STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675740	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Nursing & Rehab Center Inc	202 Billie Dr Fredericksburg, TX 78624

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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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that the assessment accurately reflected the residents' status for 2 of 7 (Resident #10 and Resident #20) whose MDS assessments were reviewed in that: Resident #10 had a diagnosis of anxiety and depression that was not coded on the MDS assessment.Resident #10 had orders for psychotropic medications that were not coded on the MDS assessment.Resident #20 had a diagnosis of Alzheimer's disease and depression that was not coded on the MDS assessment. This deficient practice could place residents at risk for inadequate care and services to meet their needs based on inaccurate MDS assessments.Findings included: Resident #10Review of Resident #10's admission Record dated 1/20/2026 reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included other specified viral disease (encompass a range of viral infections that do not fit neatly into established categories), weakness, and repeated falls. Review of Resident #10's Care Plan (undated, printed 1/20/2026) reflected the following: The resident uses phychotropic [psychotropic] med (date initiated 1/06/2026) . Intervention: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness (date initiated 1/06/2026) .The resident uses antidepressant medication (date initiated 1/09/2026) . Intervention: Administer ANTIDEPRESSANT medications as ordered by physician (date initiated 1/9/2026) .The resident uses anti-anxiety medications (date initiated 1/9/2026: revision 1/12/2026) . Intervention: Administer ANTI-ANXIETY medications as ordered by physician (date initiated 1/9/2026).The resident has depression (date initiated 1/9/2026: revision 1/12/2026) . Interventions: Administer medications as ordered (date initiated 1/9/2026). Review of Resident #10's Order Summary Report dated 1/12/2026 reflected the following physician's orders: FLUoxetine HCl Oral Tablet 20 MG Give 80 mg by mouth one time a day for DEPRESSION (order date 12/29/2025) ALPRAZolam Oral Tablet 0.25 MG Give 0.25 mg by mouth two times a day for ANXIETY (order date 12/29/2025) Review of Resident #10's Consent for Antipsychotic or Neuroleptic Medication Treatment consent form dated 12/31/2025 reflected Medication prescribed: Alprazolam and Diagnosis/Reason for Treatment was left incomplete. Record review of Resident #10's initial comprehensive assessment dated [DATE] did not reveal an active diagnosis for psychiatric/mood disorders of depression and anxiety. Further review of Resident #10's initial MDS reflected that Resident #10was taking antidepressant and antianxiety medications and there was an indication notified for these medications in the drug class. Resident #20 Review of Resident #20's admission Record dated 1/20/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included encounter for other orthopedic aftercare (denote instances where a patient has an encounter with healthcare providers for aftercare following other orthopedic procedures), cognitive communication deficit (refers to difficulties in communication that arise from underlying cognitive impairments rather than primary language or speech issues), and weakness. Record review of Resident #20's initial comprehensive assessment dated [DATE] did not reveal an active diagnosis for Alzheimer's Disease. Further review of Resident #20's initial comprehensive assessment reflected that Resident #20 was not taking antidepressant nor antianxiety medications. Review of Resident #20's Care Plan (undated, printed 1/20/2026) reflected the following: The (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident has depression r/t (date initiated 1/14/2026).Goal: the resident will remain free of s/sx [signs and symptoms] of distress, symptoms of depression, anxiety or sad mood by/through review date (dated initiated 1/14/2026: revision on 1/18/2026).Interventions: Administer medications as ordered.Arrange for psych [psychiatric] consult, follow up as indicated (initiated 1/15/2026). Review of Resident #20's admission Referral from hospital to Skilled Nursing Facility (SNF) dated 1/2/2026 reflected the following: Medications [ordered list]Donepezil 10 mg Tablet 10 MG PO BEDTIME 1/2/2026 Donepezil (Aricept) 10 mg ODT/10 mg tab Donepezil 10mg tabDonepezil (Aricept) 23 mg tab Two Donepezil 10 mg tabsALZHEIMERS DZ [disease] (start date 1/2/2026)]. Review of Resident #20's Medication Administration Record 1/1/2026 - 1/31/2026 (printed 1/20/2026) reflected the following physician's orders: Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) Give 10 mg by mouth at bedtime for memory deficit (start date 1/5/2026). In an interview on 1/20/2026 at 6:30 PM the DON said the MDS Coordinator was responsible for obtaining information for incoming residents from providers for diagnosis and medications to enter accurately on the initial comprehensive assessment [MDS Assessment] for new admissions. In an interview and record review on 1/20/2026 at 6:45 PM the MDS Coordinator said she was responsible for completing all resident assessments. She said she has been employed for roughly 18 months at this facility and has received training in MDS assessments. She said RN A signs off on the completed MDS assessments. She said the MDS assessment was completed with resident's electronic medical records, which include history and physical notes, progress notes, any physician documentation, psychiatric, and hospital records. MDS Coordinator said if the MDS assessment is not completed accurately it can impact reimbursement and would not capture the whole picture of what was going on with the residents and their care. She said she does not have a staff member providing oversight of her completed assessments other than RN A who signs and certifies that the assessment was completed. MDS Coordinator went over Resident #10's and Resident #20's electronic medical record with surveyor and said she cannot recall why the diagnoses, nor the medications taken were not coded correctly on the MDS assessment and she would look into this further. In an interview and record review with the DON on 1/20/2026 at 7:15 PM she said RN A was responsible for signing and certifying that the assessment was completed. She said she believes RN A reviews the MDS assessments for accuracy. DON said she does not have staff who provide oversight or audits to ensure MDS assessment accuracy. DON went over Resident #10's and Resident #20's electronic medical record with surveyor and said she was not sure why the MDS Coordinator would not have used the supporting documentation in their electronic medical record when completing the admission MDS assessment. She said Resident #10 and Resident #20's diagnoses and medication summary were present in their electronic medical record. She said she does not generate a diagnosis; however, the medication summary was used to identify the residents' diagnoses, which she also uses when developing the initial care plan for each resident. In an interview on 1/20/2026 at 8:15 PM the RN A said she has been employed with the facility for 2 1/2 years and was a charge nurse. She said when the DON left the facility early in 2025, she was asked if she would take on the task of signing and certifying that resident assessments are completed. She said she completed an 8-hour training course online and became responsible with this task as she was an RN. She said the assessment can outline if someone who requires more care to be billed or reimbursed at a higher rate. She added that she believes the MDS assessment was for billing purposes and was not sure of anything else. She said if MDS assessments were not completed accurately then this could affect billing reimbursement for the facility. RN A said she sometimes reviews the MDS assessments against the resident's electronic medical record, but not always. She said she was not reviewing the assessments for accuracy, she was not tasked with auditing them for accuracy, and she was not sure who ensures assessment accuracy. RN A said she believed the assessments were accurate and she signed off with this idea. She said she trusts the MDS Coordinator and never had a reason to think she was being left astray or completing assessments inaccurately. RN A said she was not sure why Resident #10 or Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#20's MDS Assessments were inaccurate as she signed off on them as the RN Assessment Coordinator verifying assessment completion. In a subsequent interview with the MDS Coordinator on 1/21/2026 at 12:10 PM she said the facility does not have specific policy related to initial comprehensive assessments and she follows State regulations and Resident Assessment Manual.No pages of policies related to comprehensive assessments were provided by the facility. Review of Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 reflected the following: In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It was important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, for 2 of 6 NAs (NA C and NA F) reviewed for competent staffing. The facility failed to ensure NA C and NA F completed the required training and competency evaluation program for nursing assistants within four months of full-time employment. This failure could result in incompetent care provided for residents and decreased quality of life. Findings included: Record review of the facility document titled Employee List 01.08.2026 revealed 6 total NAs employed by the facility. The job titles of NA C and NA F were documented as N.A. (nursing assistant), and the job titles for the remaining 4 NAs were documented as C.N.A. (certified nursing assistant). NA C's hire date was listed as 3/24/2024, and NA F's hire date was listed as 9/20/2025. In an interview with the BOM on 1/20/2025 at 9:15 AM, she said NA C has completed all of the requirements required for the nursing assistant program, but she has not yet taken the test. She was unsure why NA C had not taken the test. She was unsure if NA F was enrolled in a competency program but said she did not have a certificate of completion. She said the facility will begin the training requirements with any newly hired NA within the first week of hire, if the staff member has not completed a competency program prior to hire. She was not aware of a timeline imposed by the facility for completion of the program. Record review of the Nurse Aide Public Registry accessed on 1/20/2026 (https://tulip.hhs.texas.gov/TULIP/s/public-search) did not reveal records for NA C or NA F. In an interview with the DON on 1/20/2026 at 10:34 AM, she said she was aware NA C and NA F had both been employed by the facility for greater than four months without completion of the required competency program. She said NA C had not yet taken the test for program completion due to personal issues. She said NA F had just reached four months of employment, and she had not taken her test yet due to issues with the required FBI fingerprinting, a name change after marriage, and credentialing from a nursing program she had completed outside of the country. She said she had no concerns with the competency of NA C or NA F and did not consider there to be potential harm to residents by this deficiency. She said there was no facility policy related to competency program completion by nursing assistants.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of every nurse aide at least once every 12 months and to provide regular in-service education based on the outcome of these reviews for 3 of 6 NAs (NA C, NA D, and NAD E) reviewed for competent staffing. The facility failed to complete a performance review and outcome based in-service education for NA C since hire on 3/24/2024, NA E since hire on 5/20/2024, and NA D since hire on 10/16/2024. These failures could lead to incompetent care provided for residents and decreased quality of life. Findings included: Record review of the facility document titled Employee List 01.08.2026 revealed 5 total NAs employed by the facility. Three of these NAs had been employed by the facility for longer a period greater than 12 months as of 1/19/2026:NA C's hire date was 3/04/2024NA D's hire date was 5/20/2024NA E's hire date was 10/16/2024 In an interview on 1/20/2025 at 9:15 AM with the BOM, she said NA D was incorrectly listed as LVN on the employee roster, and she was actually NA. The BOM said she was unsure where the facility stored the annual performance reviews for NAs as they were typically performed by the DON or ADON. She said the facility should be performing annual reviews of all staff, including NAs but she was unsure if they had been completed for NA C/D/E. In an interview with the DON on 1/20/2026 at 10:34 AM, she said she did not complete annual performance reviews of any staff member, including NA C/D/E. She said the facility did not have a policy or procedure regarding that requirement, and she was unaware it was required for licensure. She said she counseled her staff individually when there was a performance issue, and the annual skills competency from the facility for all NAs was the same every year based on the template provided by the facility. She said she did not think the lack of performance review and subsequent education based on the reviews had potential for harm. In an interview with NA E on 1/21/2026 at 10:00 AM, she said she spoke with the DON whenever she has questions, but she had not ever had a scheduled review of her overall performance in her job. In an interview with the ADM on 1/21/2026 at 11:57 AM, she said they did not complete annual performance reviews and they just talk to them [staff] whenever we need it. She said the facility did not have a policy or procedure regarding performance reviews.

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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 store all drugs and biologicals in locked compartments for 1 of 1 medication storage rooms reviewed for medication storage. The facility failed to ensure the prescription medication MediHoney gel (a topical medication used for wound care) was not stored in a resident's room. This failure could result in residents having unintended access to medications or accidental administration of medications. Findings included: Record review of Resident #45's admission Record dated 1/18/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included weakness. Record review of Resident #45's MDS submissions did not reveal an admission MDS submission. Record review of Resident #45's Order Summary Report dated 1/18/2026 revealed the following physician's orders: May apply barrier cream topically with incontinence care as needed (order date 1/16/2026)Further record review of Resident #45's Order Summary Report did not reveal an order for MediHoney gel (a topical medication used for wound care) application. In an observation and interview on 1/21/2026 at 10:30 AM, NA F and NA E were observed performing routine catheter care for Resident #45. NA F was observed removing a partially used tube of MediHoney gel from the resident's bedside table. NA F was observed applying a layer of MediHoney gel to Resident #45's genitals, thigh creases, and buttocks. NA F said MediHoney gel was the same as barrier cream and used for wounds. She was unsure if Resident #45 had an order from the physician for MediHoney gel. NA E said the barrier cream she typically used for residents did not have the same packaging or appearance as the MediHoney gel. She said she knew which cream to apply during incontinence care by asking the nurse but she had not asked the nurse prior to providing care for Resident #45. In an interview with LVN H on 1/21/2026 at 11:55 AM, she said Resident #45 did not have a physician's order for MediHoney gel application as barrier cream. She said NA F should have told her about the mistake. She was unsure why the MediHoney gel was in Resident #45's drawer and said it should have been stored securely in the medication cart or medication storage room. In an interview with the DON on 1/21/2026 at 12:20 PM she said NA F should not have used any creams on Resident #45 without asking the nurse, and the MediHoney gel should not have been stored in Resident #45's room. She said since Resident #45 did not have an order for MediHoney gel application during wound care, the medication probably belonged to the previous occupant of the room. A policy regarding medication storage was requested from the facility during the interview with the DON but not provided prior to exit.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 dietician and 1 of 1 director of food and nutrition services reviewed. The facility failed to employ a qualified dietician or other clinically qualified nutrition professional from October 2025 to January 2026.The facility failed to employ a full-time director of food and nutrition services. FSS works less than 25 hours per week at the facility. These failures could place residents at risk of not having their nutritional needs met.Findings included: In an interview on 1/21/2026 at 11:00 AM, the FSS said she has been employed with the facility for nearly 21 years. She said a new dietician was hired on to the facility that week on a consultation basis. She said she had yet to be introduced to the dietician and was not familiar with the new contract developed between her and the facility management staff. The FSS said the last dietician, or other clinically qualified nutrition professional, was employed with the facility in October 2025. She said the last dietician resigned abruptly. She said the facility management had challenges with finding a dietician on a consultant basis due to being in a rural area. She said that she worked 40 hours between two different facilities owned by the company at that time. She said she was a salaried staff, and she usually does exceed 40 hours per week. She said she feels she possesses the competencies to carry out the food and nutrition services for the facility. She said that she was tasked with completing resident assessments, collaborating with the physician, DON, speech therapist, resident, and at times, families to develop individual plans of care. She said that all the tasks required of a dietician or other clinically qualified nutritional professional are being met by her. She said there was no effect on residents' nutritional needs by not having a dietician on staff. In an interview on 1/21/2026 at 11:39 AM, the DON said she and the FSS worked together for resident diet changes. She said she works with the speech therapist, and together, they can identify any change in a resident and recommend a diet change. The DON said the facility has been without a qualified dietician or other clinically qualified nutrition professional for a period, and she could not recall the dates. She said she did not see any concerns with the lapse of dietician at the facility as there were other interventions in place to ensure resident nutritional needs were being met. She said the facility was actively seeking a dietician. In an interview on 1/21/2026 at 12:02 PM the ADM said the FSS was not a full-time dietary manager, and she recently hired a dietician on a consultation basis of 16 hours per month. She said the dietician position was vacant for less than six weeks, and during this vacancy, the FSS was tasked with nutrition changes for residents. She said the diets were followed by a physician, and if residents were experiencing weight loss, the DON would take the lead and coordinate with physicians and start interventions for residents. She said she did not see a problem and there was no impact on the residents' nutritional needs by not having a qualified dietician or other clinically qualified nutrition professionals. Record review of document titled, Agreement to Provide Dietary Consultant Services dated 1/14/2026 reflected the following: AGREEMENT made this 14th day of January, 2026 by and between [facility] hereinafter referred to as the Facility and . RD, LD hereinafter referred to as Provider.1. PURPOSEThe purpose of this Agreement is to arrange for dietetic consultation. for the Facility, and when indicated for any resident served by the Facility.3. RESPONSIBILITIES OF THE [NAME]:Consultant shall provide the services of a qualified registered dietitian acceptable to and subject to the approval of the Facility. Said registered dietitian shall assume the exclusive duties of providing consultation to the Facility and personnel located on the premises of the Facility. As such consultant, the registered dietitian shall give guidance and counsel to the nutrition services program as follows:a. Correlate and integrate the nutritional aspects of (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care with other resident care services to include directing the following:Reviewing the resident's medical history and assessing the resident's nutritional status.Interviewing and counseling the residents.Recording pertinent resident information in the medical record.Assessing, planning, and implementing nutrition care for all residents.Developing nutrition care goals.Conferring with other members of the resident care team.Sharing specialized knowledge with other members of the resident's care team.Developing and providing all nutrition assessment forms. Record review of undated document titled, POLICY AND PROCEDURAL GUIDE FOR THE FOOD SERVICES OF [FACILITY]reflected the following: ORGANIZATION OF THE DEPARTMENTA qualified Dietitian will serve as consultant to the Administrator and to the Food Service Supervisor.The Dietary Consultant works with the Administrator and Food Service SupervisorThe consultant will make regular scheduled visits of (16) sixteen hours each month or (20) twenty hours depending on monthly census. Record review of document titled, Dietary Consultant dated March 1, 2012, reflected the following: Purpose: To maintain a dietary department in compliance with roles and regulations of Federal, State and local authorities. To provide therapeutic diets and meals, as prescribed by the physician, in a well-balanced, attractive and appetizing manner under safe, sanitary conditions for a reasonable cost. Qualifications: Must be a professional dietitian who is a member of the American Dietetic Association and meets the registration requirements, or is a graduate of a baccalaureate degree program with major studies in food service management, or foods and nutrition. The Chief Nutritionist, Bureau of Long Term Care and Texas Department of Health shall evaluate and determine suitability of this person. A minimum of 15 clock hours of appropriate continuing education per year shall be completed, reported and approved according to instructions issued by the Texas Department of Health, Long [NAME] Care Division.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 laundry area and 1 of 5 residents (Resident #45) reviewed for infection control. The facility failed to ensure clean laundry was stored to prevent contamination in the laundry room. The facility failed to ensure laundry staff utilized PPE during handling of linen identified as potentially infectious. The facility failed to ensure appropriate level of TBP was initiated for Resident #45. The facility failed to ensure soiled linens from Resident #45 were properly secured and identified for cleaning. These failures could result in the spread of infection and illness, or the unnecessary seclusion and isolation of a resident. Findings included: 1. In an observation and interview on 1/21/2026 at 11:36 AM, a moveable rack of clothing on hangers and a fixed rack of clothing on hangers were observed in the room of the laundry area that contained the washing machine. LA I identified the area as the location in which soiled linens and clothing were sorted. She said the clothing on the two racks was clean, and she knew they should not be stored in their current location, but she was instructed by the DON to put the clothing there. She said the clothing could get contaminated by being stored in that area. In an interview with the ADM on 1/21/2026 at 2:30 PM, she said the clean clothing should not be stored in the area where laundry was sorted due to potential contamination. 2. In an observation and interview on 1/21/2026 at 11:36 AM, no PPE was observed in the sorting area of the laundry area. LA I said if linen is received in a red bag, it means that it is infectious and should be washed separately. She said they use disposable gloves but do not have gowns. She said no one had ever told her to use a gown, and she said she had not received training related to infection prevention or control. In an interview with the DON on 01/21/2026 at 12:14 PM, she said she was the Infection Preventionist for the facility. She said she did not oversee the laundry process because she did not think it related to infection prevention. She said she did not know if laundry aides should be utilizing PPE when handling potentially infectious laundry. She said she had not provided PPE or guidance to the laundry aides regarding infection prevention and control because she did not see the laundry area as a threat of infection spread. 3. Record review of Resident #45's admission Record dated 1/18/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included weakness. Record review of Resident #45's MDS submissions did not reveal an admission MDS submission. Record review of Resident #45's Care Plan Report undated/printed 1/29/2026, did not reveal care planning related to TBP. Record review of Resident #45's Order Summary Report dated 1/18/2026 did not reveal an order for TBP. In an observation and interview on 1/19/2026 at 2:21 PM Resident #45 was observed to have a urinary catheter. No signage indicating TBP or PPE cart was observed outside of Resident #45's room. NA J said she had just come on shift and was unsure why Resident #45 did not have TBP initiated. She said Resident #45 was a new admission, but she was agency staff and unsure of the protocol for initiating TBP at the facility. Resident #45 was unable to participate in attempted interview due to cognitive decline. In a subsequent observation on 1/21/2026 at 10:30 AM PM, two signs were observed on Resident #45's door. One indicated Resident #45 required Contact Precautions, and the second indicated Resident #45 required EBP. In an interview with the DON 1/21/2026 at 12:14 PM, she said she required staff to initiate Contact Precautions as well as EBP for any resident with an indwelling catheter, including Resident #45. She said Resident #45 did not have any infection that was spreadable but was on Contact Precautions to ensure staff used when providing care. She said she was aware that Resident #45 met criteria for EBP level of preucations, but she said she felt like staff were not properly initiating EBP in the past, so she decided to enforce a higher level of TBP to increase compliance. She said the difference between Contact Precautions and EBP was wearing gloves so she felt it was an appropriate measure for the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevention of infection. She said Resident #45 did not have TBP in place on 1/19/2026 because the resident was the last admission on [DATE] and she had not yet initiated TBP at the time of the observation. Record review of the facility policy titled Infection Prevention & Control undated/ reviewed 1/19/2026 revealed the following:6) . If the disease or infections requires isolation or precautions the resident will be isolated only to the delineated in these policies and procedures. If the disease or infections requires isolation of precautions, the resident will be isolated only to the degree necessary to isolate the infecting organism. Contact precautions are indicated (unless other orders are received from physician) for residents with MDROs who are ill and totally dependent upon HCWs for ADL assistance or whose secretions of drainage cannot be contained. Further review of the policy did not reveal findings related to EBP. 4. In an observation and interview on 1/21/2026 at 10:30 AM, NA E and NA F were observed providing catheter care to Resident #45. Resident #45 had signage on her door indicating she required Contact Precautions and EBP. At the completion of the procedure, NA E removed her PPE and pushed a large, lidded bin on wheels to the doorway of Resident #45's room. NA F then deposited soiled linen from Resident #45 directly into the bin, on top of other, soiled, unbagged linen. NA F was asked why Resident #45's soiled linen was not put into a red, biohazard bag, as she was on Contact Isolation. NA F said the red bags indicating contamination are only used if an item is heavily soiled with bodily fluids, like vomit or blood. She also said facility staff will usually bag soiled linen into garbage bags before putting it into the larger bin, but she did not bag the linen this time because she did not have a bag available and the bin was brought to the room. In an interview with the DON on 1/21/2026 at 12:14 PM, she said soiled linen leaving a resident's room on Contact Isolation, such as Resident #45, did not need to be bagged prior to being put into the soiled linen bin. She said the red, contaminated bags are only indicated when a resident had a spreadable infection, and Resident #45 was not infectious and only on Contact Isolation due to the urinary catheter. The DON was asked how staff could differentiate which resident on Contact Precautions had a contagious infection and required bagging of soiled linen if the precaution procedures were not uniform for all residents on Contact Precautions. The DON said she would tell the staff which resident required their linen to be bagged, and they would pass the information to each other verbally. Record review of the facility policy titled Infection Prevention & Control undated/ reviewed 1/19/2026 revealed the following:Key principles for handling soiled laundry are as follows: (1) not shaking the items or handling them in any way that may aerosolize infectious agents; (2) avoiding contact of one's body and personal clothing with the soiled items being handled; and (3) containing soiled items in a laundry or designated bin.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 1 of 1 Resident Council group reviewed. The facility failed to follow up on concerns and requests expressed in Resident Council meetings from July 2025 through December 2025.The facility failed to provide the Resident Council group with a response, actions, and rationale taken regarding their concerns. This failure placed residents at risk of not having their grievances followed up and addressed.Findings included: Review of the Resident Council Meeting minutes from July 2025 through December 2025 reflected there was no documentation of the facility's responses to Resident Council grievances identified during Resident Council group meetings:* Resident Council Meeting dated December 27, 2025, reflected: Resident Council group members communicated concerns with dietary items, housekeeping, laundry, maintenance and activities.* Resident Council Meeting dated November 28, 2025, reflected: Resident Council group members communicated concerns with dietary items, housekeeping, laundry, maintenance and activities.* Resident Council Meeting dated October 24, 2025, reflected: Resident Council group members communicated concerns with dietary items, housekeeping, laundry, maintenance and activities.* Resident Council Meeting dated September 26, 2025, reflected: Resident Council group members communicated concerns with housekeeping, maintenance and activities. *Resident Council Meeting dated August 29, 2025, reflected: Resident Council group members communicated concerns with dietary items, housekeeping, laundry and maintenance.*Resident Council Meeting dated July 25, 2025, reflected: Resident Council group members communicated concerns with dietary items and housekeeping. In an interview on 1/19/2026 at 1:30 PM the Resident Council group said the AD takes the monthly minutes and hears all their concerns with the facility and notifies the management staff. The group said they did not get information on the outcome of the grievances and would like this to change. In an interview on 1/19/2026 at 2:13 PM AD said the residents will go to her directly with grievances and they are addressed. She said the grievances are addressed verbally, they do not fill out the grievance form that was available and located near the ADM's office. She said most grievances are issues that can be addressed quickly, so she will go directly to the department head that the grievance was regarding and notify them of the grievance so they may provide a resolution. She said this process was done verbally or via text message. She said she was the staff that will go back and notify the resident verbally that the grievance has been resolved. She said there was not a need to document the grievance as it was handled quickly. AD said the grievances that she was unable to handle quickly she will write them down and turn them into the ADM to resolve. She said ADM should have these grievances documented. She said that she believed the grievance was handled by the ADM and ADM would be responsible for notifying the Resident Council group of the resolution. She said the ADM does not address the Resident Council group to notify them of the status of their grievances and she was not sure if it was documented, but she was confident the ADM addresses. AD said if grievances are not responded to and actions are not taken to address resident concerns can make them feel unimportant. In an interview on 1/21/2026 at 11:39 AM, the DON said the ADM was the grievance coordinator. She said ADM normally gets complaints and she works on them. She said most grievances are received verbally. She said if a grievance addresses an incident, it will be logged in the facility's system for reporting purposes. DON said AD will provide her with the monthly Resident Council meeting minutes that outline the grievances the group has communicated. She said the AD was responsible for documenting these grievances and she was not sure if this was occurring. She said the grievances identified during Resident Council meetings are handled and she does not document the actions taken to resolve them, but she does provide a response to the group. She said if grievances whether individuals or groups are not provided with a response or actions are not taken to (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	address the grievance, she believes it would make the residents feel as if their concerns were not important. In an interview with the AD and DON on 1/21/2026 at 11:50 AM, the AD informed the DON directly that she only obtains Resident Council group concerns and handles them verbally with department heads or by text; but does not document the actions taken or if resident or group received a response to their grievances. She said since her employment two years back she was tasked with the Resident Council group, and she has not had to document grievances or concerns identified during the Resident Council monthly meetings. Both the DON and AD agreed that moving forward they would document all Resident Council group grievances on a standard grievance form and provide a response verbally and in writing. AD said the impact of not knowing if grievance was being addressed can make the residents and the group feel unimportant and not wanting to discuss further. In an interview on 1/21/2026 at 12:02 PM ADM said the facility handles grievances. She said the facility follows the grievance policy when addressing grievances. She said this task was handled by the AD. Review of the facility policy dated 2005, titled Complaint/Grievance reflected the following: 2. Prompt efforts by the facility to resolve grievances the resident may have.3. Complaints will be acknowledged by the staff of the agency that receives the complaint. All complaints will be investigated, whether oral or written.PURPOSE: To ensure that all complaints are investigated thoroughly and that appropriate corrective action is taken.PROCEDURE:2. The administrator &/ or the DON review the complaint at weekly care plan meeting or immediately depending on the severity of the complaint.3. The administrator and / or the DON does a follow up with the resident / family.4. Resident council or other resident meeting minutes are given to the administration and department heads. The administrator meets with resident council officers as requested. Review of facility document undated titled Concern/Grievance Investigation and Response reflected the following: PURPOSE:To assist in identifying concerns of staff, residents and/or families.To assure appropriate investigation is made and concern has been addressed.To provide an on-going record of concerns which will assist in program and procedure modification.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 8 residents (Resident #45) reviewed for care planning. The facility failed to ensure Resident #45's baseline care plan included TBP and planning for urinary catheter care. This failure could result in residents not receiving necessary care and decreased quality of life. Findings included: Record review of Resident #45's admission Record dated 1/18/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included weakness. Record review of Resident #45's MDS submissions did not reveal an admission MDS submission. Record review of Resident #45's Order Summary Report dated 1/18/2026 revealed the following physician's orders:[Urinary [sic] Catheter 14f 10 cc balloon every night shift starting on the 1st and ending on the 1st every month [sic] (order date 1/16/2026) Record review of Resident #45's Care Plan Report (undated, printed 1/19/2026) reflected the following: The resident has (SPECIFY: Condom/Intermittent/Indwelling/Suprapubic) [sic] catheter (date initiated 1/18/2026) . CATHETER: The resident has (SPECIFY Size [sic]) (SPECIFY Type of Catheter [sic]). Position catheter bag and tubing below the level of the bladder and away from the entrance room door (date initiated 1/18/2026). Further record review of Resident #45's Care Plan Report did not reveal care planning for TBP. In an observation on 1/18/2026 at 2:09 PM, Resident #45 was observed to have a urinary catheter in place. The resident's room did not have signage to indicate the resident required TBP. In a subsequent observation on 1/19/2026 at 1:50 PM, two signs were observed on Resident #45's door. One indicated Resident #45 required Contact Precautions, and the second indicated Resident #45 required EBP. In an interview with the DON on 1/21/2026 at 12:14 PM, she said she was primarily responsible for resident's care planning. She said she did not have a formal process for creating and revising the care plans but reviewed them on a daily basis. She said the care planning in Resident #45's care plan report was sufficient to provide care for Resident #45 because staff would know the care needed for the urinary catheter based on the physician's orders. She said staff would know the resident required isolation precautions because she had a urinary catheter. She did not feel the exclusion of this information from Resident #45's baseline care plan had potential for harm. Record review of the facility titled Care Plan/Comprehensive Interdisiplinary dated 2005 revealed the following:The care plan must include measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs as identified in the comprehensive assessment. Also [sic] a temporary care plan will be completed by the admitting nurse for every new patient to the facility (see form on next page). No additional pages or policies related to care planning, including aforementioned form for temporary care planning, were provided by the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents (Resident #45) reviewed for urinary catheters. The facility failed to ensure NA E performed proper catheter care for Resident #45 when she did not protect the catheter tubing from unnecessary tension while cleansing. This failure could result in the unintentional dislodgement of the urinary catheter or pain and injury to a resident's urinary tract. Findings included: Record review of Resident #45's admission Record dated 1/18/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included weakness. Record review of Resident #45's MDS submissions did not reveal an admission MDS submission. Record review of Resident #45's Order Summary Report dated 1/18/2026 revealed the following physician's orders:[Urinary [sic] Catheter 14f 10 cc balloon every night shift starting on the 1st and ending on the 1st every month [sic] (order date 1/16/2026)May apply barrier cream topically with incontinence care as needed (order date 1/16/2026) Further record review of Resident #45's Order Summary Report did not reveal an order for MediHoney gel (a topical medication used for wound care) application. Record review of Resident #45's Care Plan Report (undated, printed 1/19/2026) reflected the following: The resident has (SPECIFY: Condom/Intermittent/Indwelling/Suprapubic) [sic] catheter (date initiated 1/18/2026) . CATHETER: The resident has (SPECIFY Size [sic]) (SPECIFY Type of Catheter [sic]). Position catheter bag and tubing below the level of the bladder and away from the entrance room door (date initiated 1/18/2026). Resident #45 was unable to participate in an interview attempted on 1/18/2026 at 2:30 PM due to cognitive decline. In an observation and interview on 1/21/2026 at 10:30 AM, Resident #45 was observed to have a urinary catheter in place. NA F was performing catheter care for Resident #45, and she was observed grasping the tube near Resident #45's knees with one hand. She then used a disposable cleaning cloth in the other hand to wipe the tube away from the resident, away from the entrance point of the catheter. While wiping, the area of tubing between the resident's genitals and the point at which NA F's hand was grasping tube became taut, and Resident #45 was observed verbalizing a sound of discomfort when the tubing was pulled, approximately three times.NA F asked Resident #45 if she was okay, and Resident #45 said she was fine. After cleansing, NA E asked NA F to obtain barrier cream for application before the disposable brief was applied. NA F was observed to remove a partially used tube of MediHoney gel from the drawer near Resident #45's bed. NA F was observed applying a layer of MediHoney gel to Resident #45's genitals, thigh creases, and buttocks. NA F said MediHoney gel was the same as barrier cream and used for wounds. She was unsure if Resident #45 had an order from the physician for MediHoney gel. NA E said the barrier cream she typically used for residents did not have the same packaging or appearance as the MediHoney gel. She said she knew which cream to apply during incontinence care by asking the nurse but she had not asked the nurse prior to providing care for Resident #45. NA E also said the purpose of grasping the catheter tube during cleaning was to prevent accidentally pulling the catheter out. In an interview with LVN H on 1/21/2026 at 11:55 AM, she said Resident #45 did not have a physician's order for MediHoney gel application as barrier cream. She said NA F should have told her about the mistake. She was unsure why the MediHoney gel was in Resident #45's drawer and said it should have been stored securely in the medication cart or medication storage room. In an interview with the DON on 1/21/2026 at 12:20 PM, she said NAs at the facility are trained to grasp catheter tubing near the patient's body and cleanse away from the area being grasped, in order to prevent the catheter from being dislodged. She said NA F should not have used any creams on Resident #45 without asking the nurse, and the MediHoney gel should not have been stored in Resident #45's room. Record review of the facility policy titled Catheter Care, Indwelling Catheter dated 2005, reflected the following: 6. Hold (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter tubing to one side and support it so as to avoid traction or unnecessary movement of the catheter while performing care.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week for 2 of 141 days reviewed for sufficient staffing. Additionally, the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis for 1 of 1 DON reviewed for staffing. The facility failed to use the services of a registered nurse for 8 consecutive hours on 9/24/2025 and 10/19/2025.The facility designated an LVN to serve as the director of nursing effective 3/1/2024. These failures could lead to residents not receiving necessary care or oversight of their care and decreased quality of life. Findings included: 1. Record review of the facility document titled Employee Timesheet [RN A] dated 9/16/2025- 9/30/2025 reflected RN A utilized 8 hours of paid time off on Wednesday, 9/24/2025. Record review of the facility document titled Employee Timesheet [RN A] dated 10/1/2025 - 10/15/2025 reflected RN A utilized 8 hours of paid time off on Thursday, 10/9/2025. In an interview with the DON on 1/20/2026 at 8:43 AM, she said the facility did not have RN coverage on 9/24/2025 or 10/9/2025 as indicated by RN A's timesheets. She said she spoke with RN A regarding the two shifts, and RN A said she did not work those shifts due to personal commitments. The DON said she did not feel this impacted care provided to resident because an LVN was staffed during those times to provide any necessary nursing care. 2. Record review of the facility document titled Job Description for Charge Nurse dated 10/23/2023 reflected a signature and date from staff member RN A. Record review of the facility document titled Director of Nursing dated 3/01/2024 reflected a signature and date from the DON and the Admin. Qualifications were listed as currently licensed as a Registered Nurse in the State [sic] of Texas and graduate of an accredited university with a 4 year [sic] degree. In an observation and interview on 1/19/2026 at 2:47 PM, RN A was observed at the nurse's station working on the facility computer. She said her job title is Charge Nurse. She said she is not the DON and has no oversight or management responsibilities of the facility other than signing MDS assessments performed by the MDS nurse. She said that she does not review any work performed by the DON and was asked previously by the facility to serve as the DON, but she declined the position. In an interview with the DON on 1/20/2026 at 10:17 AM, she stated her job title was ADON, but she was serving as the acting DON until she completed the RN program. She said RN A was the actual DON and responsible for overseeing her work. She said she felt the needs of the residents were met by her qualifications and there was no potential harm.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medication error rates are not 5 percent or greater for 2 of 4 Residents (Residents #36 and #37), and 2 of 25 medication administration observations, resulting in an error rate of 8%. The facility failed to ensure Resident #36 received medication Donepezil at 7:00 AM on 1/19/2026, as ordered by the physician.The facility failed to ensure Resident #37 received medication Pantoprazole at 8:00 AM on 1/19/2026, as ordered by the physician. This failure could result in residents not receiving correct and timely medications.Findings included: Record review of Resident #36's medication administration record for January 2026, dated 1/19/2026, reflected the following order:Donepezil HCl Oral Tablet 5mg (Donepezil Hydrochloride) Give 1 tablet my mouth one time a day related to Alzheimer's disease [a progressive neurological condition causing deterioration of memory, thinking, and daily function] with late onset . start date 11/08/2025 07:00 [AM]A check mark symbol and initials of LVN G were documented on 1/19/2026, which indicated Resident #36 had received the medication. Record review of Resident #37's medication administration record for January 2026, dated 1/19/2026, reflected the following order:Pantoprazole Sodium Oral Tablet Delayed Release 40MG (Pantoprazole Sodium) Give 40mg by mouth one time a day for gerd [sic] [chronic heartburn] . start date 01/10/2026 08:00 [AM]A check mark symbol and initials of LVN G were documented on 1/19/2026, which indicated Resident #37 had received the medication. In an observation and interview on 1/19/2026 beginning at 8:22 AM, LVN G was observed preparing and administering morning medications. At 8:33 AM, LVN G administered the Donepezil 5mg tablet to Resident #36. At 8:46 AM, LVN G was observed preparing medications for administration to Resident #37. She said Resident #37 did not have an available dose of the Pantoprazole 40mg tablet, and she was unsure where to obtain the medication because she was not full-time staff and unfamiliar with the medication reordering processes of the facility. She said she was told by another nurse that the facility did not maintain an emergency supply of medications, so she would skip the Pantoprazole for Resident #37 and ask the DON. In an interview with the DON on 1/19/2026 at 10:20 AM, she said the facility policy was to administer medications within one hour before or after the ordered time, so Resident #36's Donepezil administration would be considered late. She also said LVN G had not informed her of the missing Pantoprazole for Resident #37, and LVN G should not have documented a medication she did not administer. She said LVN G made the errors because she is agency and she does not have a process to train agency staff about the facility's expectations for medication administration or reordering. Record review of the facility policy titled Medication Administration, Oral undated, received 1/19/2026, reflected the following:Document on MAR that medication was either given or refused by patient.May give med 1 hr before scheduled time and 1 hr after