STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675703	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Timbers Rehabilitation and Healthcare Center	3315 Cross Timbers Rd Flower Mound, TX 75028

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for two (Resident #15 and Resident #65) of six residents reviewed for call lights. 1. The facility failed to ensure Resident #15's call light was not underneath her bed pillows so that she could contact staff for assistance to remove bed covers for her. 2. The facility failed to ensure Resident #65's call light was accessible so that she could request her catheter to be emptied. This failure could place the residents at risk of falling, further injury, and unnecessary pain from not being able to call for help. Findings included:1. Record review of Resident #15's Comprehensive MDS Assessment, dated 03/11/26, reflected [AGE] year-old female admitted to the facility on [DATE] with a BIMS of 10 indicating moderate cognitive impairment. Resident #15 had the following diagnoses: Stroke (sudden interruption of blood flow to the brain), Heart Failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs), unsteadiness on feet, lack of coordination. MDS further indicated Resident #15 was dependent on staff for toileting, showers, lower body dressing, putting on /talking off footwear and personal hygiene, rolling left to right, sitting to lying, lying to sitting, transferring, and substantial/maximal assistance with upper body dressing, and supervision or touching assistance with eating. Record review of Resident #15's Care Plan, initiated on 04/10/26, reflected the resident had an activities of daily living self-care performance deficit related to impaired balance, limited mobility, and musculoskeletal impairment. Goal: Resident will maintain current level of function in activities of daily living. Interventions included encouraging residents to use bell to call for assistance. Resident #15 is High risk for falls. Goal: The resident will be free from falls. Interventions included anticipate and meet the resident's needs. Place frequently used personal items within reach. Ensure resident is aware that they need to call for assistance before getting out of bed. Maintain call light within reach. Resident #15 has an alteration in musculoskeletal status to right upper extremity related to a contracture. Goal: The resident's mobility will be stabilized by use of wrist hand finger orthosis (externally applied device such as a brace or splint). Interventions included anticipating and meeting needs. Be sure call light is within reach and respond promptly to all requests for assistance. During an observation and interview on 04/14/26 11:03 a.m., revealed Resident #15 was lying in bed, and she began throwing items from her breakfast tray onto the floor from her bedside table. When Resident #15 was asked if she needed assistance. Resident #15 responded, Yes, I need to get help with removing my blankets, I am hot. I need to get help, and no one is coming in here to help me. Resident #15 was asked to use her call light to get assistance, and Resident #15 stated, I don't know where my call light is. Resident #15's call light was underneath her pillow, and not within her reach. Resident #15 only had use of her left hand, her right hand was contracted, and she was not able to move without assistance of her left hand. 2. Record review of Resident #65's Quarterly MDS Assessment, dated 04/04/26, reflected [AGE] year-old female admitted to the facility on [DATE] with a BIMS of 09 indicating moderate cognitive impairment. Resident #65 had the following diagnoses: Heart Failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs), (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	high blood pressure (force of blood against the artery wall is consistently too high), Renal Insufficiency (kidney failure - kidneys lose their ability to function properly), Neurogenic Bladder (nerve damage disrupts communication between the brain and the brain, spinal cord, and bladder) and retention of urine (inability to completely empty bladder), Hip Fracture (break in the upper part of the thigh bone). The MDS further indicated Resident #65 was dependent on staff for toileting, showers, lower body dressing, putting on /talking off footwear and personal hygiene, rolling left to right, sit to lying, lying to sitting, transferring, and substantial/maximal assistance with toileting hygiene and transfers, showers, lower body dressing, and personal hygiene. Resident #65 utilized an indwelling catheter. Record review of Resident #65's Care Plan, initiated on 01/28/26, reflected the resident had a right hip fracture related to a fall. Goal: Resident will be free of complications related to hip fracture. Interventions included, anticipate and meet the resident's needs. Be sure call light is within reach and respond promptly to all request for assistance. The Care Plan also reflected Resident #65 had an indwelling catheter: Neurogenic bladder. Goal: Resident will be/remain free from catheter-related trauma. Interventions included check tubing for kinks and empty as needed per shift. Monitor and document intake and output as per facility policy. Monitor/document for pain/discomfort due to catheter. During an observation and interview on 04/14/26 11:04 a.m., revealed Resident #65 lying in bed. Resident #65 began pointing down to her catheter and stated, That bag seems to be full and needs to be emptied, and no one has come to empty the bag yet. During an observation revealed the catheter bag was full. Resident #65 was asked to initiate her call light and she replied, I would if I knew where it was. Resident #65 stated she could not reach the call light that was located behind her head and was tied to the corner of the bed. During an observation and interview on 04/14/26 11:30 a.m., LVN F stated she was the nurse assigned to 200 Hall. LVN F stated aides were waiting for the surveyor to exit the room so they could go in to assist residents. LVN F observed Resident #15's call light to be behind her head tucked underneath two pillows. LVN F observed Resident #65's call light to be tied to the left corner of the bed behind her head. LVN F began to unravel Resident #65's call light to place it within reach. LVN F stated she was not aware that residents were not able to reach their call light. LVN F stated resident call lights should be kept within reach of the resident to prevent accidents and emergencies, call lights should be available so that residents were able to communicate their needs to staff. LVN F stated all staff were responsible for ensuring call lights were within reach of the residents, and not doing so placed residents at risk of injury and not getting the care they need. During an observation and interview on 04/14/26 11:40 a.m. with DON revealed Resident #15's call light was underneath her two pillows. The DON pulled the call light chord from underneath the pillows and placed the call light within reach for Resident #15. The DON then asked Resident #15 if she could assist with anything and Resident #15 expressed that she was hot and would like to have the blankets removed from her body. Resident #15 further said that she had gotten upset and started throwing items because she needed someone to come into the room to help her. During an interview on 04/14/26 11:44 a.m., CNA G revealed she was not the aide working the hall, however, was pulled to come and assist Resident #15 and Resident #65. CNA G stated all residents should have call lights within reach so that they could contact staff when they were in need of care. CNA G stated all staff were responsible for ensuring call lights were within reach for residents, and not doing so placed residents in prolonged need of care and possible injury. During an interview on 04/16/2026 1:48 p.m., the DON revealed all staff were responsible for ensuring call lights were within reach for all residents. The DON stated not doing so placed residents at risk of possible injury and not getting adequate care. Review of the facility's Answering the Call Light policy, Revision date September 2022, reflected: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receive proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 19 resident (Resident #8) reviewed for foot care.The facility failed to ensure Resident #8's toenails were trimmed.This failure had the potential to affect place residents by placing them at risk for poor personal hygiene, odors and a decline in their quality of life. Findings included:Record review of Resident #8's 5-day MDS assessment dated [DATE], revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #8 had diagnoses which included metabolic encephalopathy (brain dysfunction), muscle wasting and atrophy (the loss or thinning of muscle tissue), depression (mood disorder), Non-Alzheimer's Dementia (problems with memory and thinking), hypertension (high blood pressure) and heart failure. Resident #8's BIMS score was 11, which indicated moderate cognitive impairment. The MDS further revealed Section GG - Functional Abilities indicated resident required partial/moderate/maximal assistances from staff to assist with getting personal hygiene. Record review of Resident #8's care plan, revised on 03/16/26, revealed Focus: The resident has an ADL self-care performance deficit muscle wasting and atrophy. Goal: The resident will maintain current level of function through the review date. Interventions: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.During an observation and interview on 04/15/26 at 8:50 a.m., Resident #8 was observed in her room, lying in bed watching television. Observed Resident #8's toenails for both feet, and the big toenails for both feet were approximately quarter of an inch past the tip of the toe curving to the side. The other toes nails were approximately a quarter of an inch past the tip of the toe. Resident #8 stated she would cut her own toenails because no one would ask to cut them. Resident #8 stated lately she had not been able to cut them due to not being able to bend over. Resident #8 stated no one had asked to trim them or been asked to see podiatry. Resident #8 stated she would like her toenails to be trimmed. During an interview on 04/16/26 at 12:18 p.m. CNA E revealed the nurses were responsible for trimming residents' fingernails and toenails. She stated if the resident was diabetic then podiatry would trim the nails but if they were not diabetic then the nurses would trim them. CNA E stated she was aware of Resident #8 toenails being long, and they needed to be trimmed. She stated she could not recall if she notified the nurse or therapy a few days ago about Resident #8 toenails. She stated she did not know if Resident #8 was seen by podiatry. She stated if a resident needed to be seen by podiatry the CNAs would notify the nurse and then the nurse would follow up. During an interview on 04/16/26 at 12:32 p.m., the Social Worker revealed Resident #8 was not being seen by podiatry. She stated she was waiting for family to sign a podiatry consent. She stated from her understanding if the resident was not being seen by podiatry, then the nurses were responsible for trimming toenails unless the resident was diabetic. During an interview on 04/16/26 at 12:34 p.m., RN D revealed Resident #8 was not diabetic and was not sure if she was being seen by podiatry. She stated since Resident #8 was not diabetic then it was the responsibility of the CNAs to trim the resident's toenails. Observed RN D enter Resident #8's room and observe her toenails. RN D stated they were long and needed to be trimmed by podiatry due to the thickness of the big toenails. RN D stated she was not aware of Resident #8's toenails being long and was never notified that they needed to be trimmed. She stated the potential risk of not trimming toenails could lead to infections. During an interview on 04/16/26 at 3:31 p.m., the ADON revealed the nurses were responsible for trimming residents' toenails unless the resident was diabetic then a podiatry referral needed to be completed. She stated Resident #8 was not receiving podiatry services. She stated the nurses were responsible for notifying her and the DON for any podiatry referral request. She stated her expectation was for the nurses to be checking residents' toenails and trim them if the resident was not diabetic. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated the potential risk of not trimming toenails could lead to ingrowing toenails. During an interview on 04/16/26 at 4:29 p.m., the DON revealed the nurses were responsible for trimming residents' nails unless the residents were diabetic. She stated if a resident needed to be referred to podiatry, then the nurses were expected to notify the ADON or herself, they would notify the Social Worker, and the Social Worker would send a referral. She stated she was not sure if Resident #8 was being seen by podiatry. She stated the expectation was for the nurses to trim toenails unless the resident refuses. The DON stated the potential risk of not trimming toenails would be resident injuring herself or ingrowing toenails. Record review of facility Activities of Daily Living (ADL), Supporting; ADL Support policy, revised 04/2025, reflected the following: Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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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 observation, interview and record review, the facility failed to ensure a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections based on the resident's comprehensive assessment for 1 of 3 residents (Residents #65) reviewed for urine incontinence/catheters. The facility failed to ensure Resident #65's catheter urine collection bags were emptied in a timely manner. This failure could place residents with catheters at risk of infections and loss of dignity. Findings included: Record review of Resident #65's Quarterly MDS Assessment, dated 04/04/26, reflected [AGE] year-old female admitted to the facility on [DATE] with a BIMS of 09 indicating moderate cognitive impairment. Resident #15 had the following diagnoses: Heart Failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs), high blood pressure (force of blood against the artery wall is consistently too high), Renal Insufficiency (kidney failure - kidneys lose their ability to function properly), Neurogenic Bladder (nerve damage disrupts communication between the brain and the brain, spinal cord, and bladder) and retention of urine (inability to completely empty bladder), Hip Fracture (break in the upper part of the thigh bone). The MDS further indicated Resident #65 was dependent on staff for toileting and personal hygiene, rolling left to right, sitting to lying, lying to sitting, transferring, and substantial/maximal assistance with toileting hygiene and transfers. Resident #65 utilized an indwelling catheter. Record review of Resident #65's Care Plan, initiated on 01/28/26, reflected the resident had a right hip fracture related to fall. Goal: Resident will be free of complications related to hip fracture. Interventions included Interventions include Anticipate and meet the resident's needs. Be sure call light is within reach and respond promptly to all requests for assistance. Resident #65 has indwelling catheter: Neurogenic bladder. Goal: Resident will be/remain free from catheter-related trauma. Interventions included check tubing for kinks and empty as needed per shift. Monitor and document intake and output as per facility policy. Monitor/document for pain/discomfort due to catheter. Record review of Resident #65's physician orders dated 01/04/26 revealed:Foley Catheter 16 French 10 cubic centimeter bulb change as needed. Foley Catheter Care every shift and as needed. And Foley Catheter Output every shift dated 03/13/26. During an observation and interview on 04/14/26 11:04 a.m., revealed Resident #65 was lying in bed. Resident #65 began pointing down to her catheter and stated, That bag seems to be full and needs to be emptied, and no one has come to empty the bag yet. The catheter bag was full of urine. Resident #65 was asked to initiate her call light, and she replied, I would if I knew where it was. Resident #65 stated she could not reach the call light, which was behind her head and tied to the corner of the bed. During an observation and interview on 04/14/2026 11:30 a.m., LVN F stated she was the nurse assigned to 200 Hall. LVN F stated aides were waiting for the surveyor to exit the room so they could go in to assist residents. LVN F stated she was not aware that Resident #65's catheter bag was full and had not been emptied. LVN F stated Resident #65's was holding 800 cc's of urine, indicating that her catheter bag had not been emptied by the overnight shift. According to LVN F, the overnight shift should have made rounds and emptied Resident #65's catheter bag prior to the end of the shift. LVN F further stated when the aides came on the morning shift (6:00 AM - 2:00 PM) should have made rounds to ensure resident needs were met, not doing so placed residents at risk of infection, urine backing up and pain. During an interview on 04/14/26 11:44 a.m., CNA G revealed she was not the aide working the hall, however, was pulled to come and assist Resident #65 with emptying her catheter bag. CNA G stated aides were responsible for ensuring catheter bags were emptied in a timely manner, not doing so placed residents in prolonged need of care and possible injury. During an interview on 04/16/26 1:48 p.m., the DON revealed she noted Resident #65's catheter bag to be full, appearing that the bag had not been emptied. The DON stated the aide scheduled for the hall had gone home sick, and CNA G was pulled (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from another hall to cover resident needs. The DON stated aides were responsible to ensure catheter bags were emptied at least every shift. The DON stated not doing so placed residents at risk of possible infection, injury and not getting adequate care. Record review of the facility Catheter Care, Urinary policy, revised June 2025, reflecting the following: The purpose of this procedure is to prevent catheter-associated urinary tract infections.Empty the drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing, and prevent contact of the drainage spigot with the nonsterile container. Empty the collection bag at least every eight (8) hours.

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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 needs respiratory care was provided such care, consistent with professional standards of practice for 2 (Resident #59 and Resident #61) of 3 residents reviewed for respiratory care. The facility failed to ensure that Resident #59 and Resident #61 received adequate oxygen to maintain their O2 sat above 92 % per physician's orders. This failure could place residents who receive oxygen therapy at risk of receiving inadequate oxygen support, which could result in serious harm. Findings included: 1.Record review of Resident #59's Quarterly MDS assessment dated [DATE], revealed at [AGE] year-old female who admitted to the facility on [DATE]. The resident's BIMS score was 14, which indicated intact cognition. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #4 required moderate assistance with most self-care ADLs. The MDS Assessment under Section I-Active Diagnoses, reflected Resident #59's active diagnoses included: COPD with acute exacerbation (lung disease with sudden worsening of symptoms), respiratory failure, and heart disease. The MDS Assessment under Section O-Special Treatments, Procedures, and Programs, reflected Resident #59 required oxygen therapy. The document did not specify if the oxygen therapy was continuous, intermittent, or high-concentration. Record review of Resident #59's Care Plan, revised 11/13/25, reflected the resident had shortness of breath related to COPD. Intervention included: encouraging sustained deep breaths, providing adequate rest periods with activities, and proper body alignment for optimal breathing. The document reflected that Resident #59 had asthma with episodes of wheezing. Interventions included: advising the resident to minimize contact with known allergens, assisting in identifying asthma triggers and strategies for prevention, education on how stress can cause asthma attacks, education on pursed-lip breathing, education regarding overuse of inhalers, elevating head of bed to help with breathing, and encouraging fluid intake. The document also reflected Resident #59 had altered respiratory status and difficulty breathing r/t COPD. Interventions included: administering medications as ordered, assisting the resident in learning signs of respiratory compromise, clearing airway with effective coughing, and monitoring and documenting changes in orientation, restlessness, anxiety, and air hunger. Further review of the document reflected it was not documented that the resident was non-compliant with care, including administration of oxygen therapy as needed or how smoking directly affected Resident #59's oxygen levels. Record review of Resident #59's active consolidated physician's orders, dated 04/16/26, reflected in part the following: -Check O2 SAT every shift for O2 SAT related to chronic obstructive pulmonary disease with acute exacerbation (sudden worsening of symptoms); Order date: 11/13/25. -Maintain O2 levels 1-5 (LPM) to keep O2 > 92 % every shift related to chronic obstructive pulmonary disease with acute exacerbation (sudden worsening of symptoms); Order date: 11/13/25. Record review of Resident #59's EHR under vitals reflected the following the following documented oxygen saturation rates for Resident #59: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 04/06/26 - 91% - 04/08/26 - 91% Further review revealed it was not documented that oxygen therapy was provided when oxygen sat was outside of normal limits. During an observation and interview on 04/15/26 at 10:45 a.m., revealed Resident #59 was sitting on the side of her bed. Resident #59 was breathing deeply and appeared to have shortness of breath; however, she was not wearing her nasal cannula to receive oxygen therapy. RN I was asked to check Resident #59's oxygen saturation rate, and the pulse oximeter initially measured at 85%. After approximately one minute, the resident's oxygen saturation rate went up to 90%. Resident #59 stated she was not feeling very well due to her breathing, but this was normal due to her diagnosis of chronic COPD. Resident #59 stated it was not bad because she was not wheezing. Resident #59 stated she knew when it was time to put on her oxygen, and she would do so when her O2 SAT was low. Resident #59 stated she knew when her O2 SAT was low when the nurses checked her vitals or when she felt shortness of breath and wheezing. Resident #59 stated she did not wear her oxygen continuously, but she would not refuse to wear it if she or the nurses felt she needed it. During an interview on 04/15/26 at 10:52 a.m., RN I stated the nurses followed the physician's orders when administering oxygen to residents. RN I stated Resident #59 had an order for her O2 SAT to be checked once each shift and administer oxygen to keep the resident's O2 SAT above 92 %. RN I stated Resident #59 was a former nurse and was very knowledgeable about her diagnosis. RN I stated Resident #59's O2 SAT at 90% indicated that she needed oxygen therapy. During an interview on 04/16/26 at 1:55 p.m., the DON stated Resident #59 was diagnosed with chronic COPD and should be on continuous oxygen therapy to maintain her O2 SAT above 92 %; however, the resident was not getting enough oxygen because she continued to smoke and would have to remove her oxygen to do so. The DON stated Resident #59 was good about wearing her oxygen when it was needed and was complaint with care in general. The DON stated not receiving adequate oxygen could place residents at risk of not having sufficient oxygen to oxygenate organs and affect overall health. During an interview on 04/16/26 at 2:28 p.m., the MD stated Resident #59 had an order in place to use oxygen therapy at 1-5 LPM to maintain her O2 SAT above 92 %, with the nurses checking her O2 SAT each shift. The MD stated the only way to truly ensure that Resident #59's O2 SAT remained above 92% was to use a continuous pulse oximeter and he was not sure if the nursing facility had the capability to do that. The MD stated Resident #59 was experiencing a decline in health due to chronic COPD but despite the decline and respiratory status, Resident #59 still refused to stop smoking. The MD stated Resident #59 required continuous oxygen therapy; however, she could not stay on oxygen while smoking. The MD stated Resident #59 would benefit more if she at least used the oxygen continuously while in the building. The MD asked the surveyor to tell him how his order should read to ensure that Resident #59 was receiving adequate oxygen and the surveyor explained that she could not offer advice. The MD stated Resident #59 was a retired intensive care nurse and liked to direct her own care; however, the resident was not exactly non-compliant. The MD stated his expectation was for the nurses to follow his orders as written and notify him of any issues with non-compliance or changes that need to be addressed in the resident's care plan. The MD stated the nurses would assess for changes such as increased shortness of breath and low O2 SAT and report to him as needed. The MD stated not receiving sufficient oxygen could place residents at risk of hypoxia (body (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tissue does not receive enough oxygen) and respiratory failure.^ 2. Record review of Resident #61's entry MDS Assessment, dated 03/9/26, reflected he was an [AGE] year-old male who admitted to the facility on [DATE]. The resident had moderate cognitive impairment with a BIMS score of 8, and his diagnoses included chronic obstructive pulmonary disease (COPD) (a progressive, incurable lung disease that restricts airflow, causing chronic breathing difficulties, coughing, and wheezing), and he was on continuous oxygen therapy. Record review of Resident #61's care plan dated 04/9/2026 reflected: Focus [Resident#61] has oxygen therapy rule out ineffective gas exchange, Respiratory illness COPD. Goals: Resident#61 residents will have no signs and symptoms of poor oxygen absorption through the review date. Interventions: Oxygen Settings: O2(Oxygen Monitor) via Oxygen via nasal cannula at 2-6liters continuous to keep spo2 (Peripheral Oxygen Saturation) measures the percentage of oxygen-carrying hemoglobin in the blood, with a normal, healthy reading typically between 95% and 100%)>90%. Record review of Resident #61's active physician's orders dated 03/14/26 revealed oxygen at 2-6 Liters by Nasal Canula continuous every Shift for shortness of breath. During an observation and interview on 04/14/26 at 11:00 a.m., revealed Resident #61 was lying in bed. She was not receiving oxygen from an oxygen concentrator. The oxygen tubing was covered with bedsheets, and the oxygen concentrator was marked at 5 liters per minute and was actively running. The resident stated he thought the tubing fell off during the day. The residents could not tell how long the oxygen had not been connected. During an observation on 04/14/26 at 2:24 p.m., revealed Resident #61 was lying in bed sleeping and not receiving oxygen. The oxygen tubing was folded and packed in plastic bags. During an observation on 04/15/26 at 7:15 a.m., revealed Resident #61 was lying in bed not receiving oxygen. The tubing was folded and packed in plastic bags. During an observation and interview on 04/15/26 at 8:37 a.m., RN D revealed she was the nurse assigned to Resident #61. Resident #61 was observed in bed without oxygen. She stated Resident #61 had oxygen orders for continuous oxygen. RN D checked the oxygen levels for Resident #61, and it was at 87%. She stated she was aware FResaident#61 oxygen was not on, and she said she checked his oxygen saturation at 6:45AM and it was at 90%, but she could not tell why she did not put the oxygen back on resident. She stated it was nurses' responsibility to be checking on residents on oxygen to ensure they were getting oxygen and maintained as per doctors' orders. She stated she was aware Resident #61 would remove his oxygen tubing. She stated she had notified the DON of Resident #61 of removing oxygen, and she was not sure of the actions taken. She stated the possible negative outcome for not receiving oxygen could be difficulty breathing. During an interview on 04/16/26 at 2:30 p.m., the DON revealed it was the responsibility of the charge nurse, to ensure physicians' orders were followed and ensure Resident #61's oxygen was always on and they checked oxygen every shift. She stated she was not aware Resident #61 was not always keeping oxygen on. She said if the nurses could have made her aware she could have contacted hospice, got new orders and updated care plans for noncompliance. The DON said the risk of not administering oxygen would be oxygen levels could drop, and organs not getting enough oxygen and shortness of breath. (continued on next page)

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	675703	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Timbers Rehabilitation and Healthcare Center	3315 Cross Timbers Rd Flower Mound, TX 75028

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/26 at 2:51 PM, the Doctor revealed his expectation was for Resident #61, who was on continuous oxygen, to be on oxygen at all times. He stated that if nurses were not ensuring oxygen was on, that could lead to an error of not following physicians' orders. He stated he expected nurses to follow physician orders as given and said he did not know Resident #61 was not using oxygen continuously. He said the risk of not administering oxygen continuously would make resident hypoxic (a dangerous condition where tissues receive inadequate oxygen, leading to symptoms like shortness of breath, confusion, headaches, and rapid heart rate). Record review of the facility's policy titled Oxygen Administration and Oxygen Safety, reviewed 03/03/26, reflected in part the following: Purpose- The purpose of this procedure is to provide guidelines for safe oxygen administration and oxygen safety guidelines. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess any special needs of the resident. 3. Assemble the equipment and supplies as needed. .12. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated (see Assessment) Assessment Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); 4. Vital signs; 5. Lung sounds; 6. Arterial blood gases and oxygen saturation, if applicable; and 7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide laboratory services to meet the needs of its residents for 1 of 5 residents (Resident #4) reviewed for laboratory services. The facility failed to provide proper monitoring of Resident #4's immunodeficiency disorder by not completing routine specialized laboratory services to ensure that treatment remained effective. This failure could place residents at risk of a delay in medical evaluation and treatment, which could result in worsening of conditions or serious harm. Findings included: Record review of Resident #4's Annual MDS Assessment, dated 03/20/26, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident's BIMS score was 15, which indicated intact cognition. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #4 was independent with all self-care ADLs. The MDS Assessment under Section I-Active Diagnoses, reflected Resident # 4's active diagnoses included: cerebrovascular accident (stroke-loss of blood flow to the brain), hypertension (high blood pressure), viral hepatitis (inflammation of the liver), and an immunodeficiency disorder (weakened immune system). Record review of Resident #4's Care Plan, revised 04/07/26, reflected the resident had impaired immunity and was at risk for dehydration and increased infections r/t to disease process. Interventions included: encouraging fluids and rest, administering medications as ordered, monitoring for signs of infection, monitoring for abnormal laboratory values, monitoring for changes in behavior and cognition, and keeping the environment clean. The document reflected Resident #4 experienced nausea and vomiting r/t disease process (initiated 05/07/25). Interventions included: monitoring for weakness and unsteadiness, administering medications as ordered, avoiding foods that cause overactive bowels, and keeping the resident clean, dry, and comfortable. Record review of Resident #4's laboratory results report, dated 04/12/26, reflected in part the following: Collection date: 04/07/26 Received date: 04/07/26 Reported date: 04/12/26 Order provider: [MD] -WBC (white blood count-measures the number of infection-fighting cells in the blood)- (L) 3.5; last comparison on 03/25/26- (L) 3.7 (reference range (3.8-11.8)) -[laboratory markers for immunodeficiency disorder]- Non Reactive (no detection of infection) . No comparison lab documented. -CD4- 375 (reference range [PHONE NUMBER]). No comparison lab documented Further review of this document reflected there was no evidence that these labs, specific for immunodeficiency disorder, were completed at any other times . Record review of Resident #4's consolidated physician's orders, dated 04/16/26, reflected in part the following: -Amylase (digestive enzyme), Lipase (digestive enzyme), CBC (analyzes cels in the blood to diagnose or monitor conditions like infections, anemia, or clotting issues), CMP (analyzes chemicals in blood for metabolism, organ function, and blood chemistry), UA with C&S; (analyzes urine for infections). Order date: 03/24/26. These were routine labs for general health monitoring and were completed as ordered.- CMP, CBC, UA in a.m.; Order date: 05/05/25 - lipid panel (measures cholesterol levels), vit B12 (measures vitamin B12 levels to diagnose deficiencies that could affect nerve health and red blood cell production), vitamin D (measures vit D levels to assess bone health), one time a day every 90 day (s) for quarterly labs. Order date:11/11/25. These were routine labs for general health monitoring and were completed as ordered. - vitamin B12, vit. d, lipid panel, CBC, CMP, HgA1c (measures average blood sugar levels), TSH (measures level of thyroid stimulating hormones in the blood), T4 (measures thyroid function), folic acid (measures vitamin B9 levels to diagnose deficiencies and anemia), ammonia (measures levels of ammonia in the blood to monitor for liver disorders), one time a day every 12 months starting on the 13th for 1 day(s) for annual labs; Order date: 11/11/25. These were routine labs for general health monitoring and were completed as ordered. - LABS: CBC, CMP, CD4 (measures the number of white blood cells to assess immune health, specific to an immunodeficiency disorder), [laboratory markers for immunodeficiency disorder] STAT for labs; Order date: 04/06/26; End date: 04/06/26. Completed. Further review reflected there were (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no prior orders for these labs, specific for immunodeficiency disorder, to be completed. During an observation and interview on 04/16/26 at 8:43 a.m., revealed Resident #4's body appeared to be thin and fragile. Resident #4 stated she still felt weak after returning to the facility from the local hospital due to nausea and vomiting caused by an issue with her esophagus. Resident #4 stated she resided at the facility for about 5 years and felt okay until last May 2025 when she had a stroke. Resident #4 stated since then, she had issues with vomiting off and on, and the vomiting increased and was more consistent about 2.5 weeks ago. Resident #4 stated prior to her admission to the facility she saw an infectious disease doctor about every 3 months for check-ups and lab work and was supposed to continue doing so; however, she had not seen one since her admission to the facility. Resident #4 stated she recalled speaking to a nurse about it a while ago but there was no follow-up. Resident #4 stated she was finally able to see an infectious disease doctor recently, after her vomiting got worse. During an interview on 04/16/26 at 1:11 p.m., the DON stated she worked at the facility for 2.5 years. She stated to her knowledge Resident #4 had not had any routine specialized labs regarding her immunodeficiency disorder. The DON stated there had never been an issue with care of Resident #4's disorder and it had never been a topic of discussion with the IDT. The DON stated all of Resident #4's medication was being managed by the MD, who also ordered the labs. The DON stated she was not the doctor and could not state if Resident #4 needed specialized labs to monitor her immunodeficiency disorder or how it could affect the resident if routine specialized monitoring was not completed. The DON stated she recalled speaking to Resident #4 about signing up with an immunodeficiency disorder program through the county hospital; however, she could not recall exactly when the conversation occurred or why Resident #59 never signed up. The DON stated it was possible that the resident did not want to, but she was unsure. The DON was unable to provide documentation of a referral to the program or a progress note to show that the program was discussed with Resident #4. During an interview on 04/16/26 at 2:28 p.m., the MD stated he was made aware that Resident #4 was vomiting and nauseous for over two weeks and that was found to be due to an esophageal issue. The MD stated as part of Resident #4's clinical workup to determine the cause of her nausea and vomiting, she was sent to an infectious disease doctor to see if it was related to her immunodeficiency disorder. The MD stated he had managed the care for Resident #4's immunodeficiency disorder. The MD stated Resident #4 was taking medication, but he had not ordered any routine specialized labs to monitor the effectiveness. The MD stated Resident #4 had routine foundational blood tests that he referred to for management of care, and that along with clinical assessments had been enough to detect any changes in the resident's immunodeficiency disorder. The MD stated Resident #4 had been stable on the same regimen for years, and he needed to check her previous clinical documentation prior to admission to see if there were any recommendations for labs. During an interview on 04/16/26 at 4:10 p.m., LVN H revealed she worked at the facility since May 2025. She stated she cared for Resident #4 and the resident had been well for the most part; however, she had random episodes of vomiting and had a long-standing order for Zofran as treatment. LVN H stated Resident #4 often complained of nausea and would only vomit sometimes; but it was never as bad as it was recently when the resident vomited consistently for two weeks. During an interview on 04/16/26 at 4:30 p.m., the DON stated there were no other residents in the facility diagnosed with an immunodeficiency disorder. Review of the facility's Laboratory Services policy, dated 03/03/26, reflected in part the following: POLICY/PROCEDURE It is the policy of this facility to ensure that laboratory services meet the needs of residents and that the results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, treatment, and that the facility has established policies and procedures. Review of the facility's policy titled Admission/readmission Orders revised April 2013, reflected in part the following: Policy Statement: Physicians shall provide appropriate admission and readmission orders. Outcomes: Residents/patients will receive appropriate treatments and services Residents and patients will not suffer complications because of incomplete, inaccurate, or delayed admission orders. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's care will be consistent with related standards and will comply with applicable laws and regulations. Review of the Center for Disease Control and Prevention website, https://www.cdc.gov/hivnexus/hcp/clinical-care/, updated 04/16/26, reflected in part the following: Clinical Care of [immunodeficiency disorder] In addition to supporting ART adherence, monitoring patients' [laboratory markers for immunodeficiency disorder] is important. A patient's plasma [immunodeficiency disorder] RNA [laboratory markers for immunodeficiency disorder] should be measured regularly to confirm initial and sustained response to ART. Most patients taking ART achieve viral suppression within 6 months The frequency of [laboratory markers for immunodeficiency disorder] testing depends on several factors. Current guidelines recommend [laboratory markers for immunodeficiency disorder] monitoring as follows.Stable Regimen. In patients on a stable, suppressive ART regimen (every 3-4 months, or every 6 months if virally suppressed for more than 2 years, to confirm durable viral suppression).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 resident rooms (Resident #15's room) reviewed for infection control. The facility failed to remove and dispose of Resident #15's wound care trash and debris, which included a cup of gauze soaked with betadine and used wound care debris trash, from Resident #15's bedside table. This failure could place residents at risk of exposure to communicable diseases and infections.Findings included:Record review of Resident #15's Comprehensive MDS Assessment, dated 03/11/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with a BIMS of 10 indicating moderate cognitive impairment. The MDS reflected Resident #15 had the following diagnoses: stroke (sudden interruption of blood flow to the brain), heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs), unsteadiness on feet, and lack of coordination. The MDS further indicated Resident #15 was at risk of developing pressure ulcers/injuries, and treatments included and applications of ointments/mediations. Record review of Resident #15's Care Plan, initiated on 04/10/26, reflected the resident had a deep tissue pressure injury/ulcer right lateral (the side of an object or body) foot, a deep tissue pressure injury to left heel, and deep tissue pressure injury/ulcer left lateral foot. Goal: Pressure injury/ulcer will show signs of healing and remain free from infection. With interventions that included Administer treatments as ordered and nominator for effectiveness. Clean right lateral foot with wound cleanser, pat dry, apply Betadine, cover with bordered dressing. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Weekly treatment documentation includes measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid that leaks from blood vessels into nearby tissues, cuts, or area of inflammation).During an observation and interview on 04/14/26 11:03 a.m., revealed there was a cup with used gauze soaked with betadine next to the trash from wound care treatment supplies on Resident #15's bedside table next to her breakfast tray. Resident #15 stated the wound care items on her bedside table were left there by the wound care treatment nurse and the nurse practitioner when they came to complete treatment on her feet this morning. Resident #15 then pulled the blankets off her feet and pointed to her feet which revealed new gauze dated 04/14/26.During an observation and interview on 04/14/26 11:30 a.m., LVN F stated she was the nurse assigned to the 200 Hall. LVN F stated she observed Resident #15's tray table to have wound treatment debris remaining from morning rounds with the wound nurse and doctor next to Resident #15's breakfast tray. According to LVN F, she could not say whether the breakfast tray was delivered before or after wound care treatment was completed; however, the breakfast tray and wound treatment debris on the bedside table together posed a big risk for Resident #15. LVN F stated if the aide noticed the wound care debris on the tray table prior to delivering breakfast, the aide should have reported the concern or cleaned the tray table before leaving the breakfast for Resident #15. LVN F stated the Wound Care Nurse was responsible for cleaning after wound care treatment and not doing so placed residents at risk of infection and illness.During an interview on 04/14/26 at 11:34 a.m., the Treatment Nurse revealed she conducted rounds with the Wound Care Doctor early morning. The Treatment Nurse stated the Wound Care Doctor must have left the would care trash and debris on the bedside table. The Treatment Nurse stated, The doctor must have thought I was going to return back to clean after her. I was not aware there was trash and debris left on [Resident #15's] bedside table. The Treatment Nurse stated she was responsible for disposing of the trash and anything associated with treatment care after treatment was completed, and not doing so placed residents at risk of proper infection control practices and illnesses to the residents. During an interview on 04/16/26 at 1:48 p.m., the DON revealed she saw the wound care treatment debris and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trash on the bedside table next to Resident #15's breakfast tray. The DON stated the Treatment Nurse was responsible for minimizing the spread of infections. The DON further stated the Treatment Nurse was expected to provide supplies for wound care on a tray with disposable paper, once treatment is completed all items should be disposed in the disposable paper in the trash, nothing should have been left on the tray table. The DON stated leaving wound treatment debris on Resident #15's bedside table left her at risk of infection. Record review of the facility's Infection Prevention and Control Program policy, revised 06/30/25, reflected the following: An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Record review of the facility's .Skin Integrity Prevention and Treatment Program policy, revised 06/30/25, reflecting the following: Wound Carea. Will follow the Non-Sterile Dressing Change Competency Protocolb. Emphasizes resident comfort, expectations, and pain management.c. Adheres to infection control best practices.