STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675700	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Brookshire	710 Hwy 359 S Brookshire, TX 77423

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement.1. The facility failed to ensure leftover food to be used later with a temperature in the danger zone was discarded which pan of mechanical soft sausage in the steamtable 131.1 degrees Fahrenheit2. The facility failed to ensure that food past the used by date were discarded which included a pan of cooked rice in the refrigerator use by date 2/7/26, a pan of mashed potato use by date 2-3-26, a pan of Salisbury steak use by date 1-7-26, a package of shredded cheddar cheese use by date 1-12-26, a package of deli meat turkey use by date 1-29-26,a package of shredded swiss cheese use by date 12-15-25.3. The facility failed to ensure food was stored 6 inches off the floor. 1 case of frozen ground beef in the freezer. 2 fruit cocktail cases on the storeroom floor These failures could place residents who consumed food from the kitchen at risk of food borne illness and disease. Observation of the facility kitchen on 02-09-26 at 8:45 AM revealed the following. 1. A pan of mechanical soft sausage 131.1 degrees Fahrenheit in the refrigerator .2. A pan of cooked rice use by date 2-7-26 in the refrigerator.3 A pan of mashed potatoes use by date 2-3-26 in the refrigerator .4. A pan of Salisbury steak use by date 1-7-26. in the refrigerature5. A package of shredded cheddar cheese use by date 1-12 26 in the refrigerator6. A package of deli meat turkey use by date 1-29-26 in the refrigerator.7. A package of shredded Swiss cheese use by date 12-15-25 in the refrigerator.8. 1 case of frozen ground beef in the freezer on the floor.9. 2 cases of fruit cocktail cans on the storeroom floor in the kitchen area. In an interview with the Dietary Food Service Manager on 2-07-26 at 8:45 AM, she stated that the following foods were stored in the refrigerator to be used for later date should be discarded prior to the use by date. She stated the leftover food within the danger zone (40 degrees Fahrenheit to 140 degrees Fahrenheit) should have been discarded. She further stated that she will in-service dietary staff on proper handling, storing, dating leftover food for compliance. The dietary manager stated that all foods should be stored off the floor to prevent cross contamination like pest and vermin. Record review of the facility's policies and procedures for Food Safety dated 3-30-23 read in part .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded on the used by date unless otherwise indicated. For food storage keep off floor.

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. During a confidential group meeting, residents stated that staff had not knocked on their doors and announced themselves before entering their room. One of 10 confidential group residents stated that she had been in the middle of dressing when staff walked into her room. She stated that the staff had no regard in providing her with privacy and freedom of feeling exposed. During an interview on 02/12/2026 at 09:27 a.m. the Administrator (ADM) stated that he had been made aware that knocking on residents' doors before entering their rooms had been an issue. He stated that the staff received in-service training on customer service once a month which included - no expectations knock on resident's doors before entering a resident's room. He stated staff were to knock, wait and give the residents the ability to welcome the staff in, and then enter, and announce the goal of the visit. He stated during the visit with the residents, staff were to communicate with the residents what care service they were provided the entire visit. He stated staff received in-service training on abuse, neglect and exploitation 3 times a month which also covers customer service responsibilities. During an interview on 02/12/2026 at 10:16 a.m. the Activities Director (AD) stated that she had been made aware by the residents during resident council meetings in the past (exact date unknown) concerns about staff not knocking and announcing themselves before entering a resident room. She stated she had informed the Director of Nursing (DON) (exact date unknown) and the DON had made herself present at one of the resident council meetings to address the residents' concerns. She stated thereafter, the nursing and certified nursing staff (CNAs) received an in-service training on customer service

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure the residents' rights to privacy for 1 of 10 confidential residents reviewed for personal privacy. The facility failed to ensure facility staff knocked on residents' doors prior to entering their rooms.This failure could allow residents' protected HIPAA information to be shared with individuals who did not have a need or right to know and could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. During a confidential group meeting, residents stated that staff had not knocked on their doors and announced themselves before entering their room. One of 10 confidential group residents stated that she had been in the middle of dressing when staff walked into her room. She stated that the staff had no regard in providing her with privacy and freedom of feeling exposed.During an interview on 02/12/2026 at 09:27 a.m. the Administrator (ADM) stated that he had been made aware that knocking on residents' doors before entering their rooms had been an issue. He stated that the staff received in-service training on customer service once a month which included - no expectations knock on resident's doors before entering a resident's room. He stated staff were to knock, wait and give the residents the ability to welcome the staff in, and then enter, and announce the goal of the visit. He stated during the visit with the residents, staff were to communicate with the residents what care service they were provided the entire visit. He stated staff received in-service training on abuse, neglect and exploitation 3 times a month which also covers customer service responsibilities.During an interview on 02/12/2026 at 10:16 a.m. the Activities Director (AD) stated that she had been made aware by the residents during resident council meetings in the past (exact date unknown) concerns about staff not knocking and announcing themselves before entering a resident room. She stated she had informed the Director of Nursing (DON) (exact date unknown) and the DON had made herself present at one of the resident council meetings to address the residents' concerns. She stated thereafter, the nursing and certified nursing staff (CNAs) received an in-service training on customer service

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to provide, based on the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 10 of 10 confidential residents reviewed for activities. The facility failed to provide activities to meet the residents' interests on Saturdays and Sundays for 10 confidential residents. These failures placed residents at risk for decline in quality of life, social and mental psychosocial wellbeing. During a confidential group interview on 02/11/2026 at 02:10 p.m., with 10 confidential residents, all residents stated that there were no weekend activities and nothing to do around the facility on those days. Four of the 10 residents stated it was boring, and it was nonsense that the facility could not provide them with activities on the weekends. Four of the 10 residents stated the morale was down in the facility because there were no activities on the weekends. One of the 10 residents stated that not having activities on the weekends proved that the facility did not give a shit about them. Five of the 10 residents stated that the facility left out coloring sheets for them to do when the Activities Director was not at the facility but stated they could color on their own time and did not consider coloring an activity worth calling an activity. Interview on 02/12/2026 at 10:16 a.m. the Activities Director (AD) stated she had been in her role at the facility since 10/27/2025 and worked Monday – Friday between 8:00 a.m. and 5:00 p.m. She stated prior to that date, she had been the AD's assistant for 1.5 years. She stated that she had not been working at the facility on Saturdays or Sundays, but left activity packets out that contained coloring sheets, daily chronicle news for that day, and a [NAME] for the residents to do on the weekends. She stated that the facility had a job posting for a part-time weekend activity director that would offer 16 total hours per week. She stated that she had interviewed a few prospects, but they were not interested in taking the position unless it offered the opportunity to acquire more hours, which she stated the facility would not. She stated that every 3rd Sunday, a pastor from a local church provided the resident's a church service and other volunteer groups came into the facility such as a sorority and high school band which they showcased on their facility Facebook page. She stated however, there were no staff led activities on Saturdays and Sundays at the facility. She stated that she would provide the job posting for the weekend part-time AD position. During an interview with the Administrator (ADM), he stated that he was aware that the residents had no activities on Saturdays and Sundays. He stated that the facility was looking to fill a weekend part-time AD position and stated he would defer to the AD for the progress on filling that position. Record review of the facility's Activities Calander titled December 2025 reflected Activities Packets Available for Saturdays 12/06, 12/13, 12/20, and 12/27. On Sunday 12/01, 12/14, 12/21 and 12/28 the calendar listed Activities Packets Available. Record review of the facility's Activities Calander titled January 2026 reflected Activities Packets Available for Saturdays 01/03, 01/10, 01/17, 01/24 and 01/31. On Sunday 01/04 and 01/11 the calendar listed Activities Packets Available and on 01/18 and 01/25, no activities listed. Record review of the facility's Activities Calander titled February 2026 reflected, Activities Packets Available for the Saturdays on 02/07, 02/14, and 02/21 and on 02/28 a Black History Program with [NAME] at 10:30 a.m. On Sunday 02/01, 02/08, 02/15, and 02/22 the calendar reflected Activities (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Packets Available on those days. Record review of the facility job posting on a job board reflected that as of 01/14/2026 an Activities Director position had been posted. Record review of policy titled Nursing Home Resident Activities Policy reflected, 1. Purpose To establish a comprehensive, person-centered Activities Program that supports residents' physical, cognitive, emotional, social, and spiritual well-being in alignment with federal and state regulations, professional standards, and residents' goals, preferences, and cultural backgrounds. 2. Scope This policy applies to the Activities Director, activities staff, volunteers, contracted service providers, nursing, social services, rehabilitation, dietary, environmental services, and all other personnel who plan, implement, or support resident activities. 5. Policy Statement The facility provides an ongoing, person-centered program of activities that is directed by a qualified Activities Director and designed to meet the interests and enhance the physical, mental, and psychosocial well-being of each resident. Activities are accessible and equitably offered to residents across all functional levels, including those who are short-stay, on isolation/precautions, or living with dementia or behavioral health conditions. Activity goals and interventions are integrated into each resident's care plan and evaluated at least quarterly and with significant change in condition. Residents are offered meaningful choices, can refuse participation without retaliation, and may request reasonable accommodation to support participation. 6.3 Program Planning & Calendar - Publish a monthly activities calendar in accessible formats and locations; provide alternate formats for residents with low vision or language needs. - Offer a balanced mix of physical, cognitive, creative, social, intergenerational, outdoor, cultural, and spiritual options seven days per week, including evenings and weekends as indicated by resident preference. - Ensure adaptation for residents with dementia (validation, Montessori-based, music, sensory stimulation) and those on isolation/precautions (in-room or virtual engagement). - Schedule community outings with risk assessment, supervision ratios, transportation safety, and emergency plans.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 14% based on 5 errors out of 34 opportunities, which involved 2 of 7 residents (Resident #35, and Resident #83) reviewed for medication errors.The facility failed to ensure MA P administered the correct dose of Vitamin B-12 (use to make and support healthy) to Resident #35 on 2/10/26.LVN G failed to administer Timolol Maleate (used to lower high fluid pressure inside the eye) Ophthalmic Solution 0.5 % eyedrops ophthalmic drops, on 2/11/25, initialed as given to Resident #83, when it was not given.LVN G failed to administer Brimonidine Tartrate (used to lower pressure of the eye) 0.2 % Solution eyedrops ophthalmic drops, on 2/11/25, initialed as given to Resident #83, when it was not given.LVN G failed to administer Dorzolamide HCl Solution(commonly used to lower high fluid pressure inside the eye) 2 % Solution eyedrops ophthalmic drops, on 2/11/25, initialed as given to Resident #83, when it was not given.LVN G failed to administer a substantial amount of potassium CL via GT (medication used for essential mineral and electrolyte that keep the heart beating regularly, muscles contracting and nerves communicating) to Resident # 83 after dissolving potassium CL in water in the medication cup, on 2/11/26. These failures could place residents at risk for increased negative side effects, and a decline in health. h.Record review of Resident #35's face sheet dated 02/11/26 revealed an [AGE] year-old male was admitted on [DATE]. Resident #35 had diagnoses which included: anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress) hypertension(blood vessels is too high), and heart failure (heart does not pump enough blood for the body's needs),hyperlipidemia (abnormally high fat and lipids), Parkinson's disease is (progressive neuro degenerative disorder, not a condition with a functional use. It involves the death of brain cells that produce dopamine), chronic kidney disease (cannot properly filter waste and extra fluid from your blood, causing toxins to build up). Record review of Resident #83's Physician order dated 2/4/2026 reflected in part . 2/4/26 had give Vitamin B complex B_12 1 tablet by mouth AM. There were no physician order for Vitamin B-12 500 mcg.Record review of Resident #83's MAR dated February 2026 reflected in part . take Vitamin B complex B_12 one tablet by mouth AM.Observation of medication administration on 2/10/26 at 9:55AM by MA A revealed MA A gave Resident#35 Vitamin B-12 500mcg 1 tablet and Vitamin B complex B 12 1 tablet by mouth. During medication administration, MA stated [Resident #35] takes 2 Vitamin B. Resident #83 Record review of Resident #83's face sheet dated 2/11/26 revealed a [AGE] year-old female resident that was admitted to the facility on [DATE] and was readmitted [DATE]. Resident #83 had diagnoses included: other cerebral infarction (a type of ischemic stroke where blood flow to part of the brain id blocked usually by a clot due to occlusion or stenosis (narrowing) of small artery, essential (primary) hypertension(high blood pressure) heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), hypokalemia (lower than normal potassium level in the bloodstream), dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach) glaucoma(high fluid pressure inside the eye) and protein-calorie malnutrition. Record review of Resident #83's quarterly MDS assessment, dated 11/30/25, reflected a BIMS score of 3 out of 15, which indicated severe cognition impairment. She required total assistance from staff with ADL's care.Record review of Resident #83's physician order for February 2026 revealed in part . Potassium Chloride Crys ER 20 MEQ Tablet extended release Give 1 tablet via PEG -Tube one time a day for low potassium order date 2/01/26 . may swirl and dissolve in 4-6oz of water.Record review of Resident #83's physician order for February 2026 revealed in part. instill Timolol Maleate Ophthalmic Solution 0.5 % 1 drops ophthalmic to both eyes twice dailyRecord review of Resident #83's physician order for February 2026 revealed in part. instill (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	0.2 % Solution eyedrops both eyes 1 drops, twice daily.Record review of Resident #83's physician order for February 2026 revealed in part. instill Dorzolamide HCl Solution 2% 1 drop to both eyes three times daily. During an observation on 2/11/26 at 8:10 a.m. revealed LVN G punched 3 medications into a medication cup, crushed them and diluted with 20mls of water and dissolved Potassium Chloride Crys ER 20 MEQ in 20 mls of water in a medication cup and administered all medication via GT. LVN G was about to discard the medication cups with a substantial amount of Potassium residual left. The state surveyor intervened after showing LVN G the Potassium left in the medication cup. LVN G said It takes a long time for Potassium to be administered via [Resident #83's GT. I will give it. She then poured 20mls of water and Potassium to administer in via GT. LVN G did not administer LVN G Aspirin 81 mg chewable give 1 tablet per peg tube and the following eye drops medications Timolol Maleate Ophthalmic Solution 0.5 % eyedrops ophthalmic drops, on 2/11/26, initialed as given, when it was not given to Resident #83 Brimonidine Tartrate 0.2 % Solution eyedrops ophthalmic drops, on 2/11/26, initialed as given when it was not to Resident #83 administered Dorzolamide HCl Solution 2% eyedrops ophthalmic drops, on 2/11/26, initialed as given, when it was not given to Resident #83 Interview with LVN G on 2/12/26 at 9:00 AM, regarding not administering Potassium Chloride Crys ER 20 MEQ and not diluting with 4oz-6oz of water (120mls -180mls of water), she said she would be careful. LVN G said she omitted Aspirin 81 mg during medication administration on 2/11/26 at 8:10 AM; she went back and administered it to Resident #83. LVN G was asked about the eye drops initialed when it was not given on the MAR. LVN G did not give any response. She knew that potassium ER not given in totality would cause low potassium in the leading to muscle weakness, cramps, spasms, severe fatigue, heart palpitations and constipation. In an interview with the DON on 2/12/26 at 2:38 PM, regarding her expectation for medication administration was for nurses to administer medication as ordered by the physician. The DON said the facility was working on changing medication pass times to 6:00 AM to 11:00 AM since 2/6/2026 but she had not gotten to many residents because the census was over 80 and she had not gotten to Resident #83. She said always monitored the staff periodically and the pharmacist did monitor the staff also and last time the pharmacist monitored staff was in December 2025.In an interview on 2/12/26 at 2:40 PM, the Administrator said he expected nursing staff to give medications timely, correctly, and according to the physician orders.Record review of the facility's Administering Medications policy, undated 3/2024 revealed in part Policy StatementMedications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation.The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions.Medications must be administered in accordance with the orders, including any required time frame.Record review of the facility medication administration updated 3/2024 MED - PASS, Inc reflected in part . Medications are administered in a safe and timely manner, and as prescribed .Record review of facility policy on administering medications through an enteral tube updated 3/2024 reflected in part . Purpose . the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube .

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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 observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 5 of 28 residents (Resident #96, Resident #2, Resident # 65, Resident #83 and Resident #32) and 3 of 3 staffs (CNA H, LVN S,LVN G) reviewed for infection control. -The facility failed to ensure CNA H performed hand hygiene during incontinent care on Resident #32. During incontinent care for Resident #32 CNA used wet wipes to clean in-between the buttocks, cleaning the buttocks from the top of the buttockstoward the vaginal area.- LVN S failed to change gloves and perform hand hygiene before opening the medication cart twice and did not wear PPE while performing Accu-Chek for Resident #83 on EBP.- LVN G failed to wear PPE and gloves while checking Resident #83's blood pressure on 2/11/26. -The facility failed to clean and line the trash can with a trash liner in Resident #96's room.-The facility failed to label and store Resident # 2 and Resident #65's personal care item at sink area of a semi-private shared room. These failures could place residents at risk for spread of infection and cross contamination and decrease in quality of life.During an observation/interview on 02/10/2026 at 10:01 a.m. toothbrush and toothpaste were observed at sink side of shared room of Resident #2 and Resident #65. Resident #2 stated that the toothbrush and toothpaste were his as he had just brushed his teeth that morning. During an observation on 02/10/2026 at 11:58 a.m. toothbrush and toothpaste were observed at sink side of shared room of Resident #2 and Resident #65. During an observation/interview on 02/12/2026 at 11:51 a.m. toothbrush and toothpaste were observed at sink side of shared room of Resident #2 and Resident #65. Resident #2 stated that no one had spoken to him about the placement of his toothbrush and toothpaste at the sink and asked had he needed to move them. Record review of Resident #32's face sheet, dated 2/11/2026, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses of other venous thrombosis and embolism(blood clot that forms in a vein), hypokalemia(low potassium in the blood), tracheostomy status(surgically created hole in the front of the neck that leads directly into the windpipe (trachea) to help a person breathe), essential (primary) hypertension(high blood pressure), hyperlipidemia, (abnormal high fat in blood), hyperosmolality and hypernatremia(a condition in which the blood has a high concentration of salt), gastrostomy status(a surgical opening into the stomach), elevated white blood cell count, unspecified(immune system working hard to fight something off,most common infection, inflammation or stress), acute and chronic respiratory failure with hypoxia(body tissues and organ are not getting enough oxygen in the blood), functional quadriplegia(total loss of use of all four limbs (both arms and both legs and the torso), anoxic brain damage (a serious often permanent injury that occurs when the brain is completely deprived of oxygen), anemia, protein-calorie malnutrition. and sepsis(a life -threatening medical emergency caused by the body's extreme. Dysfunctional response to an infection) . Record review of Resident #32's admission MDS, dated [DATE], reflected the BIMS score was blank out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent to bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #32 was incontinent to bladder with indwelling Foley (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Catheter and bowel with colostomy . Record review of Resident #32's care plan dated 12/24/25 reflected Resident #32 has an ADL self-care performance deficit, the goal was resident will improve current level of function through the review date: Resident #32 required total assist with one to two person for bathing/showering, dressing, bed mobility, personal hygiene, toilet use and follow principles of infection control and universal precaution to incontinent care. Review of Resident #32's Physician's orders from 12/22/2025 through 12/22/2025 reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 12/22/2025. Record review of Resident #32's MAR revealed she was on antibiotics Augmentin ES on 1/14/26 for urinary tract infection. Observation of F/C and incontinent care performed by C.NA H and assisted by RN W, revealed Resident #32 was lying on the bed on her right side, C.NA H donned clean gloves and using the wet wipes, cleaned in-between the buttocks from top to bottom of the perineal area, and around the buttocks, then placed a brief under Resident #32's buttocks. She then cleaned the perineal area, cleaned the groin, and cleaned exposed F/C tubing. Without changing gloves she fastened the clean brief then took off dirty gloves. Interview with RN W on 2/11/26 at 2:32 PM, regarding F/C and incontinent care, she said the did not change gloves throughout the procedure. Interview with C.NA on 2/11/26 at 2:36 PM she said she has been working 7 months, 6:00 AM -2:00 PM to 10 :00PM, she said she thought she did good.She was told about not changing gloves. C.NA H said she was very sorry. C.NA H said she had bi-weekly in-services about hand washing and not changing the gloves could cause cross contamination and infection. Interview with DON on 2/11/26 at 5:10 PM, she said she had handwashing in-service, a month ago and she was the one that trained CNA H. DON said she does monitor CNAs randomly for incontinent care/infection control. Resident #83 Record review of Resident #83's face sheet dated 2/11/26 revealed an [AGE] year-old female resident that was admitted to the facility on [DATE] and was readmitted [DATE]. Resident #83 had diagnoses including: other cerebral infarction (a type of ischemic stroke where blood flow to part of the brain id blocked usually by a clot due to occlusion or stenosis (narrowing) of small artery, essential (primary) hypertension(high blood pressure) heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), hypokalemia (lower than normal potassium level in the bloodstream), dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach) glaucoma(high fliud pressure inside the eye) and protein-calorie malnutrition Record review of Resident #83's quarterly MDS assessment, dated 11/30/25, reflected a BIMS score of 3 out of 15, which indicated severe cognition impairment. She required total assistance from staff with ADL care. (continued on next page)

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	675700	A. Building B. Wing	02/12/2026

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Harmony Care at Brookshire	710 Hwy 359 S Brookshire, TX 77423

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation rounds on 2/10/26 at 4:22 PM, Resident #83 had an Enhanced Barrier Precaution sign posted on the door. Observation on 2/10/26 at 4:36 PM, revealed LVN S Resident #83's opened medication cart , picked up the Accu check machine and lancet strip, then entered Resident #83's room to check her blood glucose. He donned clean gloves, but did not wear PPE. LVN S then proceeded to check Resident #83's blood glucose. He did not have enough blood on the lancet to read the blood glucose level. At 4:47 PM LVN S left Resident #83's room with the soiled gloves, picked up the medication cart key from his uniform pocket, opened the medication cart, then picked up a lancet, then doffed gloves. LVN S donned cleaned gloves without washing hands and without using PPE, went to Resident #83's room to check blood glucose. LVN S went to the medication cart with the same gloves, opened it and picked up Germicidal wipes and cleaned the Accu-Chek machine then doffed gloves and used hand sanitizer. In an interview with LVN S on 2/10/26 at 5:41 p.m., regarding not donning PPE and changing gloves while opening the medication cart, he said he forgot. He said he did have in-service about using PPE and hand washing every 2 weeks to prevent infection to him and the resident. Observation of LVN G on 2/11/26 at 8:10 a.m., during medication administration to Resident #83 revealed LVN G entered resident room and checked the blood pressure without PPE and gloves. In an interview with LVN G on 2/12/26 at 12:00 PM, regarding not wearing PPE and not wearing gloves while checking Resident #83's blood pressure, LVN G said she forgot, and she was very sorry. She knew not donning PPE and gloves while taking care of Resident on EBP could spread infection to other residents. She said she had in-services monthly on the use of PPE and handling residents on EBP. In an interview with DON on 2/12/26 at 2:00 PM, regarding EBP and hand washing the nurses were not performing, the DON stated nurses were supposed don PPE. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. Resident #96: Record review Resident #96's Facesheet reflected the resident admitted to the facility on [DATE] with diagnosis of muscle weakness, dysphagia (difficulty swallowing), other lack of coordination, cognitive communication deficit, need for assistance with personal care, traumatic subarachnoid hemorrhage (bleed in the brain due to trauma) with loss of consciousness of unspecified duration, fracture of facial bones (breaks in the facial bone due to trauma), traumatic pneumothorax (collapsed lung), nondisplaced intertrochanteric fracture of left femur (break in bone but remains in proper alignment), tracheostomy status, and gastrostomy status . Record review of Resident #96's Care Plan reflected the resident had a tracheostomy , was at risk for increased secretions/congestion, infection and respiratory distress, ensure tracheostomy in place date initiated/revision: 02/10/2026. Record review of Resident #96's MDS dated [DATE] reflected a BIMS of 99 reflecting the resident was unable to answer the questions. During an observation on 02/10/2026 at 09:03 a.m. Resident #96's trash can was observed sitting next to the resident's door with no trash lining within and a blue surgical glove and brown (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discoloration/debris at the bottom of the trash can. During an observation on 02/10/2026 at 11:53 a.m. Resident #96's trash can was observed sitting next to the resident's door with no trash lining within and a blue surgical glove and brown discoloration/debris at the bottom of the trash can. Resident #2: Record review of Resident #2's factsheet reflected he admitted to the facility on [DATE] with diagnosis of hemiplegia and hemiparesis following cerebral infarction (blood clots formed in the brain, disrupting blood flow causing a stroke) affecting right dominant side, iron deficiency anemia (low level of the iron vitamin in the body restricting blood flow), type 2 diabetes mellitus (chronic condition where the body does not produce enough insulin or does not use insulin effectively, leading to high blood sugar levels as glucose restricting energy) with unspecified complications, hyperlipidemia (high cholesterol and triglycerides—in the blood, often leading to dangerous plaque buildup in arteries), hypomagnesemia (low serum magnesium levels leading to neuromuscular, cardiac, and neurological dysfunction.), depression (a serious, common mood disorder causing persistent sadness, loss of interest, and physical symptoms that impair daily life), generalized anxiety disorder (persistent, excessive, and uncontrollable worry about everyday events), atrial fibrillation (heart's upper chambers (atria) quiver instead of beating effectively), weakness, acquired absence of left leg below knee (post-amputation), other abnormalities of gait and mobility, and other lack of coordination . Record review of Resident #2's undated Care Plan reflected resident wanders, deemed a risk for wandering, with a cognitive communication deficit diagnosis. Date initiated/date revision: 12/26/2025. Record review of Resident #2's undated Care Plan reflected resident cognitive impairment: as impaired cognition and was at risk for further decline and injury (Resident has cognitive impairment in short-term memory) date Initiated: 12/24/2025 Revision on: 12/31/2025. Record review of Resident #2's MDS dated [DATE] reflected the resident had a BIMS score of 06 reflecting he had severely impaired cognition. Resident #65 Record review of Resident #65's facesheet reflected resident admitted on [DATE] with diagnoses of fracture of right acetabulum (break in right side of hip fracture), multiple fractures of ribs, muscle weakness, unsteadiness on feet, other lack of coordination, and cognitive communication deficit. Record review of Resident #65's MDS dated [DATE] reflected the resident had a BIMS score of 12 reflecting the resident had moderately impaired cognition. Record review of Resident #65's care plan reflected resident had cognitive impairment, impaired cognition and was at risk for further decline and injury due to cognitive impairment in short-term memory) date initiated/revision on 01/26/2026. During an interview on 02/11/2026 at 08:44 a.m. ADON A stated she was over the facility's infection prevention program. She stated after learning that the trash can in Resident #96's room without a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trash liner while containing debris and a disposal surgical glove violated proper infection control protocols. She stated that someone would have to reach into the trash can to discard the glove and they were unaware as to what the glove was used for. She stated unlined and soiled trash cans in resident rooms place all who came in contact at risk of potential bacteria agents, especially Resident #96 who had a tracheostomy system and gastrostomy status with multiple injuries. She stated that it would have been her expectations that the trash would have been cleaned out when the bag was discharged and that the glove would not have been thrown into the trash can while not containing a liner. She stated it had been the responsibility of the housekeeping staff to pull the trash, re insert a new liner and clean out and/or replace the trash can. She stated it was also the responsibility of the nursing and CNA staff to inform housekeeping if trash cans went without liners, were found soiled and/or not placing trash items including surgical gloves within the trash can. She stated the can was to remain lined with a trash bag for infection control purposes. She stated it was the housekeeping director's (HD) responsibility to perform regular monitoring of housekeeping tasks. She stated Resident #2 and Resident #65's toothbrush and toothpaste at sink side of a semi-private shared room was against facility policy. She stated it posed an additional infection control risk as the residents could grab and use the wrong toothbrush sharing saliva, other residents could enter in to the room and use the items and nursing and CNAs staff could wash their hands at the sink after providing incontinent or other care that could potentially splash or drip on to the items at sink side. She stated that the resident's toothbrushes and toothpastes should have been stored away. During an interview on 02/11/2026 at 10:38 a.m. HD stated that he had been the HD for 1-year and was responsible for making rounds of the facility to ensure that the housekeeping and laundry responsibilities were performed. He stated he had not been made aware that the trash can in Resident #96's room was not lined with a trash bag and contained a surgical glove and discoloration debris. He stated that typically, a trash can should never be left unlined as the staff line the cans with 2-3 liners and each time they pull, the trash reline the trash with another bag . He stated if his staff found a trash can soiled, they were to immediately clean/sanitize, and/or replace or dispose of the soiled trash can, but it should not be relined with debris within. He stated he took responsibility for the condition of the trash can in Resident #96's room and stated that there were no excuses. He stated the soiled trash can would not place any risks to Resident #96's health as the resident was bedbound. During an interview on 02/12/2026 at 01:39 p.m. ADON A stated that she told the ADM and DON about Resident #2 and Resident #65's toothbrushes and toothpaste at sink side on 02/11/2026 and the staff on that hall were educated on storing personal items. She stated that there was a new set of staff working the hall on this date and more than likely contributed to the personal items being back at sink side. She stated that both residents' personal items were to have been labeled and stored away out of sight either in their bedside table or bathroom. She stated she will reshare that information with ADM and the DON. She stated she was not aware of any in-services performed on infection control because of the personal items at sink side. During an interview on 02/12/2026 at 2:45 p.m. DON stated that nursing and CNA staff received skills check off training upon hire that covers infection control. She stated that it had been her expectation that the trash cans would be lined at all times and that trash would not be put within an unlined trash can because it was appropriate not to . She stated it was also her expectation that if a trash can had become dirty it would be cleaned and sterilized immediately. She stated that unlined and soiled trash cans posed no risks to residents with tracheotomy status. She stated that CNAs were responsible for informing housekeeping if a trash can needed a trash bag and the HD was responsible for ensuring housekeeping staff emptied and relined trash cans. She stated it was the responsibility of everyone at the facility to ensure resident's toothbrushes were not at the sink and labeled and stowed away. She stated that toothbrushes left at the sink unlabeled in a shared room could put residents at risk of using the wrong toothbrush. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that CNAs received in-service training on infection control last week. During an interview on 02/12/2026 at 05:57 p.m. ADM stated he had no comment regarding infection control and deferred to the DON for expectation. He stated that resident's toothbrushes left at a shared room sink should be clearly identified so that the roommates do not share toothbrushes. He stated he was unaware of the risk of sharing toothbrushes. Record review of policy titled Interview Cleaning and Disinfecting Non-Critical Resident-Care Items reflected: Level I PurposeThe purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items. Preparation1. Assemble the equipment and supplies as needed. 2. Record review of the facility's Hand Hygiene policy dated 6/2019 and updated 3/2024 revealed in part: .It is the policy of this facility that proper hand hygiene/hand washing technique will be accomplished at all times that handwashing is indicated. Hand Hygiene/Hand washing is the most important component for preventing the spread of infection. Procedure: After: After removal of medical/surgical or utility gloves. NOTE: Wash hands at end of procedures where glove changes are not required. For procedures in which change of gloves, e.g., clean gloves to sterile gloves, is indicated follow the specific standard of practice. However, hand washing may not be necessary until completion of the procedure. If glove hands become contaminated as gloves are changed hands can be washed. Contact with a patient's/resident's intact skin (e.g. taking a pulse or blood pressure, performing physical examinations, lifting the patient/resident inn bed . 3. Record review of the Infection Control Program (Revised 3/2024) revealed in part: .Policy: Evidence-based policies and procedures are the foundation of a facility's infection control and prevention program. Goals: A Decrease in the risk of infections and communicable diseases to residents, employees, volunteers, and visitors .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who was incontinent of bladder and bowel received appropriate treatment and services for 1 of 3 residents (Residents #32) reviewed for incontinent care, in that: CNA H did not clean Resident #32's open labia during indwelling Foley Catheter incontinent care. During incontinent care for Resident#32 CNA used wet wipes to clean in-between the buttocks, cleaning the buttocks from the top of the buttockstoward the vaginal area. These failures could place residents at-risk for infection due to improper care practices. Record review of Resident #32's face sheet, dated 2/11/2026, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses diagnosis of other venous thrombosis and embolism (blood clot that forms in a vein), hypokalemia(low potassium in the blood), tracheostomy status(surgically created hole in the front of the neck that leads directly into the windpipe (trachea) to help a person breathe), essential (primary) hypertension(high blood pressure), hyperlipidemia, (abnormal high fat in blood), hyperosmolality and hypernatremia(a condition in which the blood has a high concentration of salt), gastrostomy status(a surgical opening into the stomach), elevated white blood cell count, unspecified(immune system working hard to fight something off, most common infection, inflammation or stress), acute and chronic respiratory failure with hypoxia(body tissues and organ are not getting enough oxygen in the blood), functional quadriplegia(total loss of use of all four limbs (both arms and both legs and the torso), anoxic brain damage (a serious often permanent injury that occurs when the brain is completely deprived of oxygen), anemia, protein-calorie malnutrition. and sepsis(a life -threatening medical emergency caused by the body's extreme. Dysfunctional response to an infection). Record review of Resident #32's admission MDS, dated [DATE], reflected the BIMS score was blank out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #32 was incontinent to bladder with indwelling Foley Catheter and bowel with colostomy (a surgical procedure that creates an opening (called a stoma) in the abdomen to allow stool and gas to leave the body). Record review of Resident #32's care plan dated 12/24/25 reflected Resident #32 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #32 required total assist with one to two persons for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use and follow principles of infection control and universal precautions to incontinent care.Review of Resident #32's Physician's orders from 12/22/2025 through 12/22/2025 reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 12/22/2025. Record review of Resident #32's MAR reflected she was on antibiotics Augmentin ES on 1/14/26 for urinary tract infection. Observation of F/C and incontinent care performed by CNA H 2/11/26 at 2:20 PM and was assisted by RN W revealed Resident #32 was lying in bed on her right side. CNAH donned (put on) cleaned gloves and using the wet wipes cleaned in-between the buttocks from top to bottom of the perineal area, and around the buttocks The CNA placed a brief under Resident #32's buttocks and she then proceeded to clean the perineal area, cleaned the groin, and she did not open the resident's labia. to clean. She cleaned the exposed F/C tubing , not from the insertion site and did not clean the F/C in a circular motion. Without changing gloves she fastened the clean brief then doffed (take off)her dirty gloves. Interview with RN W on 2/11/26 at 2:32 PM, regarding F/C and incontinent care, what she thought C.NA H did not do when performing incontinent/ F/care. RN W said C.NA H did not change gloves throughout the procedure. CNA H did not open the labia to clean and she did not clean the F/C at the insertion site. Interview with CNA on 2/11/26 at 2 2:36 PM she said she has been working 7months, she works 6:00 AM -2:00 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM to 10 :00PM. She said she thought she did good. She stated she was told about not changing her gloves, not opening the resident's labia and not cleaning in-between her buttocks from the inside out CNAH said she had in-services bi-weekly about hand washing and had one time on indwelling Foley Catheter. Interview with the DON on 2/11/26 at 5:10 PM, she said she had a handwashing in-service a month ago and she was the one that trained CNA H. The DON said she did monitor CNAs randomly for incontinent care/infection control. Record review of the Skilled check list, titled Catheter Care-Skill, not dated . 10. With non-dominant hand: Female: Gently retract labia to fully expose urethral meatus and catheter insertion site. Maintain position of hand throughout.14. Using a clean washcloth, clean catheter tubing using one cloth per stroke, in a circular motion. Clean from the most proximal (Closest to the body) to the most distal (Farthest for the body). Continue cleaning in this manner until tubing is clean.Record review of Resident #32's face sheet, dated 2/11/2026, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses diagnosis of other venous thrombosis and embolism (blood clot that forms in a vein), hypokalemia(low potassium in the blood), tracheostomy status(surgically created hole in the front of the neck that leads directly into the windpipe (trachea) to help a person breathe), essential (primary) hypertension(high blood pressure), hyperlipidemia, (abnormal high fat in blood), hyperosmolality and hypernatremia(a condition in which the blood has a high concentration of salt), gastrostomy status(a surgical opening into the stomach), elevated white blood cell count, unspecified(immune system working hard to fight something off, most common infection, inflammation or stress), acute and chronic respiratory failure with hypoxia(body tissues and organ are not getting enough oxygen in the blood), functional quadriplegia(total loss of use of all four limbs (both arms and both legs and the torso), anoxic brain damage (a serious often permanent injury that occurs when the brain is completely deprived of oxygen), anemia, protein-calorie malnutrition. and sepsis(a life -threatening medical emergency caused by the body's extreme. Dysfunctional response to an infection). Record review of Resident #32's admission MDS, dated [DATE], reflected the BIMS score was blank out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #32 was incontinent to bladder with indwelling Foley Catheter and bowel with colostomy (a surgical procedure that creates an opening (called a stoma) in the abdomen to allow stool and gas to leave the body). Record review of Resident #32's care plan dated 12/24/25 reflected Resident #32 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #32 required total assist with one to two persons for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use and follow principles of infection control and universal precautions to incontinent care.Review of Resident #32's Physician's orders from 12/22/2025 through 12/22/2025 reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 12/22/2025. Record review of Resident #32's MAR reflected she was on antibiotics Augmentin ES on 1/14/26 for urinary tract infection. Observation of F/C and incontinent care performed by CNA H 2/11/26 at 2:20 PM and was assisted by RN W revealed Resident #32 was lying in bed on her right side. CNAH donned (put on) cleaned gloves and using the wet wipes cleaned in-between the buttocks from top to bottom of the perineal area, and around the buttocks The CNA placed a brief under Resident #32's buttocks and she then proceeded to clean the perineal area, cleaned the groin, and she did not open the resident's labia. to clean. She cleaned the exposed F/C tubing , not from the insertion site and did not clean the F/C in a circular motion. Without changing gloves she fastened the clean brief then doffed (take off)her dirty gloves. Interview with RN W on 2/11/26 at 2:32 PM, regarding F/C and incontinent care, what she thought C.NA H did not do when performing incontinent/ F/care. RN W said C.NA Hdid not change gloves throughout the procedure. CNA H did not open the labia to clean and she did not clean the F/C at the insertion site. Interview with CNA on 2/11/26 at 2 2:36 PM she said she has been working 7months, she works 6:00 AM -2:00 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #96) of 4 residents reviewed for enteral nutrition. The facility failed to properly label Resident #96's enteral feeding formula to identify what date, time and by which staff administered and hung the feeding. This failure could place residents who had gastrostomy tube at risk receiving expired fluids. Findings included: Record review Resident #96's Facesheet reflected the resident admitted to the facility on [DATE] with diagnosis of weakness, dysphagia (difficulty swallowing), cognitive communication deficit, need for assistance with personal care, traumatic subarachnoid hemorrhage (bleed in the brain due to trauma) with loss of consciousness of unspecified duration, gastrostomy status. Record review Resident #96's Minimum Data Set (MDS) dated [DATE] Brief Interview for Mental Status (BIMS) 99 reflecting the resident was unable to answer the questions. Record review Resident #96's Care Plan reflected the resident had a tracheostomy date initiated/revision: [DATE]. Record review Resident #96's Order dated order [DATE] 01:05 p.m. summary: NPO nothing by mouth (NPO) diet. NPO texture, NPO consistency. Record review Resident #96's Order dated [DATE] at 02:57 p.m. summary order date: [DATE] 02:57 p.m. Turn off continuous enteral feeding. Record review Resident #96's Order dated: [DATE] at 15:04 Restart continuous enteral feeding. Formula: Isosource 1.5; Rate: 75 mL/hr for 20 hours. one time a day for to provide feeding Order Summary: Restart continuous enteral feeding. Formula: Isosource 1.5; Rate: 75 mL/hr for 20 hours. one time a day for to provide feeding. During an observation on [DATE] at 09:03 a.m. revealed Resident #96's iso-source formula had no date/time to indicate when the formula was administered or initialed by which nurse administration the formula. During an observation on [DATE] at 11:53 a.m. revealed Resident #96's iso-source formula had no date/time to indicate when the formula was administered or initialed by which nurse administration the formula. During an observation on [DATE] at 11:53 a.m. revealed Resident #96's iso-source formula had no date/time to indicate when the formula was administered or initialed by which nurse administration the formula. During an interview on [DATE] at 01:00 p.m. LVN A stated on [DATE] he had not hung Resident #96's formula but had hung it on [DATE]. He stated Resident #96's formula on [DATE] should have had a label dated/initialed to know when it was hung and by whom so if there were ever any questions the (continued on next page)

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	675700	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Brookshire	710 Hwy 359 S Brookshire, TX 77423

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility knew who to hold accountable and when and what time it had begun being administered. He stated in addition it was important to date the formula to know of the formula's expiration date. He stated the formula should also be labeled with the volume the resident was to receive an hour and the rate of full. During an interview on [DATE] at 01:39 p.m. ADON A stated Resident #96's formula should have been labeled with the resident's name, rate and amount of flow, and date and time it was hung and initialed by whichever staff hung the formula to know who hung the formula and when it was hung. She stated that licensed vocational nurse (LVN A) had labeled Resident #96's formula on [DATE], but the label had fallen off on the floor and was found and relabeled. During an interview on [DATE] at 2:45 p.m. the DON stated residents who require tube feeding formula should have their formula bags labeled to reflect the resident's name, room number, rate and amount of flow, date and time the formula was hung. She stated that labeling information should be taken directly off the resident's medication administration record (MAR). She stated the importance of labeling the formula was to know who hung it and when as they did not want to be giving residents expired formula. Residents receiving expired formula could lead to gastrointestinal issues, nausea, and vomiting. Nurses received a training skills check on tube feeding administration upon hire and annually, last given in [DATE]. She stated labeling the formula bag was an expectation and covered in the training. Record review of policy titled Enteral Feedings – Safety Precautions dated 2001 reflected: Level III. Purpose To ensure the safe administration of enteral nutrition. Preparation 1. All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. 2. The facility will remain current in and follow accepted best practices in enteral nutrition. Preventing errors in administration. 2. On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order. Record review of policy titled Enteral Nutrition dated 2001, revised [DATE] reflected: Policy Statement Adequate nutritional support through enteral nutrition is provided to residents as ordered. Policy Interpretation and Implementation The interdisciplinary team, including the dietitian, conducts a full nutritional assessment within current initial assessment timeframes to determine the clinical necessity of enteral feedings. The assessment includes: evaluation of the resident's current clinical and nutritional status; relevant functional and psychosocial factors; and a review of interventions to maintain oral intake prior to the use of a feeding tube and the resident's response to them. The recommendation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice, the residents' advance directives, treatment goals and facility policies.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 6 residents (Residents #83) reviewed for significant medication errors. LVN G failed to administer a substantial amount of potassium CL via GT (medication used for essential mineral and electrolyte that keep the heart beating regularly, muscles contracting and nerves communicating) to Resident # 83 after dissolving potassium CL in water in the medication cup, on 2/11/26 This failure could place residents at risk of abnormal heart rhythms, and potential hospitalizationRecord review of Resident #83's face sheet dated 2/11/26 revealed a [AGE] year-old female resident that was admitted to the facility on [DATE] and was readmitted [DATE]. Resident #83 had diagnoses included: other cerebral infarction (a type of ischemic stroke where blood flow to part of the brain id blocked usually by a clot due to occlusion or stenosis (narrowing) of small artery, essential (primary) hypertension(high blood pressure) heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), hypokalemia (lower than normal potassium level in the bloodstream), dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach) and protein-calorie malnutritionRecord review of Resident #83's physician order for February 2026 read in part . Potassium Chloride Crys ER 20 MEQ Tablet extended release Give 1 tablet via PEG-Tube one time a day for low potassium order date 2/01/26 . may swirl and dissolve in 4-6oz of water.During an observation on 2/11/26 at 8:10 a.m.,LVN G punched Potassium Chloride Crys ER 20 MEQ dissolved in 20 mls of water in medication cup and did not administer all medication via GT and discarded the medication cup with Potassium residual it, the state surveyor intervened after showing LVN G the Potassium left in the medication cup. LVN G said it takes a long time for Potassium to be administered via Resident 83's GT, I will give it she then poured 20mls of water and Potassium to administer in via GT. Interview with LVN G on 2/12/26 at 9:00 AM, regarding not administering all of the Potassium Chloride Crys ER 20 MEQ and not diluting with 4-60oz of water (120mls -180mls of water), she said she will be careful. LVN G said she knew that potassium ER not given in totality would cause low potassium in the leading to muscle weakness, cramps, spasms, severe fatigue, heart palpitations and constipation. During an interview on 2/12/26 at 2:38 p.m., the DON said potassium ER should be dissolved in water as ordered by the physician. The DON said Resident #83 could not be getting the dosage required to maintain his potassium level, and Resident #83 could have signs and symptoms of hypokalemia. The DON said monitored the nurses and made random rounds. The DON said the nurses had skills - check off for medication administration before the nurses passed out medication to residents. She was requesting for Potassium in liquid form the pharmacy.Record review of the facility undated policy on medication administration and management revealed in part . step 111: administering the medication pass .#6 the authorized licensed or certified/permitted medication aide .seeks assistance from the nursing supervisor/designee and consulting pharmacist when any aspect of medication administration is in question . #7 E . medications which cannot be crushed: #2 . or extended - release tablets .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 3 medication carts (secured unit). -The secured unit nurse medication cart A contained opened undated medication. These failures placed residents at risk of receiving expired medication and improperly stored medications which could result in delayed healing.During an observation on [DATE] at 9:58 AM of the nurse medication cart A for the locked unit, the following opened medications were not dated when they were opened:Azelastine HCL Nasal spray 0.1% Fluticasone Propionate Nasal spray 50 mcg In an interview with LVN K, on [DATE] at 9:58AM, she said the medication should be dated when opened and it was good for 30 days and it would not be effective after 30 days. LVN K said she was not aware when it was open and she checks the medication cart for expired medication weekly.During an interview on [DATE] at 2:38 p.m., the DON said nasal spray medications opened should have an open date. The DON said the medicines would not be effective for the treatment after 30 days.Record review of the facility policy Revised February 2023: Storage of drugs and Biologicals: Medication Labeling reflected:Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.1. The medication label includes, at a minimum: expiration date, when applicable;resident's name; route of administration; andappropriate instructions and precautions.