STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 12 residents (Resident #43) reviewed for rights and dignity. - The facility failed to ensure that nursing staff used privacy curtain between the hallway door and the resident, removing resident from public view and prevent exposure of body parts while providing peri care to Resident #43. - The facility failed to ensure that the nursing staff used the privacy curtain between Resident #43 and Resident #45 while providing incontinence care to Resident #43, to prevent exposure of body parts. This failure could place residents at risk for loss of dignity, self-worth, and diminished quality of life. Record review of Resident #43's face sheet dated 06/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and originally admitted on [DATE]. The diagnoses included dementia, stroke, swallowing disorder, language disorder, arthritis, muscle weakness and delusional disorders. Record review of Resident #43's annual MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. She required substantial/maximal assistance with toileting, sit to stand: helper does more than half the effort; helper lifts or holds trunk or limbs and provides more than half the effort. Resident #43 was frequently incontinent of bowel and bladder. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #43's undated care plan revealed: Focus- the resident had impaired cognitive function and impaired thought processes and may miss the intent when spoken to d/t Moderate Dementia with Behaviors. BIMS score of 5; Goal- will maintain current level of decision-making ability by review date. Target date 06/18/25. Interventions included - Communicate with the resident/family/caregivers regarding resident capabilities and needs. Cue, reorient and supervise as needed. Don't argue or correct me if I get confused to reality. Identify yourself at each interaction. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues-stop and return if agitated. Focus - Resident #43 has an ADL self-care performance deficit r/t Dementia and stroke. Interventions included - Provide the following assistance with ADLs in self-performance and staff support, Transfer - limited-total assist of 1; Toileting - limited-total assist of 1. Focus - Resident #43 is always incontinent of bladder and bowel and requires assistance AEB self-care deficit, confused, disoriented related to dementia disease process. Goal- promote dignity by keeping resident clean, dry, and free from odor every shift through the next review. Target date: 06/18/2025. Resident will not develop any complications associated with incontinence. Observation on 6/18/25 at 2:30 PM of the undated video footage #2 submitted by the RP revealed, CNA-E was performing incontinent care for Resident #43. The privacy curtain was not drawn between the resident and the closed door. The door was not opened during the time the resident was exposed. Observation on 6/18/25 at 2:30 PM of an undated video footage #6 submitted by the RP revealed two unidentified nursing staff performing incontinent care for Resident #43. The curtain between Resident #43 and Resident #45 was not drawn. Resident #45 was sitting next to Resident #43's bed during the incontinent care. The curtain was not drawn between Resident #43's bed and the door to the hallway. During incontinent care, one of the nursing staff partially opened the door and stood at the open door while Resident #43's pants were around her knees and thighs were exposed. Interview on 06/18/25 at 10:30 AM, Resident #43 did not remember any incidents. Telephone interview on 6/18/25 at 3:45 PM, Resident #43's RP stated there were some video footage with the curtain not being closed properly to ensure Resident #43 was not exposed. Interview on 06/20/2025 at 1:05 PM, the Administrator stated a meeting with the RP occurred after the reported incident and the RP shared video footage. The Administrator stated the RP flipped through the video quickly the Administrator was unable to view much of the detail. Interview on 6/20/25 at 2:00 PM the ADON stated she expected when providing incontinent care, the nursing staff should announce themselves, provide privacy by closing doors, pull curtains as much as possible. Interview on 6/20/25 at 2:05 PM, the Corporate Nurse stated she expected nursing staff to provide privacy during incontinent care by closing doors and closing blinds. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility investigation report revealed on 5/31/25 the Administrator received a call from the weekend supervisor LVN-E about Resident #43. LVN-E was instructed to call the RP and ask to review the cameras and to send CNA-E home. RP reported customer service issues regarding the CNA. Further review of the facility investigation revealed on 06/02/25 the Administrator and the DON met with Resident #43's RP at 11:00 AM to discuss the care concerns from the previous weekend. The meeting lasted one hour and the discussion included the resident's plan of care, incontinent care and overall needs. Record review of the facility policy for Perineal Care, revised on 1/2024 read in part: .It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed .Policy Explanation and Compliance Guidelines .4. Inform resident on procedure to be performed .5. Provide privacy by pulling privacy curtain or closing room door if a private room . Record review of the facility policy for Promoting/maintaining Resident Dignity, revised on 1/2025 read in part: .it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights 12. Maintain resident privacy .

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents had the right to self-administer medication, if the interdisciplinary team, has determined this practice as clinically appropriate for 1 out of 8 residents (Resident #45) reviewed for self-administration of medication. The failed to assess Resident #45, who suffered from tremors associated with a diagnosis of Parkinson's Disease, for the ability to self-administer lubricant eye drops in that Resident #45 self-administered eye drops to herself from admission [DATE]) to 05/21/25. This failure could place residents at risk of inappropriate medication doses, medication errors, drug interactions, and side effects. Findings include: Record review of Resident #45's Face Sheet dated 05/22/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: Parkinsonism (a group of disorders that have tremors like those identified in Parkinson's Disease), anxiety disorder, voice and resonance disorders, mild dementia without behavioral disturbance. Record review of Resident #45's Undated Care plan revealed, focus- resident has Parkinson's disease and is at risk for injury from increased tremors and involuntary muscle movements; interventions- assist with ADL's as needed and give meds per order. There was no focus area that addressed self-administration of eye drops. Record review of Resident #45's Quarterly MDS dated [DATE] revealed, the use of corrective lenses and intact cognition as indicated by a BIMS score of 14 out of 15. Resident #45 needed partial/moderate assistance with toileting, showering, lower body dressing, the resident did not have Parkinson's disease but instead had unspecified Parkinsonism. Record review of Resident #45's EMR on 05/21/25revealed, no documentation of a completed assessment for the self-administration of Medication. Record review of Resident #45's Order Summary Report dated 05/22/25 revealed, Resident #45 did not have an order for eye drops prior to 05/21/25. Record review of Resident #45's Self Administration of Meds assessment dated [DATE] at 04:11 PM completed by ADON A revealed, Resident #45 was not a candidate for the self-administration of medications because of her diagnosis of dementia. An observation and interview on 05/20/25 at 09:10 AM revealed Resident #45 in bed, well dressed, well-groomed in no immediate distress. The resident had her glasses on as she cleaned her eyes with wipes. Resident #45 experienced tremors, as both her legs and hands jerked as she cleaned her eyes. There was a cart at the resident's bedsides that contained boxes of Refresh Celluvisc and Systane lubricant eye drops. Resident #45 said she had her eyedrops at her bedside and administered the eyedrops herself. She said she had not been trained or assessed to self-administer her eyedrops and did not elaborate on how often she administered the eyedrops daily. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 05/22/25 at 04:01 PM revealed Resident #45 sitting in a wheelchair beside her bed. The cart beside her bed no longer contained eyedrops. The resident said facility staff had removed her eyedrops yesterday, and she did not know she was not supposed to have them. Resident #45 said she had the eyedrops in her room and self-administered them since she was admitted in January of 2025. She said the eye drops were originally stored on her bedside table, but the facility staff said she could not place them there, so she moved them to the cart on the side of her bed. Resident #45 said since the eyedrops were an OTC, she did not think it was an issue for her to keep them in her room or administer them herself. In an interview on 05/22/25 at 03:55 PM, the DON said she was not aware that Resident #45 had eyedrops at her bedside and self-administered the eyedrops until it was identified by the survey team and physician's order was entered. She said Resident #45 did not have an order for the eye drops so her physician entered in an order for lubricant eyedrops in the evening of 05/21/25. The DON said prior to a resident's self-administration of medication they must be assessed for their ability to do so safely, and no assessment for self-administration of medication was completed for Resident #45 yet, so she should not be instilling her own eyedrops or have them at her bedside. The DON said failure to assess a resident's ability to self-administer medication prior to the resident administering the medication could place the resident at risk for drug interactions and side effects. In an interview on 05/23/25 at 09:26 AM, the DON said Resident #45 should not have administered her own eyedrops because she had tremors which would impact her ability to instill the drops. She said the resident was assessed for her ability to self-administer her eyedrops on 05/22/25 but the resident did not pass. A request was made for a policy for self-administration of medication was made on 05/23/25 at 03:52 PM. The policy was not provided prior to exit. Record review of the facility policy titled Medication Administration revised 01/2025 revealed: Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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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 observations, interviews and record review, the facility failed to ensure the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 2 (Resident #34 and Resident #49) of 10 residents reviewed for resident call system in that: - The facility failed to ensure Resident #34's call light was within reach as it was laid on the floor This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included: Record review of Resident #34's Face Sheet dated [DATE] revealed, an [AGE] year-old female who admitted to the facility with diagnoses of: dementia, anxiety disorder, schizophrenia, and generalized muscle weakness. Record review of Resident #34's Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 13 out of 15, use of a walker and no upper and lower extremity impairments/functional limitations in range of motion. Record review of Resident #34's Care Plan dated [DATE] revealed, focus- risk of increased falls and injury related to psychoactive drug use; intervention- be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. An observation and interview on [DATE] at 09:13 AM revealed, Resident #34 in bed, her room was well organized, and her call light was on the floor. The resident as she rotated her body to get it from the floor as she laid in bed, she appeared to be at risk of falling off the bed. In an interview on [DATE] at 09:33 AM, CNA D said she last checked on Resident #34 30 minutes ago and her call light was within reach. She said the resident's call light as located on the floor was not correct and she picked it up and placed it on the residents bed. CNA D said call lights should be within reach and failure to do so could place residents at risk of falls or not having their needs met. In an interview on [DATE] at 09:56 AM the DON said call lights should be within reach and functional as failure to do so could result in a delay in care, failure to identify changes in condition, worsening of condition or pain. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Call Lights: Accessibility and Timely Response revised 02/2023 revealed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 7. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. 8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace call light, provide a bell or whistle, increase frequency of rounding, etc.).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the resident and the resident's representative of a transfer and the reasons for the transfer, effective date, location and statement of resident's appeal rights, and duration of the bed-hold policy in writing for 1 of 4 residents (CR #332) reviewed for transfers. The facility failed to ensure CR #332's representative received a written notice of transfer when she was transferred to a local psychiatric hospital on 2/21/25 and 2/26/25. These failures could place residents at risk of an insufficient preparation or orientation during transfer, inability to use their right to appeal, and lack of information. The findings included: Record review of CR #332's admission Record dated 5/21/25 revealed she was admitted to the facility on [DATE] with diagnoses of dementia (a decline in memory or other thinking abilities that can interfere with daily life), diabetes type II (when the body cannot use insulin correctly, leading to elevated blood sugar levels, major depressive disorder and fractures to the ribs, vertebra, sacrum and left pubic bone. She was [AGE] years of age. Record review of CR #332's Care Plan report (undated) revealed the following focus areas, goals and interventions: - Focus: Impaired coping. Goal: Resident would demonstrate effective coping mechanisms. Target Date: 4/7/25. Interventions: acknowledge awareness of the resident's fear. Encourage resident to verbalize feelings regarding fear and/or anxiety, explain all procedures as appropriate, using simple, concrete terms and monitor the effectiveness of resident's immediate support system. - Focus: Knowledge Deficit. Goal: Educate resident/representative of post-discharge rehabilitation plan. Resident/Representative will Understand and Participate in Treatment Regimen. Target date: 4/7/25. Interventions: Educate resident/representative regarding discharge instructions and follow-up plan, promote the importance of participation/compliance in treatment regimen, provide education regarding goals of treatment regimen. - Focus: CR #332 was an elopement risk/wanderer related to dementia. Goal: The resident's safety would be maintained. Target Date: 4/7/25. Interventions: Distract resident from wandering by offering pleasant diversions, identify patterns of wandering, monitor for fatigue and weight loss, provide structured activities, and report any attempts to exit the facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #332's admission MDS assessment dated [DATE] revealed she had a BIMS of 3, indicating she had severe cognitive impairment. She had behavioral symptoms not directed toward others, including wandering and rejection of care, that occurred 1-3 days of the review period. The behaviors significantly interfered with the resident's care and intruded on the privacy or activity of others. She required supervision for walking and required setup assistance for self-care activities. Record review of CR #332's Nurse Progress notes revealed she had wandering behaviors on 2/19/25 and refused staff to enter her room and/or refused care on 2/20/25 and 2/21/25. Former Social Worker noted she was accepted to a local psychiatric hospital on 2/21/25 at 4:01pm and was transferred for further treatment and evaluation. She was readmitted on [DATE] at 6:02pm. Further record review of CR #332's Nurse and Social Services Progress notes revealed she had wandering behaviors on 2/24/25 and refused staff to enter her room and/or refused care on 2/25/25 and 2/26/25. On 2/25/25 at 10:27am, Former Social Worker noted she called CR #332's RP regarding the resident's behaviors. RP in agreement to refer resident back to (local psychiatric hospital). She was transferred to the local psychiatric hospital on 2/26/25 at 9:18am. Record review of a Social Services Note written by the Former Social Worker dated 2/26/25 at 11:07am read in part, Spoke to (family member) about resident's behaviors this morning. (Family member) aware that resident was transported to (local psychiatric hospital). Encouraged (family member) to follow through with touring the facilities provided to her previously as well as utilize (Assisted Living placement agency) as previously discussed to find a more appropriate setting for resident. She voiced understanding and asked that the social worker call her today. Consent obtained to box up resident belongings in the meantime. Record review of CR #332's Behavioral Health Discharge summary dated [DATE] revealed the date of CR #332's last service was 2/19/25. She was discharged from services due to her transfer to another facility. At the time of discharge, she was not considered to be at risk of harm to self or others. In an interview on 5/21/25 at 3:00pm, the Administrator stated CR #332 had behaviors and they helped her family members find a more appropriate setting for her like a secure nursing home. She said facility staff encouraged her family members to find placement before she returned to the facility. She said she had not provided CR #332's family members with a discharge notice. She said the resident's family members were agreeable to move her because the facility did not have a secure unit. In an interview on 5/23/25 at 10:14am, CR #332's family member stated the Administrator told her other family member that it would be better if she did not return to the facility because of her agitation and wandering behaviors. She said it felt like they were not welcome back. She said the facility never provided either of them with a written notice of transfer. In an interview of 5/23/25 at 11:45am, the Administrator stated when a resident was transferred to the hospital, they do not provide written documentation to the resident or responsible party. She said there was an assumption that residents were allowed to return to the facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Transfer and Discharge Policy dated 1/2023 and revised on 8/2023 read in part, It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge of the resident from the facility, except in limited circumstances. 'Transfer' refers to the movement of the resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility . #4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. the specific reason and basis for transfer or discharge. B. The effective date of transfer or discharge. C. The specific location .to which the resident is to be transferred or discharged . D. An explanation for the right to appeal the transfer discharge to the State. E. The name, address, and telephone number of the State entity which receives such appeal hearing requests. F. Information on how to obtain an appeal form. G. Information on obtaining assistance in completing and submitting the appeal hearing request. H. The name, address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman . In an interview with the Administrator on 5/23/25 at 12:53pm, when asked about their Transfer policy, specifically #4 of their policy, she said they were not completing notices like this for transfers. She said she thought Resident #332's transfer was involuntary. She said they could not meet her needs based on her behaviors, and it was unrealistic in the long run.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 8 residents (Resident #45 and Resident #49) reviewed for accuracy of assessments. The facility failed to identify Resident #45's diagnosis of Parkinson's Disease in her Quarterly MDS and list of medical diagnosis. The facility failed to identify Resident #49's use of oxygen in her MDS. This failure could place residents at risk of a compromised plan of care. Findings include: Resident #45 Record review of Resident #45's Face Sheet dated 05/22/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: Parkinsonism (a group of disorders that have tremors like those identified in Parkinson's Disease), anxiety disorder, voice and resonance disorders, mild dementia without behavioral disturbance. Record review of Resident #45's Undated Care plan revealed, focus- resident has Parkinson's disease and is at risk for injury from increased tremors and involuntary muscle movements; interventions- assist with ADL's as needed and give meds per order. Record review of Resident #45's Quarterly MDS dated [DATE] revealed, resident wore corrective lenses and had intact cognition as indicated by a BIMS score of 14 out of 15. Resident #45 needed partial/moderate assistance with toileting, showering, lower body dressing, the resident did not have Parkinson's disease but instead had unspecified Parkinsonism. Record review of Resident #45's Physician's Orders dated 01/17/25 revealed: Carbidopa-Levodopa ER 25-100mg- Give 1 tablet by mouth in the morning at Parkinson's Disease; scheduled at 08:00 AM Carbidopa-Levodopa 25-100 mg (IR)- Give 1 tablet by mouth in the morning at Parkinson's Disease; scheduled at 08:00 AM. Carbidopa-Levodopa 25-100 mg (IR)- Give 1 tablet by mouth in the morning at Parkinson's Disease; scheduled at 12:00 PM. Record review of Resident #45's Medication Administration Record provided by the Administrator of 05/21/25 at 05:47 PM revealed, Resident #45 was administered Carbidopa-Levodopa for Parkinson's Disease. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 05/20/25 at 09:10 AM revealed Resident #45 in bed, well dressed, well-groomed in no immediate distress. The resident had her glasses on as she cleaned her eyes with wipes. Resident #45 experienced tremors, as both her legs and hands jerked as she cleaned her eyes. Resident #45 said she had Parkinson's Disease and received medications to treat her tremors. In an interview on 05/22/25 at 03:55 PM, the Interim DON said resident's diagnoses with Parkinson's Disease suffer from symptoms such as tremors, shuffled walking, and gait. She said Carbidopa/Levodopa was used to keep the symptoms at bay and if it was not administered in a timely manner, it would result in the worsening of symptoms. Resident #49 Record review of Resident #49's Face Sheet dated 05/22/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: bone cancer, shortness of breath, anal cancer, cognitive communication deficit, difficulty swallowing and pressure ulcer on her sacrum (triangular bone at the base of the spine). Record review of Resident #49's undated Care Plan revealed, focus: pneumonia; intervention: monitor/document/report to MD as needed for the following symptoms of pneumonia: fever, chills, cough, fast breathing, low oxygen. Focus: receiving nebulizer breathing treatments; interventions- monitor O2 saturation (levels) as needed or per orders, administer breathing treatments as ordered by MD. Focus: Hospice services due to terminal illness of anal cancer; intervention- assist with ADLs and provide comfort measures as needed, monitor for signs and symptoms of increased pain, discomfort-give medications/treatments monitor for relief. There was no focus area for oxygen administration. Record review of Resident #49's Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. Record review of Resident #49's Change of Condition MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. Record review of Resident #49's Order Summary Report dated 05/22/25 revealed, Oxygen at 4 L/min via nasal canula as needed for shortness of breath, fast breathing (tachypnea) and respiratory distress. An observation and interview on 05/20/25 at 09:33 AM revealed, Resident #49 received oxygen via nasal canula between 3.5-4 L/min. The resident was dressed in a hospital gown, appeared well fed and in no immediate distress. Resident #49 woke up and said she had no current issues or concerns, and she would talk to the surveyor at a different time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/23/25 at 10:48 AM, the MDS nurse said she was responsible for completing MDS assessments and entering the diagnosis for residents in the facility. She said she gets their diagnosis from either their recent MD visit or hospital records and that is transcribed into the resident's MDS and diagnosis list. The MDS nurse said after she clinically reviews the resident, she talks to the resident to ensure that their diagnosis match and she contacts their MD if there are any discrepancies. She said Parkinson's Disease is an actual disease while parkinsonism is just the symptoms. The MDS nurse said the items coded in the MDS (that identifies potential problems, needs, or strengths of a nursing home resident) trigger CAAs, which in return move into the resident's care plan. She said if a resident had an active problem that was treated in the facility it should be in her MDS. The MDS nurse said based on Resident #45's hospital records and admission paperwork she admitted with a diagnosis of Parkinson's Disease. The MDS nurse said Resident #45's diagnosis of Parkinson's Disease should have been in her list of her diagnosis and MDS, but it was not there, so she put a plan of correction in place to open a new cycle for Resident #45's MDS to correct the error. The MDS Nurse said failure to have accurate diagnosis and areas triggered in a resident's MDS, and diagnosis list can create resident rights & quality of life issues if a resident did not receive the correct care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' mental, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 Residents (Resident #49) reviewed for care plans. - The facility failed to identify Resident #49's use of oxygen in her care plan. This failure could place residents at risk of not having their needs met. Findings include: Record review of Resident #49's Face Sheet dated 05/22/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: bone cancer, shortness of breath, anal cancer, cognitive communication deficit, difficulty swallowing and pressure ulcer on her sacrum (triangular bone at the base of the spine). Record review of Resident #49's undated Care Plan revealed, focus: pneumonia; intervention: monitor/document/report to MD as needed for the following symptoms of pneumonia: fever, chills, cough, fast breathing, low oxygen. Focus: receiving nebulizer breathing treatments; interventions- monitor O2 saturation (levels) as needed or per orders, administer breathing treatments as ordered by MD. Focus: Hospice services due to terminal illness of anal cancer; intervention- assist with ADLs and provide comfort measures as needed, monitor for signs and symptoms of increased pain, discomfort-give medications/treatments monitor for relief. There was no focus area for oxygen administration. Record review of Resident #49's Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. Record review of Resident #49's Change of Condition MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. Record review of Resident #49's Order Summary Report dated 05/22/25 revealed, Oxygen at 4 L/min via nasal canula as needed for shortness of breath, fast breathing (tachypnea) and respiratory distress. An observation and interview on 05/20/25 at 09:33 AM revealed, Resident #49 received oxygen via nasal canula between 3.5-4 L/min. The resident was dressed in a hospital gown, appeared well fed and in no immediate distress. Resident #49 woke up and said she had no current issues or concerns, and she would talk to the surveyor at a different time. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/23/25 at 10:48 AM, the MDS nurse said she was responsible for completing MDS assessments and care plans. The MDS nurse said after she clinically reviews the resident, she talks to the resident to ensure that their diagnosis match and she contacts their MD if there are any discrepancies. She said if a resident had an active problem that was treated in the facility it should be in her MDS. The MDS nurse said the items coded in the MDS (that identifies potential problems, needs, or strengths of a nursing home resident) trigger CAAs, which in return move into the resident's care plan. The MDS Nurse said failure to have accurate diagnosis and areas triggered in a resident's MDS, can create resident rights & quality of life issues if a resident did not receive the correct care.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #17) reviewed for accidents and supervision. The facility failed to ensure the locking mechanism on Resident #17's bed was operating properly, which caused her to fall and hit her head and resulted in a head injury, laceration over her right eye, and need for emergency medical attention. An IJ was identified on 6/12/2025. The IJ template was provided to the facility on 6/12/2025 at 2:33 pm. While the IJ was removed on 6/13/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm that is not immediate jeopardy due to the facility ' s need to evaluate the effectiveness of the corrective systems. This failure placed all residents who have wheel locks on their beds at risk for falls, decline in health, serious injury, and hospitalization from poor maintenance of the bed rails. Findings include: Resident #17 Record review of Resident #17 ' s face sheet dated June 11, 2025 revealed an [AGE] year old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnoses of cerebral infarction (stroke-blood flow to the brain is blocked), dysphagia (difficulty swallowing), hypertension (high blood pressure), osteoarthritis, rheumatoid arthritis, chronic kidney disease, atrial fibrillation (irregular heart rate), anticoagulants (medication that prevents blood clots), repeated falls, symbolic dysfunction, and pain. Record review of Resident #17 ' s Quarterly MDS (Minimum Data Set) dated 3/29/2025 revealed memory problems with moderate impaired cognitive skills for decision making. Resident #17 had upper and lower impairments of extremities and was ambulated with a wheelchair. Resident #17 required partial/moderate assistance where the helper does less than half the effort for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. She required set up or clean-up assistance for rolling left and right, and partial/moderate assistance where the helper does less than half the effort for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfers. Walking 10 feet was not attempted due to medical conditions or safety concerns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #17 ' s Care Plan last reviewed on 04/17/2025 revealed Resident #17 required assistance to perform functional abilities in self-care and mobility AEB poor quality in functional range of motion r/t stroke with intervention to provide self-care assistance: .toilet hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene, chair/bed-to-chair transfer, and toilet transfer were all partial assistance. Resident #17 was at risk for falls and increased falls and injury r/t psychoactive drug use with interventions to anticipate needs, provide prompt assistance with ADLs and other special needs, assess for psych services, be sure the resident ' s call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, call MD of any falls, ensure that resident is wearing appropriate footwear or nonskid socks when ambulating or when up in wheelchair for mobility, fall risk assessments per facility protocol and rehab screen/evaluate and treat as indicated for therapeutic exercises and safety measures. Record Review of Provider Investigation Report dated 9/10/2024 written by former Administrator revealed Resident #17 Fell out of the bed and hit her head receiving a hematoma and laceration to the right eye, and skin tear on forearm 911 was contacted and the patient was transferred to the hospital for further evaluation and treatment. Patient was returned to the facility few hours later with four sutures and laceration above her right eye. Resident is prescribed Eloquis 2x daily. Record review of Resident #17 ' s Order Summary Report revealed acetaminophen tablet 325 mg for pain, apixaban tablet 2.5 mg for anticoagulants, and Lexapro oral tablet 5 mg for generalized anxiety disorder. In an observation and attempted Interview on 05/20/25 at 1:30 Pm Resident #17, was observed to be nonverbal and was non interview able. At the time of the attempted interview and observation, Resident #17 had no marks or bruises. Resident #17 ' s bed was observed, and locks were not working at the time of the observation of her room. Interview on 05/20/2025 at 2:40 PM with CNA E she stated she was no longer employed by the facility. CNA E stated that on 9/10/24 at 9PM she was helping Resident #17 get out of the bed due to resident having bowel movement in the bed. The resident has to be physically lifted out of bed. While CNA E was assisting with lifting the resident, she somewhat swung her arms out, falling off the bed and hitting her head. She stated that the wheel on the bed was not working and therefore not secured on the floor, causing the bed to move at the time the accident occurred. Interview on 05/20/2025 at 2:40 PM with the Former Interim DON, she stated that she was very familiar with Resident #17. She stated that because Resident #17 was non-verbal, she may at times swing her arms and or jerk away when being bathed or moved or aided in getting dressed. She stated that she has never witnessed her being abused. Observation on 05/21/2025 at 2:00 PM of the bed for Resident#43 and Resident # 17 revealed both beds to not have slip resistant pads to avoid movement that would lead to injury to the residents. Both beds had movement with locks on at the time of observation. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 6/12/2025. The Administrator was informed and provided the IJ template on 6/12/2025 at 2:33 PM. The Plan of Removal (POR) was requested. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following Plan of Removal was submitted by the facility and was accepted on 6/12/2025 at 8:37 PM: PLAN OF REMOVAL F689- Accidents/supervision Problem: - The facility failed to act after Resident #17, #43 and #44 injuries and possible injury occurred. -The facility failed to take prompt action after Resident #17 fell and hit her head on a cabinet after bed wheels would not lock in place to hold bed movement. Immediate action: 6/12/25 Residents #17, #43 and #44 remain in the facility in stable condition. Their beds wheels have been assessed for safety, and all wheels are working properly and have working bed locks and/or stoppers that secure the bed. Completed 6/12/25 All beds wheels observed are in working order. 6/12/25 The facility maintenance director/Designee initiated bed safety screenings on all the beds to ensure their wheels break/stoppers are working and that beds are not moving unnecessarily during resident ADL care. Wheels stopper pads have been placed on all bed wheels noted moving during ADL care. Patient beds not in use have working breaks or bed stoppers in place, unless designated as out of order with a posted sign and flagged for no use by admissions. Completed 6/12/25 Interventions: On 6/12/25 the Administrator and DON along with the corporate nurse re-review the facility Accidents and Supervision Policy and the Incident and Accidents Policy to ensure understanding of policies and expectations to always sustain compliance. No modifications or changes needed to either policy. Completed 6/12/25 On 6/12/25 the facility Adm/DON/corporate nurse initiated an in-service with all staff on the facility Accidents and Supervision Policy and the Incident and Accidents Policy to ensure understanding. Completed 6/12/25 On 6/12/25 The Corporate Maintenance Director conducted an in-service with the facility Administrator and Maintenance Director on the TELS System and how to run reports to ensure all work orders are promptly addressed. Completed 6/12/25 On 6/12/25 the facility DON/Designee initiated an in-service with all facilities in regard to the TELS system focusing on immediately reporting beds that are not secure or noted moving. A work order is entered into the EMR. Staff members are to apply wheel stoppers with spare stoppers provided to them in order to secure the beds. In the event the staff are unable to secure the wheels, the bed will be taken out of service until the Maintenance Director is able to correct. The Maintenance Director receives TELS work order and corrects the bed reported issues as soon as possible with a goal of the same business day. Defective equipment will not be in use. Completion on 6/12/25 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/12/25 The Adm/designee conducted an in-service with all nursing staff and all therapy staff on incident and accident prevention focusing on bed safety, interventions they are to initiate if resident bed wheel/breaks are noted moving during ADL care. This includes reporting it to TELS and immediately placing stopper pads onto the unsecure beds. Failure to comply will result in disciplinary action and up to termination of employment. Completed 6/12/25. Ongoing Projected Completion 6/13/25 Any staff member who is not present in the service will not be allowed to assume their duties until in-service. Ongoing In-service will be completed by DON/ADON/WC NURSE/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff complete. Monitoring On 6/13/25 The DON/designee began administering a quiz to validate the effectiveness of the training for each member of the staff. Immediate re-education will be completed by the DNS/designee if any staff are unable to answer appropriately the questions on the quiz. Staff will not be allowed to work until after completion of the quiz. Projected completion 6/13/25 Starting on 6/12/25, the facility Administrator/Designee will review TELS work order report daily to ensure completion. Administrator/ Designee will also review the incidents and accidents to promptly identify possible accidents caused by unsafe beds. Any issues identified will be addressed at that time. An impromptu QAPI meeting was conducted with the facility's Medical Director, on 6/12/25, to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved on 6/12/25 Monitoring of the Plan of Removal included the following: Observation on 6/13/25 at 11:00 AM of four beds in the facility showed that slip pads had been put in place and beds were currently stable without added movement. Record Review of Skilled services in-service dated 6/12/2025 revealed an in-service in which staff are to report if the wheel locks on the bed move, they should report to the maintenance man and have TEL stoppers placed on the bed. Record review on 06/13/2025 of in-service signature sheet, revealed in service completed with staff to ensure that they know when and how to report issues with residents' beds. Record Review on 06/13/2025 QAPI minutes and recommendation reviewed, and ad-hoc minutes and documentation reviewed. Facility and staff are aware of issues with bed locks. All locks have been secured with slip pads. Interview with the Administrator on 06/13/2025 at 9:45 AM, the Administrator presented signature sheet for staff in-service addressing resident beds and how to recognize issues with beds and how to report it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Staff A on 06/13/2025 at 11:02 AM revealed that the facility since 6/12/25 has completed training and in-service for all staff about bed safety and methods to ensure they are safe and how to report. The staff member was able to describe all steps of reporting and items to use for a bed with any function issues. Interview with Staff B on 06/13/2025 at 10:30 AM revealed that staff member was in service today prior to clocking in and start of shift. Staff B was able to discuss the procedure of reporting and how to determine if the bed needed adaptive hardware for the resident's safety. Interview with the maintenance director on 06/13/2025 at 12:34 PM revealed that the maintenance staff has checked every bed in the facility, along with tagging all non-occupied beds for future use. The maintenance director stated that he participated and will continue to participate in the in-service for new and future employees. Interview with Staff C on 06/13/2025 at 12:52 PM revealed that the staff member was in service on the beds and wheels. Staff stated that she was in service on how to report on maintenance and record work order in the system. Face to Face Staffing with Administrator on 06/13/2025 1:55 PM The Investigator currently has lowered the IJ. The facility has completed the necessary training and completed the necessary maintenance to all beds in the facility to ensure the safety and well-being of each resident. The facility was informed that the immediacy was removed on 06/13/2025 at 1:55 PM. The facility remained out of compliance at a scope of isolated and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for 1 of 5 residents (Resident #22) reviewed for pain management. The facility failed to ensure Resident #22's pain control was maintained at a level acceptable to the resident. This failure could place the resident at risk of a decrease in quality of life due to pain. Findings included: Record review of a face sheet dated 5/22/25 indicated Resident #22 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Unspecified Cerebrovascular Disease, Chronic Gout, Contracture in left and right hands, Rheumatoid Arthritis, Contracture of Muscles right and left lower legs, and Other Chronic Pain. Record review of Resident #22's Quarterly MDS assessment dated [DATE] revealed resident had a BIMS Summary Score of a 15 (cognitively intact). Section J0300 for Pain Presence was coded as 0 pain in the last 5 days. Record review of Resident #22's care plan dated 4/16/25 indicated the resident had a risk for pain related to history of gout, and limited mobility due to traumatic brain injury. The physician was to be notified if current pain medications and non-pharmacological interventions were ineffective. The care plan also indicated the resident will maintain an adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain or distress, verbalizing satisfaction with level of comfort. Record review of Resident #22's physician orders revealed the pain medication order was changed on 4/17/25. Order dated 1/6/25 was for two Hydrocodone-Acetaminophen 5-325 Mg tablets to be given by mouth every 6 hours as needed for Other Chronic Pain. This order was discontinued on 4/17/25 and replaced with an order for one Hydrocodone-Acetaminophen 5-325 Mg tablet to be given by mouth every 6 hours as needed for Other Chronic Pain. Record review of Resident #22's MAR dated 5/22/25 revealed resident was administered one Hydrocodone-Acetaminophen 5-325 Mg tablet on 4/23/25 at 5:36 AM by LVN A when she reported a pain level of 6 out of 10. At a follow-up assessment 2 hours later, resident reported the medication was ineffective. No other medication or intervention was offered until 6:12 PM when resident was given one Hydrocodone-Acetaminophen 5-325 Mg tablet. On 4/26/25 at 7:30 PM, resident was administered one Hydrocodone-Acetaminophen 5-325 Mg tablet when she reported a pain level of 7 out of 10. At a follow-up assessment 2 hours later, resident reported the medication was ineffective. No other medication or intervention was offered until 4/27/25 at 1:17 AM, when resident was given one Hydrocodone-Acetaminophen 5-325 Mg tablet. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 9:30 AM, Resident #22 reported she was satisfied with the pain management offered at the facility. She reported they give her medication when she asks and do what they can to help her. She does not have any complaints in that area. Sometimes the pain medication does not take all the pain away but she has learned to live with it. She did not recall any instances where she complained of pain and staff did not assist her in some way. During an interview on 5/23/25 at 9:45 AM, the Administrator reported that Resident #22 does not complain about pain very often but when she does, repositioning has helped. She was so constricted that she has pain and moving her sometimes takes care of the pain. The Administrator did not know why staff did not document interventions given when the resident reported the medication was ineffective. Review of the facility's policy Pain Management, dated 11/2023, read in part .The facility must ensure that pain management is provided to residents who require such services . Pain Management and Treatment: 7. i. Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen .

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received and the facility provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 2 of 5 residents (Resident #49 and Resident #77) reviewed for behavioral services. - The facility failed to assess Resident #49 and provide behavioral health services from [DATE] to [DATE] after she reported that she wanted to die. - The facility failed to immediately assess Resident #77 after he reported that he wanted to die. These failures could place residents at risk of mental and psychosocial harm, injury, and suicidal ideation. An Immediate Jeopardy (IJ) that started on [DATE] was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 04:45 PM. While the immediacy was removed on [DATE] at 01:55PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. Findings include: Resident #49 Record review of Resident #49's Face Sheet dated [DATE] revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: bone cancer, shortness of breath, anal cancer, cognitive communication deficit, difficulty swallowing and pressure ulcer on her sacrum (triangular bone at the base of the spine). Record review of Resident #49's undated Care Plan revealed, focus: pneumonia; intervention: monitor/document/report to MD as needed for the following symptoms of pneumonia: fever, chills, cough, fast breathing, low oxygen. Focus: receiving nebulizer breathing treatments; interventions- monitor O2 saturation (levels) as needed or per orders, administer breathing treatments as ordered by MD. Focus: Hospice services due to terminal illness of anal cancer; intervention- assist with ADLs and provide comfort measures as needed, monitor for signs and symptoms of increased pain, discomfort-give medications/treatments monitor for relief. There was no focus area for oxygen administration. Record review of Resident #49's Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. The resident reported no symptoms of being down/depressed/hopeless, little interest or pleasure in doing things, and feelings of social isolation. (continued on next page)

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	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #49's Change of Condition MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. The resident was on hospice, Pain was present with rare impact on sleep, rare interference with therapy activity and occasional interference with day-to-day activities. Record review of Resident #49's Hospice RN Comprehensive Visit dated [DATE] revealed, Resident #49 was experiencing pain. was uncomfortable due to her pain and her pain was located on her rectum. Mental status: disoriented, withdrawn, forgetful, unable to report anxiety/depression due to not responding. Resident #77 was co-operative, indifferent, and showed abnormal behavior/mood and effect because she was withdrawn. Record review of Resident #49's Order Summary Report dated [DATE] revealed, Admit to Hospice. Hospice Care effective [DATE]; diagnosis: anal cancer and other conditions of cancer spread to the bone. Oxycodone w/ Acetaminophen 5-325 mg- give 1 tablet every 12 hours for pain management. Oxycodone w/ Acetaminophen 5-325 mg- give 1 tablet every 6 hours as needed for pain level 7-10. Morphine 20 mg/ml- give 0.25 ml by mouth every 6 hours for severe pain. Morphine 20 mg/ml- give 0.25 ml by mouth every 4 hours as needed for pain and shortness of breath. The record indicated that Oxycodone was discontinued when the resident was started her Morphine Sulfate on [DATE]. Record review of Resident #49's [DATE] MAR revealed, all doses of PRN pain medication were documented as effective on follow up pain assessments. Record review of Resident #49's Progress Notes from admission ([DATE] to [DATE]) and saved on [DATE] at 02:23 PM revealed: - [DATE] at 11:07- Resident repositioned multiple times to relieve sacral pain - [DATE] at 04:02 PM- Resident resident in bed, no shortness of breath, no complaints of pain. - [DATE] at 10:27 PM- Resident participated in PT and OT while remaining in pain. Resident denied pain or discomfort - [DATE]: IDT met with family at this time. Family asked about DNR and hospice. Family stated they are ready to move. forward with the process. At this time, we gave Family the DNR form, and they filled out his part and a referral were sent to a hospice company. No other concerns were voiced at this time. - [DATE] at 09:27 PM- Resident refused breathing treatment, she said she was breathing fine. Resident denied pain or discomfort. - [DATE] at 09:23 PM- Resident denies pain or discomfort. Resident observed calm and pleasant in bed with eyes closed. - [DATE]: Resident #49 refused care, treatment, and meal in the morning. She shouted No, let me die, leave me alone! Hospice RN made aware, and RP stated Resident #49 had been making statements of this nature to her guests. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There was no other documentation to show Resident #49's MD was notified, Resident #49 received psychiatric evaluation/consultation, Resident #49 was evaluated by social services or any other nursing facility staff about her mental state/psychosocial condition. - [DATE] at 06:53 AM- Resident continues with routine pain medication and comfort measures as needed. All needs met, vitals stable - [DATE] at 02:54 PM- Resident states he wants to die. This started on [DATE]. The following makes this condition WORSE: resident being in pain. - [DATE]: Patient psychosocial goals are to adjust to the facility. Patient social services need to provide home health and DME. No ancillary services. There have not been any changes in the RES's family status over this past quarter. The res does get along with res and staff. The res does have family contact and involvement in help with D/C Record review of Resident #49's Clinical Assessments on [DATE] at 12:36 PM revealed, Resident #49 did not have any clinical assessments, SBARs or social services assessments completed after her statement of wanting to die made on [DATE]. Record review of Resident #49's EMR on [DATE] at 04:12 PM revealed, Resident #49 had no documented psychologist, psychiatry visits after stating she wanted to die on [DATE]. An observation on [DATE] at 09:33 AM revealed, Resident #49 received oxygen via nasal canula between 3.5-4 L/min. The resident was dressed in a hospital gown, appeared well fed and in no immediate distress. Resident #49 woke up and said she had no current issues or concerns, and she would talk to the surveyor at a different time. An observation on [DATE] at 02:45 PM revealed, Resident #49 in bed grimacing from pain. The resident said she could not think because of her pain and the pain was due to an ulcer on her bottom. She said the pain was so severe that she could not sleep, and she pressed the call light, but no one answered. The resident and the surveyor both pressed the call light and the light that indicated a call did not work. At 02:55 PM, the Administrator entered Resident #49's room after the surveyor notified her of the malfunctioning call light. She first pressed the call light to verify it was not working, then she unplugged the call light and plugged it back in, and at that time the call light became functional. The resident did not communicate any other form of distress beyond the pain from her sacral ulcer; she would not elaborate further on her mental state or feelings. An observation and Interview on [DATE] at 03:24 PM revealed, Resident #49 received wound care with the Wound Care Nurse and CNA F. The resident was on her right side with support from CNA F and wound care was completed with good technique. Resident #49 said her pain medication had been working and her pain medications were received regularly. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 12:15 PM, the DON said when a resident experienced a change of mood the nursing staff must immediately notify the administrator and DON, then the social worker interviews the resident and finally a referral for psych services should be made. She said the assessment must be immediate/ the same day. The DON said if a resident said they want to die; the statements need to be investigated immediately to find out more information like why. She said additional interventions like increased observation of the resident, and every staff member providing care for the resident should be aware of the resident's change of mood. The surveyor notified the DON that Resident #49 stated that she wanted to die on [DATE] and the DON said she was not aware of the president's statement. The DON said the facility should have taken immediate action to address Resident #49's statement that she wanted to die faster, they should have immediately notified the social worker to ensure the resident was safe and not a danger to herself or others. She said the facility had not taken any action to address Resident #49's change of mood. In an interview on [DATE] at 01:00 PM, the DON said Resident #49 was seen by her hospice nurse on [DATE] but they did not notify the facility of any concerns regarding the resident's statements of wanting to die. She said after learning about the resident's statements from the surveyor, she just completed a stat psych referral, and social services would visit the resident. The DON said the facility had not performed a mood or behavioral assessment of Resident #49 or put any interventions in place since she made the statement of wanting to die on [DATE] but she said it's going to be happening. The DON said when a resident made a statement that they want to die, the facility was expected to report and discuss the situation in their 24-hr. report, communicate the incident with all staff and follow up initiated with the resident. She said not having timely response to mood or behavioral changes could place residents in mental distress. In an interview on [DATE] at 02:58 PM, Psychiatric NP A said previously she was not following Resident #49, but she received a psychiatric consultation request today ([DATE]) at 02:18 PM. She said she received a STAT referral from the facility to evaluate the resident, which meant she would see Resident #49 by the next working day. Psychiatric NP A said since Monday was a holiday she would see Resident #49 on Tuesday [DATE], and the interventions in place prior to her visit with the patient was facility dependent/specific. In an interview on [DATE] at 03:03 PM, the MD said a resident stating they wanted to die was a mood change and she expected to receive notification within hours and the social worker should be informed. The MD said she was actively having conversations with Resident #49 about end of life and was discussing her choices of comfort care and eventually Resident #49 was placed on hospice. She said she was not notified of Resident #49's statement that she wanted to die on [DATE], but she was told by staff that she was saying that during the week ([DATE] to [DATE]). She said she never heard or discussed it with the resident but she heard rumors from staff. The MD said she expected staff to immediately assess and document a resident's change of mood and immediately notify the MD of MD on call. In an interview on [DATE] at 04:35 PM, the Social Worker said she last saw the resident on [DATE], but the resident did not feel well at the time. She said she was not aware that Resident #49 said she wanted to die on [DATE] and she had not performed a mood or behavioral assessment of Resident #49's. The Social Worker said when a resident reports a change in mood, staff were expected to initiate an assessment, notify the ADON/DON of the resident's change in mood, and document it as a change of condition. She said failure to assess and take immediate action after a resident experienced a change in mood could place residents at risk of psychosocial discomfort, depression, and psychosocial distress. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 03:45 PM, LVN C said Resident #49 was actively dying when she made the statement that she wanted to die so she took it as the resident verbalizing her feelings. She said in the morning of [DATE] she woke Resident #49 up to have breakfast and she looked at her tray and shouted she wanted to be left alone and wanted to die. LVN C said she reported the incident to ADON A, the residents family member son, the hospice service but she did not remember if she notified the doctor. She said Resident #77 had accepted her condition (terminal illness) and did not want to continue. LVN C said Resident #49 was in pain sometimes, but her pain was well controlled. She said the facility was repositioning the resident every 1-1/2 hours, she had an air mattress, wedges in place and received wound care as ordered. LVN C said she was not sure if Resident #49 received any behavioral interventions or monitoring after she verbalized, she wanted to die. She said she did not know the procedure to handle residents who voiced suicide but if the resident was not on hospice, she would have called for a psych consult and placed the resident on 1on1 observation. LVN C said she did not take Resident #49's statements as suicidal ideation because the resident was actively dying/received hospice. Resident #77 Record review of Resident #77's Face Sheet dated [DATE] revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: diabetes, colostomy (is a surgical procedure that creates an opening in the abdominal wall to allow stool to exit the body), and anxiety disorder. Record review of Resident #77's admission MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 15 out of 15, little interest or pleasure in doing things, resident did not report feeling down, depressed, or hopeless, no social isolation or behavioral symptoms. Record review of Resident #77's Care Plan completed [DATE], focus- risk for altered mood state related to depression; interventions- administer medications per MD order, document staff interventions in the clinical record, listen when resident is upset and try to resolve the issue, psych referral as needed. Focus- uses antidepressant medications; interventions- monitor/report as needed adverse reactions to antidepressant medications: change in behavior/mood/condition . social isolation, suicidal thoughts, and withdrawal. Record review of Resident #77's SBAR with effective [DATE] at 02:54 PM revealed, before calling MD/NP/PA a- evaluate the resident, c- review record: recent progress notes, labs, orders. The change in condition, symptoms, or signs I am calling about is/are resident states he wants to die. This started on [DATE]; things that make the condition/symptoms worse are resident being in pain; this condition, symptom, or sign has occurred before: No. Record review of Resident #77's Psychiatric Subsequent assessment dated [DATE] revealed, medical necessity for visit- per facility request for crisis. Resident reported chronic anxiety, depressive symptoms related to medical issues and endorses recent end of life statement. Assessment (RN) or Appearance (LPN), LPN- the resident appears: upset but safe. Request- other new orders: psych eval, reported to NP. Record review of Resident #77's Progress Notes printed [DATE] revealed, (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] at 03:34 PM- per therapy staff resident states he wants to die, maybe upset about room change. Resident in bed at time in safe position call light in reach. The writer asked the resident why he was upset resident states do not talk to me social worker notified NP and [family member] made aware. Record review of Resident #77's Trauma Screening Assessment effective [DATE] at 02:09 PM revealed, the assessment was blank. No assessment was documented. Record review of Resident #77's Order Summary dated [DATE] at 02:31 AM revealed, Hydrocodone w/ Acetaminophen 5-325 mg- Give 1 table by mouth every 6 hours as needed for pain, initiated [DATE]. Hydrocodone w/ Acetaminophen 05-325 mg- Give 2 tablet by mouth every 6 hours as needed for pain, initiated [DATE]. Fentanyl 25 mcg/hr. patch- apply 1 patch one time a day every 3 days, initiated on [DATE]. Record review of Resident #77's [DATE] MAR revealed, all PRN administration of Hydrocodone was effective on follow up pain assessment. An observation and interview on [DATE] at 10:05 AM revealed, Resident #77 in bed, resident appeared to be sleeping and said he was all right when surveyor tried to talk to him. The resident would not further interact with the surveyor. An observation and interview on [DATE] at 11:07 APM revealed, MD and LVN X talking to each other as they came out of a resident's room. When the surveyor entered the room, Resident #77 was observed in a new room in bed. Resident #77 said he was in pain and could not talk. He said the facility moved his room because something was not working in the room. The resident looked away and would not further interact with the surveyor. Record review of Resident #77's MD Progress note dated [DATE] revealed, Patient seen lying down with head of bead elevated. The resident complained of pain to his back and to his stomach with no report of cramps. Breathing was stable with no wheezing noted. The MD discussed adding a fentanyl patch and increasing his hydrocodone to 2 tablets every 6 hours for pain until fentanyl is placed and then it will continue as needed. In an interview on [DATE] at 01:04 PM, LVN X said Resident #77 had cancer and returned from the hospital with a colostomy after colitis. She said she was working with the resident since he was on the other hall. LVN X said the resident received therapy and reported pain for the last 2 weeks since his colostomy and he was being treated with PRN medications. She said she had not observed any changes in Resident #77's behaviors and the resident did what he wanted. LVN X said Resident #77 had not complained about wanting to die and had not heard about any such complaints or complaints about suicide. She said if she was notified that a resident wanted to die, she would expect the social worker to be notified and the DON as well. LVN X said so far, the resident has not had any additional behavioral monitoring, and management had not communicated any interventions such as behavioral monitoring or increased supervision. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 01:45 PM, ADON A and the Interim DON said the IDT discussed residents daily in their stand-up meeting when they go over progress notes that appeared on the 24-hour report. They said they had only discussed his room change in the standup meeting because he was changed from the 100 to 500 hall. The Interim DON said they had not heard about the resident wanting to die, or anything like that. ADON A said she may have heard that the resident said he wanted to die because she did a psych consult for him on [DATE]. ADON A and Interim DON said when a resident made a statement like they wanted to die, they should be immediately assessed and placed on observation. The Interim DON would not state what the facility's expectation of staff or interventions required when a resident stated they wanted to die, she said it depended on the assessment. The Interim DON said at the moment she did not see any form of documentation that an assessment was completed for Resident #77 after he said he wanted to die. In an interview on [DATE] at 01:55 PM, the Social Worker said the first time she talked to Resident #77 about his statement that he wanted to die was today, [DATE] at approximately 12:00 PM but she had not had the opportunity to document her visit. She said when she met with the resident, he said he was fine, but she did not ask the resident specifically if he wanted to die but asked all the questions in the PH-Q9 (depression assessment). The social worker said she asked Resident #77 what was going on and he said there were a lot of people going in and out of his room and would not further elaborate. She said her coworker told her Resident #77 said he wanted to die at around 09:00 AM and she saw him at 12:00 PM. The Social Worker said she had seen Resident #77 once and will see him again because she was new to her position and the first time a resident saw a resident they may not open up. The social worker said she had not gone back after the visit at 12:00 PM to see Resident #77 and she did not read the resident's progress notes that showed the resident was reporting pain and a room change being exacerbating factors for the resident feeling like he wanted to die. The Social Worker said the physical therapist her coworker said the resident was safe, and she asked the resident how he was feeling and did not ask about his pain, or room changes and how they made him feel. She said normally if a resident made a statement that they wanted to die, the nursing team would normally review the resident, make medication changes, and have an impromptu IDT meeting to discuss the statement, but the facility had not had a meeting regarding Resident #77's statements. The surveyor asked the Social Worker to read the time she was notified of Resident #77's statement of wanting to die by her coworker; she checked her phone and said 12:00 PM on Monday ([DATE]). After reading the text and confirming the date, the Social Worker changed her narrative and said she first talked to Resident #77 on Monday [DATE]. In an interview on [DATE] at 02:10 PM, the DON said Resident #77 was seen today, [DATE] and his MD gave an order for Fentanyl because the resident's pain was not well controlled on his medications on [DATE]. She said Resident #77 recently got a colostomy, and that was the cause of his self-esteem issues, and possibly why he was depressed. The DON said she talked to the resident, and he did not verbalize any suicidal ideation. In an interview on [DATE] at 02:15 PM, PT A said as she worked with Resident #77 on [DATE] the resident said, I want to die, I want to die, don't tell anyone I said that. She said she immediately put the resident back in bed and immediately notified the charge nurse, who was not a regular full-time nurse she knew, and the DOR. PT A did not report Resident #77 was in pain during the therapy session. Record review of Resident #77's PT Therapy Progress Report dated [DATE] signed by PT A revealed, there was no documentation of Resident #77 being in pain during the therapy session. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 04:19 AM, the Psychiatric NP B said she had just interviewed Resident #77, but the interview was short because the resident was not feeling well since he experienced nausea and vomiting. She said Resident #77 reported feeling safe and was already receiving Buspar for his old diagnosis of depression. Psychiatric NP B said Resident #77's Paxil, an antidepressant, was increased recently in response to his behaviors, she said Resident #77 had no intention to harm himself. Psychiatric NP B said she had limited availability to talk to the surveyor because she had emergent issues with other residents, she had to take care of. In an interview on [DATE] at 03:03 PM, the MD said she was not aware when she saw Resident #77 on [DATE] that he wanted to die, she said she talked to him about pain that required an increased in the use of his PRN pain occurred [DATE]. The MD said in response to the reported pain and increased used of PRN medications on [DATE] she changed his medications [DATE]. She said she was not told when she arrived the facility, but it was possible the on-call physician was notified. After reviewing the on-call physician's notes the MD said, the on-call physician was notified of Resident #77's statement and an order for a psych consult was given . The MD said when a resident state they want to die, the facility staff were expected to ensure the resident got a psychological consult and the resident should be interviewed to figure out what happened. The MD said most of Resident #77's issues were regarding pain, and his medication was increased. She said the resident says his pain was better so in her mind his is improving and in a better mood. The MD said Resident #77 said he wanted to die because of the pain, and the facility had put interventions in place since they changed his pain medication/treatment. Record review of the facility policy Behavioral Assessment, Intervention and Monitoring revised 04/2023 revealed, 1.The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and comprehensive assessment. continues on next page. Management 1.The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. a. atypical behavior will be differentiated from behavior that is dangerous or problematic for the resident(s) or staff, or behavior that signals underlying distress. b. If the behavior is atypical but not problematic or dangerous and the resident does not appear to be in distress, then the IDT will monitor for changes but not necessarily intervene to normalize the behavior. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. An IJ that started on [DATE] was Identified on [DATE]. The Administrator was notified of the IJ, and the template was provided to the facility on [DATE] at 04:45 PM. The following Plan of Removal submitted by the facility was accepted on [DATE] at 04:37 PM. Plan of Removal (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Name of facility: [Ridgewood At the Woodlands Rehabilitation and Healthcare Center Date: [DATE] F-740. Problem: The facility failed to take action for resident #49 and resident #77 when they expressed to staff that they wanted to die. 1.Resident #49 and resident # 77, no longer a resident in the facility. a. Resident #49 Expired on Hospice Services b. Resident #77 Currently hospitalized , Dx: Sepsis, with intent to return 2. The Administrator and DON received 1:1 in-service on the facility Behavioral Health Policy and procedures along with the company expectation to adhere to it by the Vice-President of Clinical Services. Completion date [DATE] 3. [DATE] the facility corporate nurse/DON/SW/designee conducted resident interviews who were able to participate and answer questions regarding their current mood status, pain needs, and identify any passive and active suicidal thoughts. No residents voiced current suicidal thoughts, intent for self-harm passive suicidal thoughts and/ or uncontrolled pain. Completion date [DATE] 4. The Facility Corporate nurse reviewed the Behavioral Health Services policy and procedure no changes were needed. Staff in-serviced on policy and procedure. Completion [DATE] Interventions 5. [DATE] The facility DON/Designee conducted an in-service with all facility License nurses and the social worker on adhering to the facility Behavioral Health Policy focusing on addressing resident behavioral needs. Completed [DATE] 6. [DATE] the DON/Designee initiated an in-service with the facility nursing staff (C.N.A, LVN's and RN) on Communicating Changes in Condition via the STOP and WATCH tool, including but not limited to changes in resident moods, expressing thoughts of suicide, increased pain, etc. Completed [DATE]. 7. [DATE] the DON/Designee initiated an in-service with the licensed nurses regarding communicating changes in condition including but not limited to changes in mood, suicidal thoughts, uncontrolled pain .etc. via SBAR to the physician to initiate and or change resident treatment, orders, recommendation for psych referral, transfers out to the hospital. Completed [DATE] 8. Staff will not be allowed to work until after completion of in-service. Completed [DATE]. (continued on next page)

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Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. [DATE] the Administrator/ Designee initiated an in-service on Maintaining the Mental and Psychosocial Wellbeing of Hospice Residents with staff. The in-service includes approaches staff can take to address and improve resident's psychosocial wellbeing. Monitoring 10. [DATE] The DON and administrator are immediately notified of residents expressing passive or active suicidal ideation, uncontrolled pain to provide guidance and ensure proper assessment, and interventions are done completed. Issues identified will be immediately addressed through further education, disciplinary action and or termination of employment. Administrator and DON are on call 24/7. 11. [DATE] The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with all employees. Immediate re-education will be completed by the DNS/designee if any staff is unable to answer appropriately the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Completed [DATE]. 12. [DATE] The Nursing management team reviews Stop and Watch Tools and SBAR for changes in residents' behaviors/mood/ pain needs .etc . daily. Any issues identified will be addressed at this time. 13. [DATE] An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval. Plan approved [DATE] Monitoring of the POR In an interview on [DATE] 11:35 AM with RN A , she said she was trained on resident behavior changes on [DATE]. She said if a resident experienced a mood change of condition you immediately stop what you are doing, RN A said that the resident will be watched constantly, and any issues and information will be reported to DON or Admin so the individual can receive whatever next step help that is needed. All information should be documented in PCC as change of condition and in the progress notes. The RN stated that staff were expected to treat hospice residents the same way they would treat a regular resident in all areas of care. In an interview on [DATE] at 11:43 AM, the Activity Director said she received an inservice on resident behaviors on [DATE]. She said that any mental health or changes in condition, would be reported to the Admin. The Activity Director said that she if a resident experienced a mood change or verbalized thoughts of suicide, she would call for assistance for someone to monitor the resident and then proceed to report to DON and Admin. She said all staff were responsible for ensuring all issues were reported and that residents received treatment and or assistance. The Activity Director said that hospice residents were are treated in the same manner, when dealing with suicidal ideations or changes in behavior. In an interview on [DATE] at 11:50 AM, the Social Worker said she received an in-service on behavior changes and or suicidal ideations. She said staff were trained on how to report in PCC and to report to the [NAME] and Admin. The Social Worker said hospice residents will go through the same process as all other residents in the

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administrating of all drugs and biologicals, to meet the needs of each resident for 1 of 8 residents (Resident #45) and 1 of 4 med carts (200 Hall Med Aide Cart) reviewed for pharmacy services. - The facility failed to administer Resident #45's Carbidopa/Levodopa (a medication used to treat tremors associated with Parkinson's Disease) on time, resulting in the resident experiencing increased tremors. - The facility failed to ensure that the 200 Hall Med Aide Cart did not contain expired OTC Aspirin 325 mg (about the weight of ten grains of rice). These failures could place residents at risk for adverse drugs reactions, side effects and uncontrolled health conditions. Resident #45 Record review of Resident #45's Face Sheet dated 05/22/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: Parkinsonism (a group of disorders that have tremors like those identified in Parkinson's Disease), anxiety disorder, voice and resonance disorders, mild dementia without behavioral disturbance. Record review of Resident #45's Undated Care plan revealed, focus- resident has Parkinson's disease and is at risk for injury from increased tremors and involuntary muscle movements; interventions- assist with ADL's as needed and give meds per order. Record review of Resident #45's Quarterly MDS dated [DATE] revealed that residents wore corrective lenses and had intact cognition as indicated by a BIMS score of 14 out of 15. Resident #45 needed partial/moderate assistance with toileting, showering, lower body dressing, the resident did not have Parkinson's disease but instead had unspecified Parkinsonism. Record review of Resident #45's Physician's Orders dated 01/17/25 revealed: Carbidopa-Levodopa ER 25-100mg- Give 1 tablet by mouth in the morning at Parkinson's Disease; scheduled at 08:00 AM Carbidopa-Levodopa 25-100 mg (IR)- Give 1 tablet by mouth in the morning at Parkinson's Disease; scheduled at 08:00 AM. Carbidopa-Levodopa 25-100 mg (IR)- Give 1 tablet by mouth in the morning at Parkinson's Disease; scheduled at 12:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's Medication Administration Record provided by the Administrator of 05/21/25 at 05:47 PM revealed, the facility failed to administer Resident #45's Carbidopa/Levodopa 25-100 mg IR tablets within 1 hour of the scheduled administration time on: 1. 03/31/25 scheduled at 08:00 AM; administered at 09:06 AM. 2. 04/01/25 scheduled at 12:00 PM; administered at 01:08 PM. 3. 04/07/25 scheduled at 08:00 AM; administered at 09:03 AM. 4. 04/09/25 scheduled at 08:00 AM; administered at 09:12 AM. 5. 04/13/25 scheduled at 08:00 AM; administered at 09:08 AM. 6. 04/14/25 scheduled at 08:00 AM; administered at 09:26 AM. 7. 04/15/25 scheduled at 08:00 AM; administered at 09:03 AM. 8. 04/16/25 scheduled at 12:00 PM; administered at 01:03 PM. 9. 04/19/25 scheduled at 08:00 AM; administered at 09:30 AM. 10. 04/21/25 scheduled at 08:00 AM; administered at 09:27 AM. 11. 04/22/25 scheduled at 08:00 AM; administered at 09:01 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. 04/23/25 scheduled at 08:00 AM; administered at 09:04 AM. 13. 04/24/25 scheduled at 08:00 AM; administered at 09:04 AM. 14. 04/26/25 scheduled at 08:00 AM; administered at 09:01 AM. 15. 04/27/25 scheduled at 08:00 AM; administered at 09:01 AM. 16. 04/28/25 scheduled at 12:00 PM; administered at 01:12 PM. 17. 05/01/25 scheduled at 08:00 AM; administered at 09:14 AM. 18. 05/03/25 scheduled at 08:00 AM; administered at 09:05 AM. 19. 05/03/25 scheduled at 12:00 PM; administered at 01:36 PM. 20. 05/04/25 scheduled at 08:00 AM; administered at 09:02 AM. 21. 05/05/25 scheduled at 08:00 AM; administered at 09:07 AM. 22. 05/08/25 scheduled at 08:00 AM; administered at 09:01 AM. 23. 05/09/25 scheduled at 08:00 AM; administered at 10:18 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	24. 05/03/25 scheduled at 08:00 AM; administered at 09:12 AM. 25. 05/12/25 scheduled at 08:00 AM; administered at 09:25 AM. 26. 05/13/25 scheduled at 08:00 AM; administered at 09:05 AM. 27. 05/14/25 scheduled at 08:00 AM; administered at 09:16 AM. 28. 05/15/25 scheduled at 08:00 AM; administered at 09:31 AM. 29. 05/18/25 scheduled at 08:00 AM; administered at 09:08 AM. 30. 05/20/25 scheduled at 08:00 AM; administered at 09:22 AM. Record review of Resident #45's Medication Administration Record provided by the Administrator of 05/22/25 at 12:26 PM revealed, the facility failed to administer Resident #45's Carbidopa/Levodopa 25-100 mg ER tablets within 1 hour of the scheduled administration time on: 1. 03/21/25 scheduled at 08:00 AM; administered at 09:03 AM. 2. 03/22/25 scheduled at 08:00 AM; administered at 10:52 AM. 3. 03/24/25 scheduled at 08:00 AM; administered at 09:36 AM. 4. 03/25/25 scheduled at 08:00 AM; administered at 09:10 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. 03/29/25 scheduled at 08:00 AM; administered at 09:37 AM. 6. 04/02/25 scheduled at 08:00 AM; administered at 11:37 AM. 7. 04/11/25 scheduled at 08:00 AM; administered at 09:23 AM. 8. 04/17/25 scheduled at 12:00 PM; administered at 09:25 AM. 9. 04/23/25 scheduled at 08:00 AM; administered at 09:04 AM. 10. 04/25/25 scheduled at 08:00 AM; administered at 09:24 AM. 11. 04/27/25 scheduled at 08:00 AM; administered at 09:24 AM. 12. 04/28/25 scheduled at 08:00 AM; administered at 09:12 AM. 13. 05/09/25 scheduled at 08:00 AM; administered at 09:01 AM. 14. 05/20/25 scheduled at 08:00 AM; administered at 09:25 AM. 15. 05/21/25 scheduled at 08:00 AM; administered at 11:11 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and and interview on 05/20/25 at 09:10 AM revealed Resident #45 in bed, well dressed, well-groomed in no immediate distress. The resident had her glasses on as she cleaned her eyes with wipes. Resident #45 experienced tremors, as both her legs and hands jerked as she cleaned her eyes. Resident #45 said the facility had failed to administer her medications (Carbidopa/Levodopa) on time and she had Parkinson's Diseases so her medications being on time was important because it controlled her tremors. In an interview on 05/22/25 at 03:55 PM, the Interim DON said resident's diagnoses with Parkinson's Disease suffer from symptoms such as tremors, shuffled walking, and gait. She said Carbidopa/Levodopa was used to keep the symptoms at bay and if it were now administered timely, it would result in the worsening of symptoms. In an interview on 05/22/25 at 04:01 PM, Resident #45 said she was ordered to receive an ER & IR dose of her Carbidopa/Levodopa at 08:00 AM and an IR dose at 12 PM. She said on the previous day (05/21/25) she did not receive her ER dose until 11 AM. Resident #45 said the facility failed to give her Carbidopa/Levodopa on time frequently which caused her tremors to worsen making it difficult for her to complete tasks. An observation and interview on 05/23/25 at 08:55 AM revealed Resident #45 sitting in a wheelchair as she read a book placed on her bedside table. The resident wore glasses and had no visible tremors. Resident #45 said she did not have tremors at the time because she had received her Parkinson's medications on time. She said when she received her medications timely, she had little to no tremors, but when the administration times were not consistent, her tremors would get worse making her unable to do basic things. In an interview on 05/23/25 at 12:15 PM, the Interim DON said all medications must be administered within 1 hour of the scheduled administration time. She said the facility identified concerns that Resident #45 had not received her Carbidopa/Levodopa timely, but she had not reviewed the records to determine how late the medication was administered or how often it was administered late. She said failure to administer Resident #45's Carbidopa/Levodopa on time placed the resident at risk of tremors, rigidity, and pain. 200 Hall Med Aide Cart In an observation and interview on 05/21/25 at 08:17 AM, inventory of the 200 Hall Med Aide Cart with MA A revealed: - An expired, open, and in-use bottle of Aspirin 325 with an expiration date of 03/25/25. MA A said nursing staff are expected to check their carts daily as used for expired medications. She said when medications expired, they could lose potency, have decreased efficacy and if administered could cause side effects in residents such as GI upset. In an interview on 05/23/25 at 09:56 AM, the Interim DON said nursing staff are expected to check their carts daily for expired medications. She said when medications expired there can be a change in their efficacy/potency, so they must be discarded. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Medication Administration revised 01/2025 revealed, Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 12- Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time. a- refer to drug reference if unfamiliar with the medication, including the mechanism of action or common side effects. b- Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Record review of the Pharmacy and Therapeutics (P &T) journal article titled Delayed Administration and Contraindicated Drugs Place hospitalized Parkinson's Disease Patients at Risk published [DATE] revealed, Patients with Parkinson's disease require strict adherence to an individualized, timed medication regimen of antiparkinsonian agents. Dosing intervals are specific to each individual patient because of the complexity of the disease. It is not unusual for patients being treated with carbidopa/levodopa to require a dose every one to two hours. When medications are not administered on time and according to the patient's unique schedule, patients may experience an immediate increase in symptoms.2 Delaying medications by more than one hour, for example, can cause patients with Parkinson's disease to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 medication carts (200 Hall Med Aide Cart) and 1 of 8 residents (Resident #45) reviewed for medication storage . The facility failed to ensure Resident #45 did not have unauthorized and unsecured OTC eyedrops at her bedside. The facility failed to ensure that the 200 Hall Med Aide Cart did not contain: loose pills and inappropriately labeled oral and liquid protein supplements. These failures could place residents at risk for adverse drugs reactions, side effects and uncontrolled health conditions. Findings include: Resident #45 Record review of Resident #45's Face Sheet dated 05/22/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: Parkinsonism (a group of disorders that have tremors like those identified in Parkinson's Disease), anxiety disorder, voice and resonance disorders, mild dementia without behavioral disturbance. Record review of Resident #45's Undated Care plan revealed, focus- resident has Parkinson's disease and is at risk for injury from increased tremors and involuntary muscle movements; interventions- assist with ADL's as needed and give meds per order. Record review of Resident #45's Quarterly MDS dated [DATE] revealed, the use of corrective lenses and intact cognition as indicated by a BIMS score of 14 out of 15. Resident #45 needed partial/moderate assistance with toileting, showering, lower body dressing, the resident did not have Parkinson's disease but instead had unspecified Parkinsonism. Record review of Resident #45's Physician Order dated 05/21/25 at 06:06 PM revealed, Systane eye drops (a lubricant)- 1 drop in both eyes every four hours as needed for dry eyes. Record review of Resident #45's Order Summary Report dated 05/22/25 revealed Resident #45 did not have an order for eye drops prior to 05/21/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 05/20/25 at 09:10 AM revealed Resident #45 in bed, well dressed, well-groomed in no immediate distress. The resident had her glasses on as she cleaned her eyes with wipes. Resident #45 experienced tremors, as both her legs and hands jerked as she cleaned her eyes. There was a cart at the resident's bedsides that contained boxes of Refresh Celluvisc and Systane lubricant eye drops. Resident #45 said she had her eyedrops at her bedside and administered the eyedrops herself. She said she had not been trained to self-administer the eyedrops and no one had informed her the eyedrops should not be stored at her bedside. An observation and interview on 05/22/25 at 04:01 PM revealed Resident #45 sitting in a wheelchair beside her bed. The cart beside her bed no longer contained eyedrops. The resident said facility staff had removed her eyedrops yesterday, and she did not know she was supposed to have them. Resident #45 said she had the eyedrops in her room since she was admitted in January of 2025 and they were originally on her bedside table, but the facility staff said she could not place them there, so she moved them to the cart on the side of her bed. Resident #45 said since the eyedrops were an OTC, she did not think it was an issue for her to keep them in her room. In an interview on 05/22/25 at 03:55 PM, the DON said she was not aware of Resident #45 had eyedrops at her bedside until it was identified by the survey team. She said the eyedrops were removed from the resident's room on 05/21/25 and since Resident #45 did not have an order for the medication, her physician entered in an order for lubricant eyedrops in the evening of 05/21/25. She said unauthorized storage of medications could result in interactions and side effects if the medication is used without the provider's knowledge. She said all medications, even those used for residents who self-administer their own medications, should be locked away to ensure residents' safety. In an interview on 05/23/25 at 09:56 AM, the Interim DON said nursing staff are expected to check their carts daily for inappropriately labeled, inappropriately packaged medications and staff are expected to identify and report any unauthorized medications found in resident rooms during their daily rounding. She said all medications should be secured inside their original containers with pharmacy or manufacturer labeling and stored in medication carts/rooms. She said loose pills should be destroyed in the drug buster because they are gross and dirty and their presence could place residents at risk for unintended administration. The Interim DON said medications should not be stored in resident rooms, and they should be secured at all times. She said Resident #45 should not have medications stored at her bedside, and she did not know how long the resident had her eyedrops in her room because she never asked the resident. She said nursing staff are expected to look for any potential hazards when rounding with residents and the resident's unauthorized and unsecured medications were a hazard in case someone gained access to the medication and administered it. 200 Hall Med Aide Cart In an observation and interview on 05/21/25 at 08:17 AM, inventory of the 200 Hall Med Aide Cart with MA A revealed: - An expired, open, and in-use bottle of Aspirin 325 with an expiration date of 03/25/25. - An open and in-use bottle of ProStat concentrated liquid protein with no open date and manufacturer instructions that read Discard 3 months after opening. -4 loose pills of varying sizes and colors (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An open and in-use bottle of Fish Oil 1000 mg (about the weight of a small paper clip) soft gel with no visible expiration date. MA A said nursing staff are expected to check their carts daily as they are used for loose pills, inappropriately labeled medications, and expired medications. She said medications should be stored in their original containers with pharmacy and/or manufacturer labeling, and multidose containers like liquid protein must be labeled with the date when opened to track the expiration date. She said when medications expired, they could lose potency, have decreased efficacy and if administered could cause side effects in residents such as GI upset. Record review of the facility policy titled Medication Storage revised 05/2023 revealed, 1-General Guidelines: a- all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prepare puree and regular food by methods that conserve nutritive value, flavor, texture and appearance for 3 out of 5 residents reviewed for food and nutrition dietary services (Residents #2, #40, #73). The facility failed to ensure that puree diet and regular diet was prepared by methods that conserve nutritive value, flavor, and appearance. This failure could place residents on regular diet and puree diet at risk of receiving inadequate diet that could affect their health. Findings included: Record review of the face sheet for Resident #2 revealed a [AGE] year-old female with admission date of 01/30/2025 and diagnoses including Type II Diabetes Mellitus (inability of pancreas to produce insulin to lower blood sugar), Hypertension (high blood pressure), Dysphagia (difficulty swallowing, Chronic Kidney Disease (long standing problems with the kidneys function). Record review of Resident #2's admission MDS revealed a BIMS score of 13, indicating intact cognitive ability. Record review of the face sheet for Resident #40 revealed an [AGE] year-old female with admission date of 04/11/2024 and diagnoses including Hypertension (high blood pressure), Cerebrovascular Disease (affect blood flow in the brain), Atherosclerotic Heart Disease (fatty deposits in your arteries). Record review of Resident #40's admission MDS revealed a BIMS score of 13, indicating intact cognitive ability. Record review of the face sheet for Resident #73 revealed an [AGE] year-old female with admission date of 06/20/2024 and diagnoses including Neuropathy (damage, disease, or dysfunction of one or more nerves), Type II Diabetes Mellitus (inability of pancreas to produce insulin to lower blood sugar). Record review of Resident #73's admission MDS revealed a BIMS score of 15, indicating intact cognitive ability. Observation of Surveyors test meal trays on 05/21/2025 at 12:08 pm revealed the pureed okra was too thick. Regular meal revealed the pinto beans was too salty. Interviewed on 05/21/2025 at 3:20 pm, The Dietary manager after he tasted the puree meal, he stated the okra was too thick, the cook did not use enough broth to puree the okra. For the regular meal Dietary manager stated, the pinto beans were too salty. He stated the cook followed the recipe, but he did not taste the food prior to sending the food out. The Dietary Manager stated the cook was nervous during the meal prep as the surveyor had requested 2 trays for taste testing and thinks this was a one time event. The Dietary Manager stated he did not feel the puree food being thick would affect residents on puree diet and too much salt could impact residents blood pressure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675739	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood at the Woodlands	10450 Gosling Rd The Woodlands, TX 77381

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/21/2025 at @ 4:04 pm Resident #2 stated the pinto beans were very salty. Interview on 5/21/25 at @ 4:07 pm with Resident #40 regarding the lunch meal today she stated the beans were very salty. Interview on 5/21/25 at @ 4:12 pm with Resident #73 regarding the lunch meal today she stated the beans were too salty. Record Review: Food Preparation Guidelines: Policy Date Reviewed/ Revised: 09/06/2024: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Definitions: Food Palatability refers to the taste and/or flavor of the food. Policy Explanation and Compliance Guidelines: 1.The cook, or designee, shall prepare menu items following the facility's written menus and standardized recipes. 2. Food shall be prepared by methods that conserve nutritive value, flavor and appearance.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 dining room reviewed for essential equipment. The facility failed to keep the ice machine and water machine free of leaks. This failure could place the residents at risk of slipping on spilled water on the floor and consuming water and ice from equipment which may be contaminated due to malfunction. Findings included: During observation on 5/20/25 at 1:10 PM, the ice and water dispenser in the dining room had a full tray of water below the spickets. When the drawer below the machine was opened, water and dust was found in the bottom of the drawer. Water was also found in the cabinet below. Observation on 5/21/25 at 1:05 PM in the dining room, the ice and water dispenser had out of order sign. Water was no longer in the tray, the drawer, or below the machine. During an interview on 5/21/25 at 3:29 PM, the Dietary Manager reported they were in the process of letting the ice melt so the machine can be moved out and replaced. It had been leaking when the ice melted so the staff will not be using it anymore. An out of order sign has been placed on the machine to remind staff not to use it. A new machine was ordered and it should be there in a day or so. During observation on 5/22/25 at 12:30 PM, observed the out of order sign still on ice and water dispensing machine. During an interview on 5/23/25 at 11:20 AM with the Maintenance Director, he reported he was not made aware of the ice and water dispenser in the dining room was malfunctioning until Tuesday, 5/20/25. He also reported that he disconnected the machine immediately and put an out of order sign on it. The ice that was remaining in the machine was melting and the water was draining out so it could be moved. He has been emptying the tray since he was informed that it was leaking. He also cleaned out the drawer that had the water in it. It can no longer dispense anything so staff and residents can't use it. Approval to purchase a new machine and a new countertop has just been attained so new equipment will be ordered shortly. Policy on maintaining equipment in safe operating condition requested from the Administrator on 5/23/25 at 3:38 PM. The policy was not received.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1(Resident #49) of 10 residents reviewed for resident call system in that: - The facility failed to ensure Resident #49'scall light was in working order leaving the resident in pain. This failure could leave residents in pain due to their call light not functioning. Findings included: Resident #49 Record review of Resident #49's Face Sheet dated [DATE] revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: bone cancer, shortness of breath, anal cancer, cognitive communication deficit, difficulty swallowing and pressure ulcer on her sacrum (triangular bone at the base of the spine). Record review of Resident #49's undated Care Plan revealed, focus: pneumonia; intervention: monitor/document/report to MD as needed for the following symptoms of pneumonia: fever, chills, cough, fast breathing, low oxygen. Focus: receiving nebulizer breathing treatments; interventions- monitor O2 saturation (levels) as needed or per orders, administer breathing treatments as ordered by MD. Focus: Hospice services due to terminal illness of anal cancer; intervention- assist with ADLs and provide comfort measures as needed, monitor for signs and symptoms of increased pain, discomfort-give medications/treatments monitor for relief. There was no focus area for oxygen administration. Record review of Resident #49's Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. Record review of Resident #49's Change of Condition MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15 and use of O2 was not indicated. The resident was on hospice, Pain was present with rare impact on sleep, rare interference with therapy activity and occasional interference with day-to-day activities. Record review of Resident #49's Hospice RN Comprehensive Visit dated [DATE] revealed, Resident #49 was experiencing pain. was uncomfortable due to her pain and her pain was located on her rectum. Mental status: disoriented, withdrawn, forgetful, unable to report anxiety/depression due to not responding. Resident #49 was co-operative, indifferent, and showed abnormal behavior/mood and effect because she was withdrawn. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's Order Summary Report dated [DATE] revealed, Admit to Hospice. Hospice Care effective [DATE]; diagnosis: anal cancer and other conditions of cancer spread to the bone. Oxycodone w/ Acetaminophen 5-325 mg- give 1 tablet every 12 hours for pain management. Oxycodone w/ Acetaminophen 5-325 mg- give 1 tablet every 6 hours as needed for pain level 7-10. Morphine 20 mg/ml- give 0.25 ml by mouth every 6 hours for severe pain. Morphine 20 mg/ml- give 0.25 ml by mouth every 4 hours as needed for pain and shortness of breath. The record indicated that Oxycodone was discontinued when the resident was started her Morphine Sulfate on [DATE]. An observation on [DATE] at 02:45 PM revealed, Resident #49 in bed grimacing from pain. The resident said she could not think because of her pain and the pain was due to an ulcer on her bottom. She said the pain was so severe that she could not sleep, and she pressed the call light, but no one answered. The resident and the surveyor both pressed the call light and the light that indicated a call did not work. At 02:55 PM, the Administrator entered Resident #49's room after the surveyor notified her of the malfunctioning call light. She first pressed the call light to verify it was not working, then she unplugged and re-plugged the call light , and at that time the call light became functional. The resident did not communicate any other form of distress beyond the pain from her sacral ulcer; she would not elaborate further on her mental state or feelings. The Administrator said the call light must have malfunctioned, and it was working now once she unplugged and re-plugged it. In an interview on [DATE] at 02:59 PM, CNA X said she had just checked on Resident #49 recently and the resident expressed some discomfort as she repositioned her and at that time her call light was working. She could not say exactly when that occurred, but it was earlier in the day. In an interview on [DATE] at 03:00 PM, LVN D said she provided service to the resident recently and was unaware her call light was not working. She said the resident was in pain and needed repositioning because she had been lying on be bottom with her body titled towards the window. An observation and Interview on [DATE] at 03:24 PM revealed, Resident #49 received wound care with the Wound Care Nurse and CNA F. The resident was on her right side with support from CNA F and wound care was completed with good technique. Resident #49 said her pain medication had been working and was received regularly. In an interview on [DATE] at 09:56 AM the DON said call lights should be within reach and functional as failure to do so could result in a delay in care, failure to identify changes in condition, worsening of condition or pain. Record review of the facility policy titled Call Lights: Accessibility and Timely Response revised 02/2023 revealed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 7. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. 8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace call light, provide a bell or whistle, increase frequency of rounding, etc.).