food that was palatable for the lunch meal observed on 09/10/25. Findings included: Record review of Resident #11's face sheet dated 09/10/25 indicated he was a [AGE] year-old male who was admitted to the facility on [DATE] with the diagnoses of legal blindness, high blood pressure, malignant neoplasm of the prostate (prostate cancer), and depression. Record review of Resident #11's quarterly MDS dated [DATE] indicated he usually understood others and usually made himself understood. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he required total assistance with toileting, transfers, bathing, and bed mobility, and required setup assistance for eating and hygiene. Record review of Resident #11's undated care plan indicated he had impaired visual function related to cataracts, poor vision, and macular degeneration, and an ADL self-care performance deficit with interventions of dependent staff participation in toileting, transfers, bed mobility, bathing, and personal hygiene. During an interview on 09/8/25, at 4:50 p.m., Resident #11 said his food was not good and was always cold when he received it in his room. He said he had never asked the staff to warm it up because he felt the facility staff were short-handed. During a confidential group interview on 09/09/25 at 2:30 p.m., the confidential group with 4 residents complained about the food being cold and bland. During an observation and interview on 09/09/25 at 1:16 p.m., the Dietary Manager and four surveyors sampled a lunch tray. The sample tray consisted of fajita chicken, refried beans, and Spanish rice. The Fajita chicken tasted good and was warm. The refried beans and Spanish rice were lukewarm and bland. The Dietary Manager said she felt all the food tasted good and was at a good temperature. During an interview on 09/09/25 at 2:00 p.m., the Dietitian said she was not aware of any food complaints. The Dietitian said the dietary cook was responsible for ensuring the residents received food that was palatable and at the appropriate temperature. The Dietitian said the Dietary Manager's responsibility was to follow up to ensure the food was palatable and temperatures were correct. The Dietitian said it was important for the residents to receive food that was palatable and at the appropriate temperature for nutritional status. During an interview on 09/10/25 at 5:01 p.m., the Dietary manager said she expected the food to be good. She said she was the overseer of the kitchen. She said they had resident council meetings, and in those meetings, the residents would say the food was good. She said she was not aware of any food concerns. She said if the food was not good or at a temperature the resident prefers, it could cause them to not eat. During an interview on 09/10/25 at 5:50 p.m., the DON said the dietary staff was responsible for the palatable and appetizing food. She said she had not heard the residents complain about the food not being good or cold. She said that if the residents did not like the food, it could cause them to lose weight. During an interview on 09/10/25 at 6:11 p.m., the Administrator said she expected the food to be served at the correct temperature, and the food was seasoned and cooked according to the recipe. She said she was not aware that the food was not good or cold. The Administrator said the Dietary Manager was the overseer of the kitchen. She said it was important to ensure food was palatable and had an appetizing temperature because it was their right and to prevent potential weight loss. Record review of the facility's policy titled, Meal Service, dated 01/01/25, indicated, Purpose: To ensure the facility provides meals to the resident that meet the requirements of the food and nutrition board of the National Research Council of the National Academy of Sciences. Record review of the facility's policy titled, Food Temperatures, dated 01/01/25, indicated, Purpose: to provide the dietary department with guidelines for food preparation and service temperature. Policy: Foods prepared and served in the facility will be served at proper temperature to ensure food safety.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide food and drink that accommodated the residents' preferences for 1 of 23 residents (Resident #1) reviewed for preferences. The facility did not honor Resident #1's preference for two milks with her breakfast on 09/09/25 and 09/10/25. This failure could result in a decrease in resident choices. Findings included: Record review of Resident #1's face sheet, dated 09/10/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included shortness of breath also known as SOB, (feeling of difficulty breathing or not being able to get enough air), obesity, depression (sadness), diabetes, and Chronic obstructive pulmonary disease, also known as COPD (a group of lung diseases that cause airflow obstruction and breathing problems. Record review of Resident #1's quarterly MDS assessment, dated 08/20/25, indicated Resident #1 understood and was understood by others. Her BIMs score was a 15, which indicated she was cognitively intact. The MDS indicated she required total assistance for showering, dressing, grooming, and transferring, and was set up for eating. Record review of Resident #1 ‘s physician orders dated 08/16/25, indicated Regular diet, Regular texture, Regular consistency. Record review of Resident #1's comprehensive care plan dated 07/21/25, indicated Resident #1 had a potential for nutritional problems related to obesity. The interventions were to serve the diet as ordered and consult a dietitian as needed. Record review of the breakfast meal ticket dated 09/10/25 for Resident #1 indicated regular diet, and under the note section indicated two milks with all meals. During an observation on 09/09/25 at 9:01 a.m., Resident #1 was in her bed eating her breakfast, and had one juice and one milk on her tray. During an observation and interview on 09/10/25 at 8:10 a.m., Resident #1 had her breakfast and only had one milk on her tray. Resident #1 said they only bring her one glass of milk most of the time, and the nurses must go back and get her another milk to take her medications. She said she likes two milks, one for her breakfast meal, and the other to help get her medications down. The Social Worker walked into the room and verified that the tray card said two milks. The Social Worker walked to the kitchen and brought Resident #1 a glass of milk. During an interview on 09/10/25 at 8:13 a.m., CNA K said she was the aide who served Resident #1 her breakfast tray this morning (09/10/25). She said she did not give her two milks; she said it was an oversight. She said the aides were responsible for putting the drinks on the hall trays. During an interview on 09/10/2025 at 10:35 a.m., MA N said most days she had to get Resident #1 either her milk or juice. She said she would not take her medication unless she had one or the other. She said Resident #1 preferred milk. She said she was not aware who was supposed to put the beverage on the tray, but knew she did not have the beverage most days when she administered medications to Resident #1. During an interview on 09/10/2025 at 10:37 a.m., RN D said she was the nurse who checked the trays before they left the dining room. She said the aides passed out the beverages on the halls, so she was unaware of why Resident #1 did not receive the milk she requested. She said she did not usually give medication, so she was unaware that Resident #1 was not receiving her milk. During an interview on 09/10/25 at 5:11 p.m., the Dietary Manager said she expected Resident #1 to receive her two milks as requested. She said she could not remember who told her Resident #1 wanted two milks with breakfast, but she added it on her tray card. She said the kitchen staff were responsible for the beverages in the dining room, but the nursing staff was responsible for the hallways. The Dietary Manager said it was important for Resident #1's beverage preference to be followed because it was what she wanted. During an interview on 09/10/25 at 5:50 p.m., the DON said if Resident #1 wanted two glasses of milk, then staff should be providing her with them. She said the aides were responsible for ensuring they provided the milk to Resident #1 according to her meal ticket. She said it was important to honor their wish because this was their home, and they should have what they wanted. During an interview on 09/10/25 at 6:11 p.m., the Administrator said she expected the meal tickets and food preferences to be followed. The Administrator said the aides should ensure it was on the tray, and the nursing staff was responsible for overseeing that it was. She said if it helped Resident #1 to take her medications more easily, then she wanted her to have it. The Administrator said it was important for their food/beverage preferences to be followed because it was their right. Record review of the facility's policy titled, Meal Service, dated 01/01/25, indicated, Purpose: To ensure the facility provides meals to the resident that meet the requirements of the food and nutrition board of the National Research Council of the National Academy of Sciences. Procedure: V. Nothing in this policy limits the resident's right to make personal nutrition choices

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure the arbitration agreement was explained in a form and manner, including a language the resident or representative understood for 3 of 3 residents (Residents #56, #57, and #70) reviewed for arbitration agreements. The facility failed to ensure the binding arbitration agreement was fully understood and explained to Residents #57, #70, and #56's responsible party, prior to signing it as part of the admission packet. These failures could place the residents or the residents' responsible parties in binding agreements not fully understood, have a loss of their legal rights, and cause negative psychological issues. The findings included: 1. Record review of Resident #57's face sheet, dated 09/10/25, reflected Resident #57 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke). Record review of Resident #57's admission MDS assessment, dated 09/02/25, reflected Resident #57 usually made herself understood and usually understood others. Resident #57's BIMS score was 11, which reflected her cognition was moderately impaired. Record review of the updated comprehensive care plan reflected Resident #57 had impaired cognitive function/dementia or impaired thought processes related to confusion. The care plan inventions included administer medications as ordered, communicate with the resident/family/caregivers regarding residents' capabilities, needs, discuss concerns about confusion, disease process and nursing home placement with the resident/family/caregivers. Record review of the What is Arbitration (page 16 of the admission Packet) revealed Resident #57 electronically signed the form on 09/03/25 at 1:36 p.m. The form further revealed the Central Intake admission Director signed the form as the facility representative on 09/03/25 at 1:36 p.m. During an interview on 09/10/25 at 8:42 a.m., the State Surveyor and the Regional Nurse Consultant went into Resident #57's room to asked if she remembered signing an arbitration agreement. The state surveyor explained to Resident #57 what the agreement meant, and Resident #57 stated she was unaware she had signed an arbitration agreement with the facility. Resident #57 expressed she was not provided a thorough explanation of the arbitration agreement because if they would have explained it to her, she would not have sign it. During a telephone interview on 09/10/25 at 10:49 a.m., the Central Intake admission Director stated the arbitration agreements were a part of the admission packet. The Central Intake admission Director stated the admission packet was either sent to the families electronically or completed at the facility. The Central Intake admission Director stated the responsibility of ensuring the admission packets were completed by the admission Coordinator, but she assisted him. The Central Intake admission Director stated when the admission packets were completed either at the facility or electronically, she went over every page individually with the resident/families. The Central Intake admission Director stated the arbitration agreement was not required to have been signed as part of admitting to the facility. The Central Intake admission Director stated Resident #57's completed the paperwork electronically. The Central Intake admission Director stated she explained the arbitration agreement word from word and provided Resident #57 with a realistic example. The Central Intake admission Director stated Resident #57 did not have any questions after she signed it. The Central Intake admission Director stated after she realized Resident #57 had a POA, she contacted her, and she also signed it electronically. The Central Intake admission Director stated Resident #57's POA was also explained the arbitration agreement and she did not have any questions either. The Central Intake admission Director stated it was important to ensure the residents or responsible parties were aware of what paperwork they were signing because they could have entered into legally binding agreements without their knowledge. During an attempted telephone interview on 09/10/25 at 11:45 a.m. with Resident #57's POA was unsuccessful. 2. Record review of Resident #70's face sheet, dated 09/10/25, reflected Resident #70 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #70's significant change in status MDS assessment, dated 08/06/25, reflected Resident #70 usually made herself understood and usually understood others. Resident #70's BIMS score was 13, which reflected her cognition was intact. Record review of the undated comprehensive care plan reflected Resident #70 had impaired cognitive function/dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). The care plan interventions included administer medications as ordered. Record review of the What is Arbitration (page 16 of the admission Packet) revealed Resident #70 electronically signed the form on 06/18/25 at 4:06

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 3 of 7 residents (Resident #8, Resident 11 and Resident #66) reviewed for hospice services. 1. The facility failed to maintain the hospice binder for Resident #8, which contained information related to the hospice services provided to the resident, including the most recent plan of care, hospice election form, medication list, and physician recertification. 2. The facility failed to obtain Resident #11's hospice election form, IDG meetings, most recent medication profile, and the most recent plan of care for his hospice book 3. The facility did not ensure Resident #12's hospice records were a part of their records in the facility. These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included: 1.Record review of Resident #8's face sheet, dated 09/10/25, indicated he was an [AGE] year-old male, admitted to the facility on [DATE] and re-admitted [DATE]. His diagnoses included malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and chronic obstructive pulmonary disease, also known as COPD (a group of lung diseases that cause airflow obstruction and breathing problems). Record review of Resident #8's significant change MDS assessment, dated 07/12/25, indicated Resident #1 usually understood and was usually understood by others. His BIMs score was a 12, which indicated he was moderately cognitively impaired. The MDS indicated Resident #8 was on hospice services. Record review of Resident #8’s comprehensive care plan dated 05/18/25 indicated Resident #8 had a terminal prognosis and was on hospice services. The intervention was to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met, and for the nursing staff to provide maximum comfort for the resident. Record review of Resident #8’s physician orders dated 07/10/25 indicated an order for {name} hospice. Record review of Resident #8’s physician orders dated 07/10/25 indicated an order for Gabapentin Oral Capsule 100 MG (Gabapentin), give one capsule by mouth two times a day for nerve pain. Record review of Resident #8’s physician orders dated 08/28/25 indicated an order for Gabapentin Oral Capsule 300 MG (Gabapentin), give 1 capsule by mouth two times a day for neuropathy. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8’s hospice binder revealed no Physician certification of the terminal illness, Hospice election form, updated care plan, updated medication list, or updated IDG (Interdisciplinary Group) meeting. The last recertification was dated 07/17/25. The hospice binder contained the last care plan, medication list, and IDG meeting dated 07/23/25. During a phone interview on 09/10/25 at 9:42 a.m., the hospice Patient Care Manager said the binders at the facility should contain any supporting notes or documentation needed for Resident #8. She said they met every two weeks for the IDG meetings and said the documentation should be updated at least by the following week after the IDG meetings. She said the marketer usually brought the IDG meeting, but for the last month, the nurses or CNAs took the IDG meeting report to the facility. She said Resident #8’s benefit period was effective from 07-10-25 through 09-10-25, his last IDG meeting was 08/28/25, the aides had visits 5 times a week, and the nurses had visits 3 times a week. She said it was important to have the binders at the facility to help the facility know the care and services they were providing. During an interview on 09/10/25 at 10:41 a.m., RN D said hospice was responsible for keeping their charts/books updated. She said she knew they signed in and out when they visited a resident, but was not sure what else was supposed to be in the folders. She said she knew they had information in the books but was unsure of what it all contained. She said the facility communicated via phone with hospice for any changes, and hospice communicated when they visited about any issues. 2.Record review of Resident #11’s face sheet dated 09/10/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses legal blindness, high blood pressure, malignant neoplasm of the prostate (prostate cancer), and depression. Record review of Resident #11’s quarterly MDS dated [DATE] indicated he usually understood others and usually made himself understood. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he required total assistance with toileting, transfers, bathing, and bed mobility and required setup assistance for eating and hygiene. Record review of Resident #11’s undated care plan indicated he had impaired visual function related to cataracts, poor vision, and macular degeneration and ADL self-care performance deficit with interventions of dependent staff participation in toileting, transfers, bed mobility, bathing, and personal hygiene. The care plan also indicated Resident #11 had a terminal prognosis related to malignant neoplasm of the prostate and he received hospice services with interventions to work cooperatively with the hospice team to ensure the resident’s spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #11’s order summary report dated 09/10/25 indicated an order for admit to [hospice company] with an order date of 03/01/24. Record review of Resident #11’s EMR on 09/09/25 at 5:18 p.m., indicated the latest hospice documents were completed uploaded on 12/04/24. Record review of Resident #11’s hospice binder on 09/10/25 at 9:29 a.m., indicated the facility did not have an IDG comprehensive assessment, the most recent plan of care was dated 08/12/25 and reviewed on 08/14/25, and the latest medication review dated 08/14/25. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/2025 at 9:35 a.m., the Hospice RN said she was responsible for ensuring Resident #11’s hospice binder was updated but the information kept changing. She said she could not tell me the dates of his benefit period at that time, but she had been evaluating to discharge him and everybody knew that. The Hospice RN said there should have been a face sheet, updated med profile, IDG notes, and an updated plan of care dated 08/27/25. She said Resident #11’s binder should have been updated every 2 weeks. The Hospice RN said she should have delivered the updated paperwork the following Tuesday (09/02/25) and the hospice company was having the next meeting the next morning on (09/11/25). The Hospice RN said the failure placed a risk for the medication list not being accurate and the facility not having any up-to-date information. The Hospice RN also said the failure could cause missed communication between the facility and hospice company staff. 3. Record review of Resident #66’s face sheet, dated 09/10/25, reflected Resident #66 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included end stage heart failure (a condition where the heart is unable to pump enough blood to meet the body’s needs). Record review of Resident #66’s quarterly MDS assessment, dated 07/08/25, reflected Resident #66 usually made herself understood and usually understood others. Resident #66’s BIMS score was 8, which reflected her cognition was moderately impaired. The assessment reflected Resident #66 had a life expectancy of less than 6 months and received hospice services. Record review of the undated comprehensive care plan reflected Resident #66 and her representative had elected to be admitted to hospice services as of 05/06/25 for diagnosis of end stage renal disease. The care plan inventions included Resident #66 had orders for comfort meds from hospice to ensure she was kept comfortable until she passed. Record review of the order summary report dated 09/10/25 reflected Resident #66 had an order to admit to hospice with an order date 05/06/25. Record review of Resident #66’s hospice binder, accessed by the state surveyor on 09/10/25 at 9:00 a.m. revealed no updated POC, medication list, nurses, aides, and social worker notes since the last IDG meeting (08/29/25). During a telephone interview on 09/10/25 at 9:14 a.m., the Case Manager for the hospice company stated Resident #66 was admitted to hospice on 05/06/25 for end stage renal failure. The Case Manager stated the last visit was on 09/04/25. The Case Manager stated the updated POC, medication list, nurses, aides, and social worker notes should have been brought in on the next visit which was the week of 09/01/25 by the nurse. The Case Manager stated the process for coordinating with the facility was face to face, via telephone/faxed. During an interview on 09/10/25 at 5:05 p.m., the DON stated she was unaware the binders were not updated. The DON stated she was unsure who was responsible for ensuring the hospice books was updated with all required information. The DON stated the updated POC, aides, nurses, social services notes from the last IDT meeting should be included in the binder. After reviewing Resident #66’s hospice binder with the state surveyor, the DON stated the binder was not updated to include all information that was needed. The DON stated the charge nurses communicated verbally one on one or via telephone with the hospice. The DON stated it was important to ensure recent hospice documentation was in the facility to keep communication between the facility and hospice for continuation of care. (continued on next page)

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/25 at 5:30 p.m., the Social Services stated technically medical records were responsible for ensuring the hospice binders was updated. The Social Services stated the facility had just hired a new medical records person in the last few weeks. The Social Services stated if the hospice providers sent her (Social Services) paperwork via email, she would update the binder when the facility did not have a medical records person. The Social Services stated hospice providers should give all documents to medical records to be placed in the binder. The Social Services stated she did not know how often the binder should be updated because it did not follow under her job category. During an interview on 09/10/25 at 6:08 p.m., the Medical Records stated she had not been aware that she supposed to be update the hospice binders. The Medical Records stated she was currently still in training and has only been at the facility for three weeks. The Medical Records stated if there were any documents in the medical records folder at the nursing station or via email she would scan and upload the documents in PCC. The Medical Records stated she had not received any hospice documentation via email or left in the folder by the hospice providers. The Medical Records stated she was not sure how the hospice providers will be delivering the documentation. The Medical Records stated she would get with her consultant to see how the process worked. The Medical Records stated it was important to ensure recent hospice documentation was in the facility for continuity of care. During a telephone interview on 09/10/25 at 6:30 p.m., the Director of EHR stated currently the Medical Records was in training and the Regional Medical Records Consultant was supposed to had come in on 09/09/25 to complete training which would have included processing hospice documentation but since state was in the building it was rescheduled. The Director of EHR stated the process was the hospice providers either send documentation via email or bring it to the facility and the Medical Records would scan in and uploaded to PCC but due training being delayed, Medical Records was not train on how to receive records. The Director of EHR stated with the previous employee there was a system in place to ensure all binders were updated but due to the change of employee it did not get picked up by someone else at the facility. The Director of EHR stated it was important to ensure recent hospice documentation was in the facility for continuation of care. During an interview on 09/10/25 at 6:40 p.m., the Administrator stated her expectation that all documents were updated and uploaded in PCC. The Administrator stated Medical Records was responsible for ensuring that the documents were scanned in the resident’s chart. The Administrator stated there was not a system in place at this time to ensure all current documents was uploaded in the resident’s chart due to Medical Records only been employed for the past 3 weeks and has not been currently trained. The Administrator stated the facility had been without a medical record person since 07/21/25. The Administrator stated it was important to ensure recent hospice documentation was in the facility for continuity of care. Record review of the “End of Life Care”, dated 08/2020, reflected, “to provide a process to assist the resident in fulfilling their spiritual, physical, and emotional needs, and to provide emotional support to families of residents with a terminal illness… IV. Coordination with hospice… B. Social Services Staff will coordinate with hospice staff to ensure that the resident’s needs are communicated to the hospice… C. Social Services Staff may include the hospice team in the resident’s IDT conference…”

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 3 of 26 residents (Resident #66, Resident #11, and Resident #18), reviewed for infection control practices. 1. The facility failed to ensure CNA O did not wear her gown and gloves out of Resident #66's room after providing direct care to Resident #66 who was on Enhanced Barrier Precautions (EBP- an infection control strategy that uses gloves/gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms) on 4/11/25.2. The facility failed to ensure CNA O did not pick up linens off Resident #66's floor, placed in a bag, and then proceeded to provide direct care to Resident #66 without changing her gloves on 4/11/25.3. The facility failed to ensure CNA S did not pick up a plastic bag from Resident #66's floor and place on the resident's bed on 6/26/25.4. The facility failed to ensure CNA N wore gloves throughout providing direct care to Resident #66 who was on EBP on 9/09/25. 5. The facility failed to ensure CNA N wore gown and gloves throughout providing direct care to Resident #66 who was on EBP on 9/09/25.6. CNA E failed to change gloves between dirty and clean surfaces while providing incontinent care for Resident #11. 7. CNA E failed to use proper hand hygiene between glove changes while providing incontinent care for Resident #11.8. The facility failed to ensure RN D changed her gloves and perform hand hygiene after she obtained Resident #18's fingerstick blood sugar on 09/09/25.These failures could place residents at risk for cross contamination, at an increased risk of infection, and the spread of infection. Findings included: 1. Record review of Resident #66's face sheet dated 9/08/25 indicated she was [AGE] years old and was admitted to the facility on [DATE] initially and re-admitted on [DATE]. Resident #66 had diagnoses which included dementia (forgetfulness), chronic kidney disease, diabetes, urinary tract infection, heart failure, chronic kidney disease, extended spectrum beta lactamase (ESBL) resistance (infection that has resistance to many common antibiotics), weakness and lack of coordination. Record review of Resident #66's quarterly MDS assessment dated [DATE] indicated she was usually understood and usually understood others. Resident #66 had a BIMS score of 8, which indicated she had moderate cognitive impairment. Resident #66 was dependent on staff for most ADL’s, including toileting. Resident #66 was always incontinent of bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #66's Care Plan indicated she had diabetes. Resident #66 was on Enhanced Barrier Precautions related to MDRO infectious disease (multiple drug resistance organism) with interventions including staff would wear a clean gown and gloves while performing high contact resident care activities to include: dressing, bathing/showering, transferring, providing hygiene, changing linens or toileting assistance, and/or caring for indwelling medical devices. Resident #66 had MASD (moisture associated skin damage) to lower extremities due to end stage renal disease causing her skin to weep (fluid comes out of skin). Resident #66 had actual skin impairment related to disease process and immobility, with skin tear to left leg, and right lower leg blister. Resident #66 had an ADL self-care performance deficit and was dependent on staff for toileting. Resident #66 had history of urinary tract infection with ESBL (extended-spectrum beta-lactamase- enzymes produced by bacteria that make them resistant to many commonly used antibiotics (medications that fight infection)). Record review of Resident #66’s Order Summary Report dated 9/09/25 indicated an order for Enhanced Barrier Precautions related to MDRO: staff members would wear a clean gown and gloves while performing high contact resident care activities to include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices … every shift for standard precautions with a start date of 6/24/25. Record review of video footage dated 4/11/25 beginning at 4:15 AM, started with CNA O and CNA Q at Resident #66’s bedside wearing gowns and gloves. CNA Q was on Resident #66’s left side of the bed between the bed and wall. CNA O was on Resident #66’s right side. CNA O and CNA Q pulled back Resident #66’s bedding and moved her pillows and CNA O placed a trash bag and a clean brief on the bed. CNA Q pulled Resident #66 toward her using a draw sheet, then CNA O was doing something behind the resident (unable to see due to the positioning of the camera) as CNA Q held Resident #66 on her side. CNA O then left Resident #66’s room, at 4:16 AM, wearing her gown and same gloves she had used to care for Resident #66. CNA O returned to Resident #66 at 4:16 AM, seventeen seconds later, carrying a white folded item that appeared to be a draw sheet. CNA O then proceeded to continue providing care to Resident #66 without changing her gloves. CNA O through linens onto the floor and then reached down and gathered the linen and placed in a plastic bag. CNA O then went back to providing care to Resident #66. Record review of video footage dated 6/26/25 beginning at 2:12 PM started with CNA S wearing a gown and gloves as she was repositioning Resident 66’s bedding. CNA S then begun providing care to Resident #66 and had placed a plastic bag toward the foot of the resident’s bed. CNA S appeared to be providing incontinent care but was not able to visualize the actual care provided due to the position of the camera. During CNA S providing care to Resident #66, the plastic bag fell off the bed onto the floor and CNA S picked up the plastic bag from the floor and placed it back on Resident #66’s bed. Record review of video footage dated 9/09/25 beginning at 4:30 AM, started with CNA N and CNA P at Resident #66’s bedside. CNA N was on Resident #66’s right side and CNA P was on her left side between the wall and her bed. CNA N and CNA P pulled back Resident #66’s bedding. CNA N and CNA P appeared to be providing incontinent care but was unable to actually see the care provided due to the position of the camera. CNA N removed her gloves and left her gown on. CNA P then removed her gown and gloves while still between the wall and the resident’s bed. CNA N and CNA P then both pull the resident’s cover over her. CNA P was not wearing a gown or gloves while leaning over Resident #66 positioning her bedding and pillows and was allowing her clothing to touch the resident’s bedding. CNA N was not wearing gloves whiling positioning Resident #66’s bedding and placing a pillow behind the resident’s head. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 9/09/25 at 8:45 AM, Resident #66 was lying in bed with her Responsible Party (RP) at her bedside. Resident #66 had a Enhanced Barrier Precautions (EBP) sign posted at the head of the bed on the wall. Resident #66’s RP said she had a camera in the resident’s room, and her main concern were with the staff not changing their gloves during incontinent care and prior to handling multiple surfaces in the resident’s room. During an interview on 9/09/25 at 11:45 AM, CNA K said she had worked at the facility for approximately six years. CNA K said staff should change their gloves after cleaning the resident during incontinent care, when going from dirty to clean areas. CNA K said staff should change their gloves after providing incontinent care and prior to touching other items in the resident’s room. CNA K said if staff did not change their gloves appropriately, their gloves would be soiled, and they would transfer any germs to other surfaces in the room and could cause the resident an infection. CNA K said staff should be wearing gown and gloves while providing care to a resident on Enhanced Barrier Precautions. CNA K said staff should not wear their personal protective equipment (PPE) after providing care and then wear gown and gloves into the hallway to get supplies. CNA K said staff should remove their gown and gloves and then put on new ones when returning to the resident’s room. CNA K said the purpose of EBP was to protect staff and to not transfer germs from one resident to another resident. During an interview on 9/09/25 at 3:11 PM, LVN A said she had worked at the facility for seven years. LVN A said when staff were providing incontinent care, the staff should change their gloves after removing dirty, after cleaning, and anytime they were soiled. LVN A said staff should change their gloves after providing incontinent care and prior to touching other objects in the resident’s room, so not to cross-contaminate. LVN A said the resident could get an infection and transfer to other residents and staff. LVN A said staff should be wearing gowns and gloves anytime while providing care for residents on EBP. LVN A said staff should remove their gown/gloves after all care had been provided. LVN A said EBP was to protect the resident and staff from transmitting infection/disease. LVN A said staff should wear the gown and gloves until all care was completed. LVN A said staff should not leave the resident’s room wearing their gown and gloves after touching the resident, and should remove their gown/gloves prior to leaving the room and then put on new gown/gloves when returning to the resident’s room. LVN A said staff could cross-contaminate anything they touched in the hall/linen cart if the staff wore there gown/gloves out of the resident’s room. LVN A said it would be an infection control issue. During an interview on 9/09/25 at 3:38 PM, CNA R said she had worked at the facility for about a year. CNA R said staff should change gloves every time you do care and use hand sanitizer. CNA R said staff should change their gloves after providing incontinent care and before touching any other items in the resident’s room. CNA R said staff should not remove their gloves and gown until they had finished everything and then take everything (gown/gloves) off just prior to leaving the resident’s room. CNA R said staff should remove their gown/gloves prior to leaving the resident’s room after touching the resident. CNA R said it would be cross-contamination if staff wore their gown and gloves out of the resident’s room and went and got clean linen from the linen cart. CNA R said EBP was, so staff did not pass germs to another resident. CNA R said it would be an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/09/25 at 5:35 PM, CNA Q said she had worked at the facility for a little over a year. CNA Q said staff should change their gloves and wash or sanitize their hands prior to starting care on the resident, and after cleaning the perineal area (private areas) before turning the resident over, after cleaning bowel movement, and change gloves before touching anything such as the resident, their bedding, and/or clothing. CNA Q said staff should change their gloves appropriately to not transmit anything they had on their gloves to the other surfaces and spread bacteria. CNA Q said staff should wash their hands and change gloves appropriately to keep infections down. CNA Q said if you have to leave the resident’s room, who was on EBP, staff should remove their gown and gloves to not transmit anything to other things, like the clean linen cart, and then transmit whatever they had on their gloves and then they could take bacteria to every room and spread bacteria. CNA Q said it was an infection control issue. CNA Q said not changing gloves, sanitizing, wearing gown/gloves out of the room into the hallway, placed the residents at a higher risk of infection. CNA Q said staff should not remove their gown/gloves when caring for a resident on EBP until they were completely done with resident care. CNA Q said the gown/gloves for a resident on EBP was a barrier between staff and the resident to prevent the spread of infection. On 9/09/25 at 5:55 PM, 9/10/25 at 11:31 AM, called CNA O called both numbers provided and there was no answer and was unable to leave voicemail. CNA O did not return call prior to surveyor exiting the facility. During an interview on 9/09/25 at 5:56 PM, CNA N said she had worked at the facility since January 2025. CNA N said staff should change their gloves every time you wipe the resident during incontinent care. CNA N said that was what she did. CNA N said you should change gloves before touching other items in the resident’s room after performing incontinent care. CNA N said so you do not transmit germs or what was on your gloves to other areas or surfaces. CNA N said the EBP was, so you did not transit infections to other residents. CNA N said if you had begun care on a resident wearing a gown and gloves and then had to leave the room to get something, you should remove your gown and gloves and then wash hands/sanitize hands. CNA N said then staff should put on a new gown and gloves to prevent spreading infection to other things such as the linen cart. CNA N said because you would have already touched the resident and could spread infection, if not removing gown/gloves prior to exiting the resident’s room. CNA N said staff should not remove their gown and gloves while still caring for a resident who was on Enhanced Barrier Precautions because the gown and gloves prevented the spread of infection and was a barrier between the staff and the resident. CNA N said she kept gloves in a bag and used hand sanitizer when she changed her gloves when providing incontinent care and placed her clean bag with supplies on a small towel on the resident’s table to keep them clean. On 9/09/25 at 6:14 PM, 9/10/25 at 11:00 AM, and 9/10/25 at 2:30 PM, called CNA P on both numbers provided and there was a recording stating it had restricted calling and was unable to leave voicemail. CNA P did not return call prior to surveyor exiting the facility. On 9/10/25 at 9:26 AM and 11:50 AM, called CNA S and there was no answer but left a detailed voicemail. CNA S did not return call prior to surveyor exiting the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/10/25 beginning at 2:54 PM, the DON said staff should change their gloves anytime soiled and perform hand hygiene. The DON said staff should change gloves prior to touching items in a resident’s room. The DON said if staff did not change gloves appropriately during incontinent care and then touched items in the resident’s room, it could lead up to an infection and it was “just nasty”. The DON said it was an infection control issue. The DON said staff should remove their gown and gloves after completing the resident’s care but could change their gloves whenever needed. The DON said staff should not remove their gown when providing care to a resident on Enhanced Barrier Precautions (EBP) until the staff was ready to leave the resident’s room. The DON said if staff remove their gown and gloves prior to completing the resident’s care, could be an infection control issue. The DON said staff should not leave a resident’s room who is on isolation or on EBP wearing their gown and gloves and should probably use the call light to have another staff member to bring them what they needed. The DON said if staff were wearing their gown and gloves out of a resident’s room who was on isolation or EBP, it could affect other residents by transferring bacteria out of the resident’s room, potentially exposing other residents. The DON said staff should not pick up anything off the floor and place it on the resident’s bed. The DON said dirty linens should not be placed on the resident’s floor but should be placed in a bag. The DON said staff should not pick anything off the floor and then continue the resident’s incontinent care without changing gloves and performing hand hygiene. The DON said whatever was on the floor would be on the resident and was an infection control issue. During an interview on 9/10/25 beginning at 3:35 PM, the ADM said she would expect staff to change gloves appropriately to prevent cross-contamination and spread of infections. The ADM said she expected the staff to follow the facility’s Infection Control and Enhanced Barrier Precautions policies. The ADM said if staff did not change their gloves appropriately during incontinent care, it could increase the resident’s risk of infection and spreading infection to other residents. 2. Record review of Resident #11’s face sheet dated 09/10/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses legal blindness, high blood pressure, malignant neoplasm of the prostate (prostate cancer), and depression. Record review of Resident #11’s quarterly MDS dated [DATE] indicated he usually understood others and usually made himself understood. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated he required total assistance with toileting, transfers, bathing, and bed mobility and required setup assistance for eating and hygiene. Record review of Resident #11’s undated care plan indicated he had impaired visual function related to cataracts, poor vision, and macular degeneration and ADL self-care performance deficit with interventions of dependent staff participation in toileting, transfers, bed mobility, bathing, and personal hygiene. During an observation 09/08/2025 at 2:45 PM, CNA E assisted the Treatment Nurse and provided incontinent care to Resident #11. During providing incontinent care CNA E cleaned Resident #11’s fecal matter off of his buttocks and grabbed the clean brief with the same dirty gloves on applied new brief on resident. She then removed her old gloves, and nurse gave her new gloves to put on. Failed to provide hand hygiene between glove changing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/08/2025 at 3:02 PM, CNA E said she should have used hand sanitizer between glove changes and changed her gloves between dirty and clean surfaces because of germs being transferred. She said she had just started her shift and forgot to grab her hand sanitizer that she usually keeps in her pocket. During an interview on 09/10/2025 at 4:55 PM, the ADON said her expectation was for all the CNAs to change their gloves between clean and dirty and provide proper hand hygiene in between. She said the failure placed a risk for cross contamination and infection. During an interview on 09/10/2025 at 6:12 PM, the DON said she expected the CNAs to change gloves any time the gloves were dirty or soiled and the CNAs should have been using hand sanitizer or hand washing between glove changes. The DON said the failure placed an increased risk for infection. During an interview on 09/10/2025 at 6:27 PM, the Administrator said her expectation was for the CNAs to be changing their gloves and sanitizing appropriately while providing care. The nurse managers were responsible, and the risk is spread of infection. 3. Record review of Resident #18’s face sheet dated 09/10/25, indicated an [AGE] year-old female who readmitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung diseases that block airflow and make it difficult to breathe) and diabetes type 2 (a group of diseases that result in too much sugar in the blood). Record review of Resident #18’s quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. Resident #18 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #18 had received insulin injections 7 days out of the 7-day look back period. Record review of Resident #18’s comprehensive care plan did not address Resident #18 diagnoses of diabetes. Record review of Resident #18’s order summary report dated 09/10/25, indicated an order for Insulin Lispro (insulin which helps lower blood sugar levels) 100unit/ml inject per sliding scale before meals and at bedtime with a start date of 02/07/25. Record review of Resident #18’s nurse administration record dated 09/01/25-09/30/25, indicated Resident #18 had received 2 units of insulin lispro at 11:30 AM on 09/09/25. During an observation and interview on 09/09/25 at 11:24 AM, RN D retrieved supplies from the nurse’s cart and entered Resident #18’s room to obtain her blood sugar. RN D donned gloves and obtained Resident #18’s blood sugar. RN D then obtained the insulin pen from the tray she had taken into Resident #18’s room and went to the nurse’s cart to look at Resident #18’s orders. RN D failed to remove her gloves or perform hand hygiene prior to obtaining the insulin pen or going to the nurse’s cart. RN D administered 2 units of insulin to Resident #18. RN D said she did not change her gloves after she obtained Resident #18’s blood sugar and should have. She said blood could have been on her gloves. RN D said failure to change gloves and perform hand hygiene placed the residents at risk for cross contamination of blood borne pathogens. She said she had been nervous due to surveyor observing her. She said she was responsible for ensuring infection control was maintained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/25 at 4:19 PM, the DON said she expected the nurse to have changed her gloves after she obtained Resident #18’s blood sugar. She said failure to do so placed the residents at risk for infections. She said the employee performing a task was responsible to ensure infection control was maintained. During an interview on 09/10/25 at 4:45 PM, the Administrator said she expected the nurse to have changed her gloves after she obtained Resident #18’s blood sugar to prevent infection. She said the nurse providing the task was responsible to ensure infection control was maintained. Record review of the facility's policy titled Perineal Care dated revised 6/2020 indicated . the purpose was to maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown … VII Turn resident to side … VIII Wash, rinse and dry buttocks and peri-anal area without contaminating the perineal area … XII Remove gloves. Wash hands or use alcohol-based hand sanitizer … Note: Do not touch anything with soiled gloves after procedure (ie. Curtain, side rails, clean linen, call bell, etc.) … XIII Put on clean gloves … XIV Clean and return all equipment to its proper place … XV Place soiled linen in proper container … XVI Remove gloves … XVII Wash hands …”. Record review of the facility's policy titled Infection Prevention and Control Program dated revised 6/2020 indicated . the purpose was … to ensure the facility established and maintained and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent to development and transmission of disease and infection in accordance with federal and state requirements … The Infection Control Policies and Procedures … C. Objectives … i. Prevent, detect, investigate, and control infections in the facility … E. Staff were trained on the infection control policies and procedures upon hire and periodically thereafter …”. Record review of the facility’s policy titled “Hand Hygiene” dated revised 6/2020 indicated “… purpose … to ensure that all individuals use appropriate hand hygiene while at the facility … the facility considers hand hygiene the primary means to prevent the spread of infections … hand hygiene was always the final step after removing and disposing of personal protective equipment … Facility Staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections … Facility Staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors … Facility staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited too … Wash hands with soap and water: Before eating … After using the bathroom … when soiled with visible dirt or debris … after unprotected (ungloved and damaged gloves) contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, intact skin soiled with blood and other body fluids, wound drainage and soiled dressings … after contact with intact and non-intact skin, clothing, and environmental surfaces of residents with active diarrhea even if gloves are worn … Before and after food preparation … Upon starting of the shift … after removing personal protective equipment before moving to another resident in the same room or exiting the room … Before putting on sterile gloves for the purpose of performing procedures for which aseptic technique is required (e. g., insertion of vascular access devices, urinary catheters, etc.) … Alcohol-based hand hygiene products can and should be used to decontaminate hands … Hand hygiene is always the final step after removing and disposing of personal protective equipment … the use of gloves did not replace hand hygiene procedures …”. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Springs Nursing & Rehab	1200 Jackson St N Sulphur Springs, TX 75482

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility’s policy “Blood Glucose Monitoring” revised 06/2022, indicated… “Purpose: To monitor blood glucose concentrations as ordered by the Attending Physician… Procedure: I. Assemble the equipment at bedside… IV. Wash hands and put on gloves… XI. After collecting the blood sample, briefly apply pressure to the puncture site to stop the bleeding… XIII. Remove the test strip and discard. XIV.