STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675756	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	941 Scotland Dr Desoto, TX 75115

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the residents had a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 2 of 10 residents (Residents #169 and #195) reviewed for resident rights.The facility failed to provide privacy covers for the urinary collection bags for Residents #169 and #195.This failure could place residents at risk of a lessened sense of self-worth.Findings included: 1.Review of Resident #169's admission MDS assessment, dated 01/11/26, reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, unspecified (a diagnosis of the progressive brain disorder where the onset, early or late, is not specified); Heart failure, unspecified (indicates a diagnosis of heart failure where the specific type, systolic, diastolic, acute, or chronic has not been detailed); and Adult failure to thrive (a syndrome of unintentional weight loss, malnutrition, dehydration, and physical/functional decline. Her BIMS score was 3, indicating she had severe cognitive impairment. Her Functional Assessment indicated she required assistance with all her ADLs. Her Bowel and Bladder assessment indicated she was always incontinent of bowel and bladder. Record review of Resident #169's care plan, dated 3/10/26, reflected she had Alzheimer's Disease, had cognitive and mobility impairments, and required the use of a urinary catheter for wound healing. Observation made on 03/08/2026 at 11:00 a.m. of Resident #169 resting in bed. Resident #169 had a catheter hooked on the right side of the bed full of urine. Catheter bag was not in a privacy bag. Catheter bag was facing the entry door to the room. Resident has DX of Alzheimer's Disease and unaware. In an interview on 03/10/2026 at 1:36 p.m. with LVN-A revealed that the nurses are responsible for providing care to the residents. The CNAs are responsible for providing incontinent care for the residents. The policy of the facility is for the catheter bags to have privacy bags in place to keep the bag from touching the floors and for the residents' privacy. If the CNA needs a privacy bag for a resident's catheter, the nurse can provide one from the supply room. In an interview on 03/10/2026 at 1:50 p.m. with CNA- B revealed that residents should always have a privacy bag over them. If the resident does not have one, the CNAs can ask the nurse for a bag. The bag is used for a resident's dignity and privacy. In an interview on 03/10/2026 at 2:00 p.m. with CNA-C stated residents who have catheters are to have a privacy bag. The Nurses have the privacy bags available in the supply closet when needed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The bag is used for residents' privacy. 2. Record review of Resident #195's quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #195 had with diagnoses which included a stroke leaving her paralyzed in all four extremities, pressure ulcers, and contractures. Her BIMS score was 7, indicating which indicated she had severe cognitive impairment. Her Functional Ability assessment revealed reflected she was dependent on staff for all her ADLs. Her Bowel and Bladder assessment indicated she was always incontinent of bowel and bladder. Record review of Resident #195's care plan, dated 07/24/25, reflected she had speech deficits, cognitive and mobility impairment, and a self-care deficit. Observation on 03/08/26 at 10:40 a.m. revealed Resident #195 was in bed, her urinary collection bag was suspended from her bed, visible from the hall, and no privacy cover was in place to protect her dignity. Observation on 03/08/26 at 12:30 p.m. revealed Resident #195's urinary collection bag remains remained in the same position, and still not covered with a privacy cover. Observation on 03/10/26 at 9:50 a.m. revealed Resident #195's urinary collection bag remains remained in the same position, and still not covered with a privacy cover. In an interview on 03/10/26 at 11:56 a.m., CNA-D stated he was Resident #195's CNA and he did not notice the lack of a privacy cover on her collection bag. He stated it was important to cover the collection bags to preserve the residents' dignity. He stated he would have to notify the nurse. In an interview on 03/10/26 at 12:03 p.m., LVN-E stated residents with urinary bags needed to have a privacy cover, even when they were in their rooms. He stated it was a dignity issue for the resident . In an interview on 03/10/26 at 12:10 p.m., LVN-F stated all residents with a urinary collection bag were required to have a privacy cover in place, even when they were in bed. She stated she thought Resident #195 had her urinary catheter placed while in the hospital recently, and the hospitals do did not use privacy covers. LVN-F stated the bag would have to be changed out for one of the facility's bags, which have had privacy covers. She stated it helped with the residents' sense of dignity. Interview on 03/10/26 at 12:15 p.m., CNA-G stated any resident with a urinary catheter in place needed a privacy cover for the collection bag for the residents' dignity. She stated that the bag needed to be in place when they were out of their rooms, as well as when they were in bed because it could be seen from the doorway. In an interview on 03/10/26 at 3:42 p.m., the DON stated privacy covers on urinary collection bags was a dignity issue, and residents needed to have them in place all the time. She stated bags that did not have one in place, usually came in with the system in place and staff had not changed them out. The DON stated the collection bag could be changed out without disturbing the actual catheter.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had a right to personal privacy and confidentiality of his or her personal and medical records for 33 of 35 and resident's admission Records and 2 of 10 (room [ROOM NUMBER] and room [ROOM NUMBER]) reviewed for personal privacy. The facility administration failed to protect the residents' privacy by having private information of residents in a binder in the front lobby of the facility.The facility failed to ensure resident rooms had full visual privacy, Rooms #114 did not have a privacy curtain and room [ROOM NUMBER] did not have window blinds. This failure could place residents at risk for low self-esteem, loss of dignity and decreased quality of life due to lack of privacy during care.Findings include:In an observation on 03/08/2026 at 9:15 a.m. revealed a red notebook on a table located in the south building facility labeled, Elopement Binder South Building. Included in the book revealed the policy and procedure, Elopement Management. The book included 33 admission records of residents in the memory care unit, Halls 200 and 300. Of the 33 admission records in the Elopement Binder, 28 were current residents on the memory care unit. In an observation on 03/08/2026 at 10.00 a.m. revealed the resident admission records included resident names, social security numbers, Medicare numbers, Medicaid numbers, responsible party information, addresses and phone numbers. In an interview on 03/09/2026 at 2:22 p.m. with the ADM revealed the policy for protecting residents' privacy r/t medical records would have to be located to be provided. The ADM could not recall when an in-service was held r/t HIPPA laws. The ADM stated the purpose of the Elopement Binder was to have a list of residents with pictures who were at risk of elopement from the facility. The binders were normally left at the nurses' station on the Memory Care Unit. The ADM stated the staff had access to the binders. The ADM revealed the risk of the Elopement Binder left on the table at the front of the building was the personal information would be seen by unauthorized individuals. The ADM stated the Elopement Binder was in the lobby for other staff to have access in the event of a resident elopement. In an interview on 03/09/2026 at 1:36 p.m. with LVN A revealed she was familiar with what HIPPA law referred to. LVN A stated staff had training on HIPPA, but could not remember the date of training. LVN A revealed the Elopement Binder was located on the Memory Care Unit at the nurse's station. The residents were at risk of elopement, and the binder had the admission record and pictures of residents on the Memory Care Unit. LVN A revealed the risk if the Elopement Book was left in the lobby was the resident's personal information and family member's personal information could be seen by others who should not have access to it. In an interview on 03/10/2026 at 3:31 p.m. with DON revealed there was a written policy r/t to HIPPA. The DON stated the nursing staff, business office, and administration had access to resident's personal medical records. The DON stated there were in-services held on residents' personal privacy of medical records. The DON revealed the Elopement Binder was normally kept out in the lobby but would now be kept at the nurses' station. The DON stated the risk of the Elopement Binder left in lobby of the building would be exposure of resident's names, social security numbers, Medicare numbers, Medicaid numbers, family members names, addresses, and phones numbers would fall into unauthorized hands causing identity theft. Observation on 03/08/26 at 11:16 AM, the resident in room [ROOM NUMBER]-B was visible from the (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hallway using his urinal. In an interview on 03/08/26 at 11:18 AM, the resident in room [ROOM NUMBER]-B stated the curtain at the end of his bed had been taken down about a month ago and never put back up. The curtain between the two beds was not long enough to provide privacy. Observation and interview on 03/08/26 at 11:48 AM, of room [ROOM NUMBER] revealed there were no blinds in the window. The window faced a parking lot. There were marks indicating blinds had been in place before. stated there had been no blinds in the window since they were admitted last month. He did not like that he could easily be seen at night when the lights were on. Interview on 03/10/26 at 11:56 AM, CNA -D stated resident privacy was necessary for their happiness and dignity. He stated housekeeping was responsible for the privacy curtains. He was not aware of any privacy issues as residents had not complained to him. Interview on 03/10/26 at 12:05 PM, LVN-E stated privacy was a priority for residents, it protected their dignity. He stated no one wants to be seen changing clothes. LVN-E stated housekeeping was responsible for the privacy curtains. Maintenance was responsible for the blinds in the windows. He was not aware of any privacy issues as residents had not complained to him. Interview on 03/10/26 at 12:12 PM, LVN-F stated resident privacy was very important for their dignity, and the privacy curtain also defined their living area. She stated housekeeping was responsible for changing out the curtains, and maintenance was notified about things like the blinds via the maintenance repair logbook. She was not aware of any privacy issues as residents had not complained to him. Interview on 03/10/26 at 1:33 PM, the Housekeeping Supervisor stated nursing staff was responsible for letting her know when a privacy curtain needed to be changed out and she would coordinate with maintenance to change them out. She had clean ones in storage that could be changed out for a dirty ones. Interview with the Maintenance Supervisor on 3/10/26 at 2:10 PM, he stated nursing staff have to notify him whenever there is a maintenance issue, and he will address it the same day usually. Occasionally he will have to order something, but blinds can be replaced the same day. Interview on 03/10/26 at 3:45 PM, the DON stated privacy for the residents is a priority for their dignity. She stated she was unaware of the missing privacy curtains, but she would have a sweep of the facility done to identify rooms in need of privacy curtains. Record review of the facility's Safeguarding and Storing of Protecting Health Information, revised March 21, 2017 revealed in part, The policy of this facility is to provide guidelines for the safeguarding of Protecting Health Information (PHI) in the facility and to limit unauthorized disclosures of PHI that is contained in a resident's medical record, while at the same time ensuring that such PHI is easily accessible to those involved in the treatment of the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure a residents who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of 35 residents (Residents #15 and #69) reviewed for ADLs. 1. The facility failed to ensure Resident #15's fingernails were routinely trimmed. 2. The facility failed to ensure Resident #69's fingernails were trimmed routinely, and her facial hair was shaved regularly. These failures could place residents at risk for a decreased sense of self-worth, as well as potential skin injury. Findings included: 1. Record review of Resident #15's quarterly MDS assessment, dated 02/14/16, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #15 had with diagnoses which included a stroke affecting the left side of his body, dementia , and legal blindness. His BIMS score was not calculated due to his medical condition. His Functional Ability assessment indicated he required staff assistance with all of his ADLs. Record review of Resident #15's care plan, dated 02/12/26, reflected he had Alzheimer's Disease , was unable to speak, and had a self-care deficit. The resident was not diabetic. Observation on 03/08/26 at 11:58 AM revealed Resident #15 was in bed, his left arm and hand were contracted with a cloth roll in his left hand. Resident #15's left 4th and 5th digit's fingernails were extremely overgrown. Observation on 03/08/26 at 1:32 PM revealed Resident #15's fingernails were measured with a disposable paper ruler. The left 4th digit's fingernail measured about 1/4th of an inch. The 5th digit's fingernail measured almost 1/2 an inch. Both nails had an upward curve and were not digging into the palm of the hand. Observation on 03/10/26 at 10:44 AM revealed, Resident #15 appeared unchanged. He did not appear to have been bathed , and his fingernails remained un-trimmed. 2. Record review of Resident #69's quarterly MDS assessment, dated 12/12/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]., with Resident #69 had diagnoses which included a stroke affecting her left side, substance abuse, and chronic pain. Her BIMS score was 15, indicating which indicated she was cognitively intact. Her Functional Ability assessment indicated she required staff assistance with her ADLs. Record review of Resident #69's care plan, dated 8/25/25, reflected she had short term memory loss, had a fall risk, had mobility issues, a self-care deficit, was diabetic, and visually impaired. Observation and interview on 03/08/26 at 11:21 AM revealed Resident #69 was in bed, her left hand was contracted, no soft roll was in her palm, and the fingernails to her left 4th and 5th digits were overgrown. The 2nd digit's fingernail was not totally visible, and her grip would not allow full visualization. Resident #69 stated she did not like anyone to mess with her left hand and arm, because they were painful. She stated staff did not take time to work with her arm and hand; they would just try to rush through everything. She stated she could not tell how long her nails were and she would allow the nurse to cut them if they took their time. Resident #69 also had facial hair on her chin and upper lip, and the chin hair was about 1/2 inch long. Resident #69 stated her family had shaved her when they visited about a month prior, but she had not been shaved by staff since then. She stated she was scheduled for a bed bath on 03/09/26 and would ask to be shaved then. Observation and interview on 03/09/26 at 2:30 PM, Resident #69 stated her bath time was scheduled for the evening shift.Observation and interview on 03/10/26 at 10:10 AM, Resident #69 stated she had been bathed the previous evening, and the CNA told her a nurse had to shave her and trim her nails since she was diabetic. She did not know if the CNA had notified the nurse. Interview on 03/10/26 at 12:00 PM, the PTA stated Resident #69 needed a soft roll, or carrot, in her palm to help with her finger contractures but the resident was resistant with anyone working with her hand. The PTA stated it was important to reduce the contractures as much as possible to prevent things like her fingernails from growing into her palm and causing a wound, which had not happened yet. The PTA stated she would talk with the resident and see if she would allow a carrot to be placed today. Interview on 03/10/26 at 12:05 PM, LVN-E stated he was Resident #69's nurse, he was unaware the resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed to be shaved or have her nails cut. He stated diabetic residents had to be shaved and their nails trimmed by a nurse and he did not know why it had not been done the previous evening, but he would address both. He stated the resident was hesitant to let anyone do anything with her left hand, due to it causing her pain. He stated the risk of not keeping nails trimmed could be wounds to the palm. Interview on 03/10/26 at 3:42 PM, the DON stated her expectation was for all residents to be bathed and groomed on a regular basis. She stated she knew Resident #69 was hesitant to let staff touch her left hand and arm, but they could still take their time and provide appropriate care. She stated being well groomed, especially for females, was a big dignity issue. The DON stated no female wanted to be seen with facial hair. Record review of the facility's policy Hair Care- Combing and Shaving, dated 02/12/20, did not state diabetic residents required a nurse to shave them. Residents could be shaved with a disposable or electric razor.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in 2 of 2 kitchens (North Kitchen and South Kitchen) reviewed for kitchen sanitation. 1. The facility failed to ensure freezers in the North and South Kitchen were functioning to prevent thawing and to keep food solid. Food items that had been thawed and were soft to touch, and kept between 40 and 50 degrees Fahrenheit, were not discarded.2. The facility failed to correctly thaw beef patty fritters served for lunch on 03/09/26 from the South Kitchen.3. The facility failed to label, date, and discard items in the reach in refrigerator, and label and date items in the dry storage in the South Kitchen.4. The facility failed to ensure the dishwasher's chemical concentration and water temperatures were logged for 4 of 9 days of March 2026 in the South Kitchen.These failures could place residents at risk of foodborne illness.North Kitchen Observation on 03/08/26 at 9:12 AM, in the North kitchen, revealed the following in one of the reach in freezers: - on the top shelf, unlabeled, undated, thawed and soft to touch chicken cubes, beef in a sauce, crumbled pork sausage, breaded chicken patties. In the middle of the freezer 1 large pork roast 1 soft with touch along with 2 unidentified pies thawed with no label or date. - the freezer had a temperature of 40 degrees Fahrenheit outside and 50- and 48-degrees Fahrenheit based on 2 thermometers inside the freezer. - a rack in the kitchen revealed 2 boxes of bagels that indicated Keep Frozen zero degrees F or below, the bagels were with condensation within the plastic bags, and the bread was soft to touch. Interview and observation on 03/08/26 at 9:34 AM, [NAME] K identified unlabeled and undated food items to be cubed chicken, BBQ beef, breakfast sausage, and breaded chicken patties. [NAME] K stated items in freezer should be frozen solid, [NAME] K stated the freezer was repaired about 2 weeks ago and had been working with no issues. [NAME] K stated she was not aware of the temperature reaching 50 degrees, [NAME] K stated she was responsible for checking the temperatures. Observation of the temperature log revealed it was blank, [NAME] K stated she had not completed temperature checks since her shift started. [NAME] K stated they had delivered on 03/06/26 and the bagels were delivered then and left out for use on Tuesday during breakfast. [NAME] K stated it was her responsibility to notify the Dietary Manager when equipment was not working properly, not doing so placed residents at risk of being served expired foods. Interview on 03/08/26 at 9:40 AM, Dietary Aide N revealed [NAME] K was responsible for checking the temperatures of the fridges and freezers. Dietary Aide N stated she had not noticed the freezer temperature showing 40 degrees because she did not use the freezer during her shift. Dietary Aide N stated if she noticed the freezer was not working properly she would notify the Cook, not doing so placed residents at risk of becoming sick. Interview on 03/08/26 at 9:45 AM, Dietary Aide O revealed [NAME] K was responsible for checking the temperatures of the fridges and freezers. Dietary Aide O stated she had not noticed the freezer temperature showing 40 degrees because she was the dishwasher. Dietary Aide O stated if she noticed the freezer was not working properly, she would notify the Cook, not doing so placed (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents at risk of being served expired foods. Record review of the March 2026 freezer temperature log reflected the temperature was blank on the AM shift for Sunday 03/08/26, indicating the temperature had not been checked. Interview on 03/08/26 at 10:25 AM, Dietary Manager HH revealed the freezer recently had the controller replaced about two weeks ago. Dietary Manager HH stated after the repair there had not been any further issues with keeping the food frozen. According to Dietary Manager HH the Cooks were responsible for making rounds to check all the temperatures at the start of their shift and document on the temperature logs. Dietary Manager HH stated the Cooks were to contact her immediately if equipment was not functioning properly so that the Maintenance Supervisor could be contacted. Dietary Manager HH stated she was notified this morning by [NAME] K that the meat freezer was reading 40 degrees ono the freezer and 50 degrees by the inside thermometer. The Dietary Manager HH stated she then involved the Maintenance Supervisor to take a look at the freezer. Not having properly working equipment in the kitchen placed residents at risk of becoming ill if we are cooking spoiled foods. Interview on 03/08/26 at 10:54 AM, with the Maintenance Supervisor revealed the meat freezer was repaired recently, vendors came out and replaced the controller, there had not been any issues with he freezer working since then. According to the Maintenance Supervisor he noticed that the doors on the freezer were not fully closed, indicating that was the reason for the temperature rising. The Maintenance Supervisor stated it was the responsibility of the dietary staff to notify him if equipment was not working properly, not doing so placed residents at risk of food born illnesses. South Kitchen Observation on 03/08/26 at 9:19 AM, in the South kitchen, revealed the following in one of the reach in refrigerators: - 3 bags of shredded lettuce not dated, one bag had brown and wilted lettuce pieces, - a large bowl of what appeared to be chocolate pudding, not labeled or dated - a large bowl of an unknown dark red and thick substance, not labeled or dated. Observation on 03/08/26 at 9:21 AM, in the South kitchen dry storage revealed a large container of cereal with plastic wrap covering it, not labeled or dated. Observation on 03/08/26 at 9:23 AM, in the South kitchen, revealed the following in one of the reach in freezers: - on the middle shelf, meat that was unlabeled and undated, in a resealable plastic bag, was leaking onto a box and shelf underneath. - on the middle shelf was 2 packages of ground beef and about 6 other packaged meats lying on top of a towel - other freezer items included chicken patty fritters, pork sausage, diced white turkey, cubed potatoes, and cheese and garlic biscuit dough (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- the freezer had a temperature of 50 degrees Fahrenheit, and 46 degrees Fahrenheit based on 2 thermometers inside the freezer. Observation on 03/08/26 at 9:34 AM, in the South kitchen, revealed 3 boxes of western style beef patty fritters sitting on the counter. Interview on 03/08/26 at 9:34 AM, [NAME] T stated items in the fridge and dry storage should be labeled and dated. She stated the bags of lettuce should have been dated. She said one bag looked wilted and it came in Friday, and she was supposed to let the Dietary Manager know when it came in like that. She said the aides were responsible for dating the pudding. She said items should be labeled and dated for freshness. [NAME] T stated the freezer had been out for a week and no residents had been served food from the freezer. She said she pulled the 3 boxes of beef patties early this morning around 7:00 AM. [NAME] T opened 2 boxes of beef patties and the patties were soft to touch. Interview on 03/08/26 at 9:44 AM, [NAME] T stated she did not have a menu for today or last week because it was locked in the Dietary Managers office. Record review of the freezer temperature log reflected the temperature was -3 degrees Fahrenheit on the AM shift on Thursday 03/05/26 with no other temperatures documented for the PM shift on 03/05/06 or for the AM and PM shifts for 03/06/26, 03/07/26 and 03/08/26. Interview on 03/08/26 at 11:16 AM, Dietary Aide U stated he did not know what the temperatures should be for fridge and freezers and did not check the temperatures. He stated he believed it was the cook's responsibility to do so. He did not know if food was served from the nonfunctioning freezer and did not know how to properly thaw meat. Interview on 3/8/26 at 11:20 AM, [NAME] T stated everybody knew the freezer was not working, especially Dietary Manager V, who told them to report it to the Administrator. She stated she was responsible for taking freezer and fridge temperatures, and the freezer was supposed to be in the negative. When asked why she did not take the freezer temperatures Friday and yesterday, [NAME] T did not provide an answer and then said Dietary Manager V was well aware and the last time the cooler was out the corporate lady instructed him to draw a line through it and write freezer was not working. [NAME] T stated according to Dietary Manager V, it was okay to keep the food stored in the freezer. She said this morning she saw a box of bread that had poofed all the way up. When asked why she did not discard any of the food items, she said it was up to Dietary Manager V and what he said to do. She said on her shift they had not served residents any food from the non-working freezer. [NAME] T stated meat to be thawed should be put on a sheet pan and put in the fridge. She said the reason she pulled out the beef patties was to keep them from being frozen and undercooked when she fried them. Interview on 03/08/26 at 11:28 AM, Dietary Manager V stated he knew the freezer was not working since Friday (03/06/26) because the Maintenance Supervisor called and told him the vendor was out working on it. He stated [NAME] T also reported on Friday it was not working and she had not reported any issues to him before Friday. He stated cooks were responsible for taking fridge and freezer temps. He said staff had put some items from the nonworking freezer into the back freezer, went day by day on the menus, and items in the nonworking freezer were what was left. He said he did not know why those items were not discarded because he was not there over the weekend. He said they should have been because it would have been outside of the appropriate temperature. Dietary Manager V stated the beef patties should not have been sitting out to thaw and should have (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been in the freezer. He stated keeping freezers at the proper temperature and safely thawing meat would prevent cross contamination and foodborne illness. Attempted interview on 03/08/26 at 11:54 AM with [NAME] W, via phone, was unsuccessful. Interview on 03/08/26 at 11:57 AM, with the Maintenance Supervisor revealed he was aware of the freezer issue in the South kitchen. He said it had gone down again on Friday (03/06/26). He said the vendor tried to fix it but said they had to order a part, so he contacted Dietary Manager V to move the food from the freezer. The Maintenance Supervisor stated he did not take the freezer temperature on Friday and just knew it was not working because he was notified by Dietary Manager V. He stated if the food was not moved, it was trash and could make residents sick. He stated he was not aware the food was not moved and was told by Dietary Manager V he was on his way up here (on Friday 03/06/26) to move the food items. He stated he reported to the Administrator that the freezer was not working. He said he did not follow up to ensure the food was moved from the freezer after contacting Dietary Manager V. Record review of work order request for South Kitchen created by Maintenance Supervisor on 03/05/26 reflected the following: Reach-in Freezer Temperature issues.The temp is increasing again it is up to 32.Tech arrived at 10:06 AM. Tech Departed at 4:30 PM. The work for this job is not yet complete for the following reason: Parts Needed.Comments from your technician: Arrived onsite. Found freezer evap coil frozen up. Removed evap coil cover and thawed out unit. plugged unit back in and unit would not power up. Check voltage and unit is receiving voltage but will not turn on. Will need to replace controller on unit. Interview on 03/08/26 at 12:06 PM, the Administrator stated no food was used from the nonworking freezer in the South Building. Attempted interview on 03/08/26 at 12:08 PM, with Dietary Manager V, via phone, was unsuccessful. Observations, interviews, and record review on 03/08/26 between 12:42 PM and 1:02 PM revealed residents in the dining room eating country fried steak for lunch. Review of meal tickets revealed Country Fried Steak, Scalloped Potatoes, and [NAME] Beans w/Bacon & Onion. Observation of outside dumpsters revealed no boxes of beef patties. [NAME] T stated she had not used the beef patties that were thawing on the counter previously. When asked where they were, [NAME] T showed surveyor 2 boxes of beef patties that she threw away in the trash bin. Each box contained about half of the patties. [NAME] T stated she was going to try and salvage some to put back in the freezer to use. Observation of the working freezer revealed no other boxes of beef patties. The nonworking freezer had no food items inside. Record review of facility's policy titled Food Storage revised 04/08/25, reflected Sufficient storage facilities are provided to keep food safe, wholesome and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. 1. Storeroom: .Air-tight containers or bags are sued for all opened packages of food. All containers are accurately labeled with the item and the date opened. 2. Refrigerator: . All food are covered, labeled, and dated. Defrosting meat, eggs, and milk shakes are labeled with the date pulled for thawing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Freezer: .Temperatures are checked and logged at least twice daily. Freezer temperature must be sufficient to keep all foods frozen during storage. Frozen items are thawed in a refrigerator for 24-72 hours. Foods are covered, labeled, and dated. Any item out of the original case must be properly secured and labeled.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, interviews and record reviews, the facility failed to maintain all mechanical and electrical equipment in safe operating condition by failing to maintain freezers in two of two kitchens (North and South Kitchen) and failed to maintain 1 of 13 (Resident #147) bed in safe operating condition.1.The facility failed to ensure freezers in the North and South Kitchens were functioning to prevent thawing and to keep food solid. Food items that had been thawed and were soft to touch and kept between 40- and 50-degrees Fahrenheit, were not discarded.2. The facility failed ensure the Resident #147's bed was in proper working condition. These failures could place residents at risk of foodborne illness and at risk for injury and a decreased quality of life. Findings included: North Kitchen Observation on 03/08/26 at 9:12 AM, in the North Kitchen, revealed the following in one of the reach in freezers: - on the top shelf, unlabeled, undated, thawed and soft to touch chicken cubes, beef in a sauce, crumbled pork sausage, breaded chicken patties. In the middle of the freezer 1 large pork roast 1 soft with touch along with 2 unidentified pies thawed with no label or date. - the freezer had a temperature of 40 degrees Fahrenheit outside and 50- and 48-degrees Fahrenheit based on 2 thermometers inside the freezer. - a rack in the kitchen revealed 2 boxes of bagels that indicated Keep Frozen zero degrees F or below, the bagels were with condensation within the plastic bags, and the bread was soft to touch. Interview and observation on 03/08/26 at 9:34 AM, [NAME] K identified unlabeled and undated food items to be cubed chicken, BBQ beef, breakfast sausage, and breaded chicken patties. [NAME] K stated items in freezer should be frozen solid, [NAME] K stated the freezer was repaired about 2 weeks ago and had been working with no issues. [NAME] K stated she was not aware of the temperature reaching 50 degrees, [NAME] K stated she was responsible for checking the temperatures. Observation of the temperature log revealed it was blank, [NAME] K stated she had not completed temperature checks since her shift started. [NAME] K stated they had delivered on 03/06/26 and the bagels were delivered then and left out for use on Tuesday during breakfast. [NAME] K stated it was her responsibility to notify the Dietary Manager when equipment was not working properly, not doing so placed residents at risk of being served expired foods. Interview on 03/08/26 at 9:40 AM, Dietary Aide N revealed [NAME] K was responsible for checking the temperatures of the fridges and freezers. Dietary Aide N stated she had not noticed the freezer temperature showing 40 degrees because she did not use the freezer during her shift. Dietary Aide N stated if she noticed the freezer was not working properly she would notify the Cook, not doing so placed residents at risk of becoming sick. Interview on 03/08/26 at 9:45 AM, Dietary Aide O revealed [NAME] K was responsible for checking the temperatures of the fridges and freezers. Dietary Aide O stated she had not noticed the freezer temperature showing 40 degrees because she was the dishwasher. Dietary Aide O stated if she noticed the freezer was not working properly, she would notify the Cook, not doing so placed residents at risk of being served expired foods. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the March 2026 freezer temperature log reflected the temperature was blank on the AM shift for Sunday 03/08/26, indicating the temperature had not been checked. Interview on 03/08/26 at 10:25 AM, Dietary Manager HH revealed the freezer recently had the controller replaced about two weeks ago. Dietary Manager HH stated after the repair there had not been any further issues with keeping the food frozen. According to Dietary Manager HH the Cooks were responsible for making rounds to check all the temperatures at the start of their shift and document on the temperature logs. Dietary Manager HH stated the Cooks were to contact her immediately if equipment was not functioning properly so that the Maintenance Supervisor could be contacted. Dietary Manager HH stated she was notified this morning by [NAME] K that the meat freezer was reading 40 degrees on the freezer and 50 degrees by the inside thermometer. Dietary Manager HH stated she then involved the Maintenance Supervisor to take a look at the freezer. Not having properly working equipment in the kitchen placed residents at risk of becoming ill if we are cooking spoiled foods. Interview on 03/08/26 at 10:54 AM, the Maintenance Supervisor revealed the meat freezer was repaired recently, vendors came out and replaced the controller, there had not been any issues with the freezer working since then. According to the Maintenance Supervisor he noticed that the doors on the freezer were not fully closed, indicating that was the reason for the temperature rising. The Maintenance Supervisor stated it was the responsibility of the dietary staff to notify him if equipment was not working properly, not doing so placed residents at risk of food born illnesses. South Kitchen Observation on 03/08/26 at 9:23 AM, in the South kitchen, revealed the following in one of the reach in freezers: - on the middle shelf, meat that was unlabeled and undated, in a resealable plastic bag, was leaking onto a box and shelf underneath. - on the middle shelf next to the meat was 2 packages of ground beef and about 6 other packaged meats lying on top of a towel - other freezer items included chicken patty fritters, pork sausage, diced white turkey, cubed potatoes, and cheese and garlic biscuit dough - the freezer had a temperature of 50 degrees Fahrenheit and 46 degrees Fahrenheit based on 2 thermometers inside the freezer. Interview on 03/08/26 at 9:34 AM, [NAME] T stated the freezer had been out for a week and no residents had been served food from the freezer. Interview on 03/08/26 at 9:44 AM, [NAME] T stated she did not have a menu for today or last week because it was locked in the Dietary Managers office. Record review of the freezer temperature log reflected the temperature was -3 degrees Fahrenheit on the AM shift on Thursday 03/05/26 with no other temperatures documented for the PM shift on 03/05/06 or for the AM and PM shifts for 03/06/26, 03/07/26 and 03/08/26. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/08/26 at 11:16 AM, Dietary Aide U stated he did not know what the temperatures should be for fridge and freezers and did not check the temperatures. He stated he believed it was the cook's responsibility to do so. He did not know if food was served from the nonfunctioning freezer. Interview on 11:20 AM, [NAME] T stated everybody knew the freezer was not working, especially Dietary Manager V, who told them to report it to the Administrator. She stated she was responsible for taking freezer and fridge temperatures, and the freezer was supposed to be in the negative. When asked why she did not take the freezer temperatures Friday and yesterday, [NAME] T did not provide an answer and then said Dietary Manager V was well aware and the last time the cooler was out the corporate lady instructed him to draw a line through it and write freezer was not working. [NAME] T stated according to Dietary Manager V, it was okay to keep the food stored in the freezer. She said this morning she saw a box of bread that had poofed all the way up. When asked why she did not discard any of the food items, she said it was up to Dietary Manager V and what he said to do. She said on her shift they had not served residents any food from the non-working freezer. Interview on 03/08/26 at 11:28 AM, Dietary Manager V stated he knew the freezer was not working since Friday (03/06/26) because the Maintenance Supervisor called and told him the vendor was out working on it. He stated [NAME] T also reported on Friday it was not working and she had not reported any issues to him before Friday. He stated cooks were responsible for taking fridge and freezer temps. He said staff had put some items from the nonworking freezer into the back freezer, went day by day on the menus, and items in the nonworking freezer were what was left. He said he did not know why those items were not discarded because he was not there over the weekend. He said they should have been discarded because it would have been outside of the appropriate temperature. He stated keeping freezers at the proper temperature would prevent foodborne illness. Attempted interview on 03/08/26 at 11:54 AM, with [NAME] W, via phone, was unsuccessful. Interview on 03/08/26 at 11:57 AM, with the Maintenance Supervisor revealed he was aware of the freezer issue in the South kitchen. He said it had gone down again on Friday (03/06/26). He said the vendor tried to fix it but said they had to order a part, so he contacted Dietary Manager V to move the food from the freezer. The Maintenance Supervisor stated he did not take the freezer temperature on Friday and just knew it was not working because he was notified by Dietary Manager V. He stated if the food was not moved, it was trash and could make residents sick. He stated he was not aware the food was not moved and was told by Dietary Manager V he was on his way up there (on Friday 03/06/26) to move the food items. He stated he reported to the Administrator that the freezer was not working. He said he did not follow up to ensure the food was moved from the freezer after contacting Dietary Manager V. Record review of work order request for the South Kitchen freezer was created by the Maintenance Supervisor on 03/05/26 reflected the following: Reach-in Freezer Temperature issues.The temp is increasing again it is up to 32.Tech arrived at 10:06 AM. Tech Departed at 4:30 PM. The work for this job is not yet complete for the following reason: Parts Needed.Comments from your technician: Arrived onsite. Found freezer evap coil frozen up. Removed evap coil cover and thawed out unit. plugged unit back in and unit would not power up. Check voltage and unit is receiving voltage but will not turn on. Will need to replace controller on unit. Interview on 03/08/26 at 12:06 PM, the Administrator stated no food was used from the nonworking freezer in the South Building. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempted interview on 03/08/26 at 12:08 PM, with Dietary Manager V, via phone, was unsuccessful. Observations on 03/08/26 between 12:42 PM and 1:02 PM, the nonworking freezer had no food items inside. Record review of facility's policy titled Food Storage revised 04/08/25, reflected Sufficient storage facilities are provided to keep food safe, wholesome and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. 3. Freezer: .Temperatures are checked and logged at least twice daily. Freezer temperature must be sufficient to keep all foods frozen during storage.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure rooms were equipped to assure full visual privacy for each resident for 3 (Rooms # 115, #116, #119) of 18 rooms reviewed for visual privacy.The facility failed to ensure resident rooms had full visual privacy, Rooms # 115, #116, and #119, did not have a privacy curtain. This failure could place residents at risk of being exposed during cares or when changing clothes.Findings included:Observation on 03/08/26 at 11:24 AM, of room [ROOM NUMBER] there was no privacy curtain for the resident in the bed closest to the door. There was a track mounted to the ceiling for a curtain, as well as the hanger clips, but no curtain. Observation on 03/08/26 at 11:31 AM, of room [ROOM NUMBER] there was no privacy curtain at the foot of the bed closest to the window. There was a track mounted to the ceiling for a curtain, as well as the hanger clips, but no curtain.Observation on 03/08/26 at 11:38 AM, of room [ROOM NUMBER] there was no privacy curtain at the foot of the bed for the bed closest to the window. There was a track mounted to the ceiling for a curtain, as well as the hanger clips, but no curtain.Interview on 03/10/26 at 11:56 AM, CNA -D stated resident privacy was necessary for their happiness and dignity. He stated housekeeping was responsible for the privacy curtains. He was not aware of any privacy issues as residents had not complained to him. Interview on 03/10/26 at 12:05 PM, LVN-E stated privacy was a priority for residents, it protected their dignity. He stated no one wants to be seen changing clothes. LVN-E stated housekeeping was responsible for the privacy curtains. Maintenance was responsible for the blinds in the windows. He was not aware of any privacy issues as residents had not complained to him. Interview on 03/10/26 at 12:12 PM, LVN-F stated resident privacy was very important for their dignity, and the privacy curtain also defined their living area. She stated housekeeping was responsible for changing out the curtains, and maintenance was notified about things like the blinds via the maintenance repair logbook. She was not aware of any privacy issues as residents had not complained to him. Interview on 03/10/26 at 1:33 PM, the Housekeeping Supervisor stated nursing staff was responsible for letting her know when a privacy curtain needed to be changed out and she would coordinate with maintenance to change them out. She had clean ones in storage that could be changed out for a dirty ones . Interview with the Maintenance Supervisor on 3/10/26 at 2:10 PM, he stated nursing staff have to notify him whenever there is a maintenance issue, and he will address it the same day usually. Occasionally he will have to order something, but blinds can be replaced the same day . Interview on 03/10/26 at 3:45 PM, the DON stated privacy for the residents is a priority for their dignity. She stated she was unaware of the missing privacy curtains, but she would have a sweep of the facility done to identify rooms in need of privacy curtains. The Administrator was unable to provide a policy addressing privacy curtains or resident privacy prior to the end of the survey.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of pest for 1 of 5 residents (Resident #232), 1 of 2 kitchens (North Kitchen), and 1 of 2 halls reviewed for pest control. The facility failed to ensure the facility was free of gnats in Resident #232 room, North kitchen and 700 Hall.This failure could affect residents by placing them at risk for the potential spread of infection, cross-contamination, food-borne illness, and decreased quality of life.Findings included: Observation and interview on 03/08/26 at 9:14 AM, revealed there were gnats in the kitchen, in the dishwasher area. According to [NAME] K, she was aware of gnats in the dishwashing area. [NAME] K stated dishwashers were responsible for reporting the gnats to the Dietary Manager and the Maintenance Supervisor . She stated the Maintenance staff were aware of the problem. Observation and interview on 03/08/26 at 4:00 PM, Resident #232 revealed about 8-10 gnats at his bedside table, in his orange juice and on his sandwich. According to Resident #232 gnats had been an ongoing problem and he had reported to the nursing staff . Resident #232 stated he did not eat the food in his room due to the gnats. Resident #232 stated he felt he lived in an unhealthy environment. Observation and interview on 03/08/26 at 4:17 PM, with LVN I in Resident #232's room revealed he saw 8-10 gnats flying around Resident #232's bedside table. LVN I stated he was aware of the gnats in the facility. LVN I stated he has notified the Maintenance Supervisor of the gnats and has seen pest control contractors in the building. LVN I stated he was responsible for reporting the sight of gnats to the maintenance department by documenting in the log book at the nurses station. LVN I stated having gnats in the building and on resident foods placed residents at risk of illnesses and cross contamination. Interview on 03/09/26 at 2:59 PM, Dietary Aide N revealed she had observed gnats on the 700 hallway when serving resident meals. According to Dietary Aide N the gnats were annoying when trying to keep them out of resident food. Dietary Aide N stated she was responsible for notifying the Dietary Manager of the gnats, not doing so placed residents at risk of illnesses and not living in a clean environment. Dietary Aide N stated she did see a pest control contractor entering the building today (03/09/26); however, she was not sure if it was helping with the pest problem. Interview on 03/09/26 at 3:06 PM, Dietary Aide O revealed she worked in the kitchen as a dishwasher. Dietary Aide O stated she observed the gnats in the kitchen, she thought it was due to the leaking water, garbage disposal, and leftover foods after meal services. Dietary Aide O stated that she had not reported the gnats to the Dietary Manager or the maintenance department. Dietary Aide O stated she was responsible for reporting the gnats and not doing so placed residents at risk of getting sick. Interview on 03/09/26 at 3:30 PM, Dietary Manager HH revealed she recognized the gnats in the kitchen, however, had not been informed that staff were seeing gnats on the hall while serving meals. Dietary Manager HH stated it was the responsibility of the kitchen staff to report issues with gnats to her or the maintenance department. Dietary Manager HH stated she would then report the issue to the Maintenance Director so that he could contact the pest control vendor. Dietary Manager HH stated having gnats around the kitchen created an unhealthy environment and placed residents at risk for foodborne illness. Interview and observation on 03/09/26 at 4:46 PM, Maintenance Assistant H revealed he was aware of gnats in the building. He stated their pest control vendor was recently in the facility. He stated it was the responsibility of everyone to report to the maintenance department when they saw pests in the building. He stated if there was an issue with gnats, staff would write their concerns in a book located at the nursing station. He stated having problems with gnats in the building and in resident rooms could place residents at risk of becoming ill or living in unsafe conditions. Interview on 03/10/26 at 2:30 PM, the Administrator revealed they have a pest control vendor entering the facility biweekly. According to the Administrator, he expected all staff to follow chain of command and communicate with the maintenance department when there was a problem with pests. The Administrator stated having pest in the building placed residents at risk for illnesses. Review of the (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 residents had the right to self-administer medications if the interdisciplinary team determined that this practice was clinically appropriate for 2 of 2 residents (Resident #102 and Resident #232) reviewed for resident rights.1.The facility's interdisciplinary team failed to ensure Resident #102 was clinically appropriate to self-administer Atrovent 17mcg hfa inhaler that was with the resident in the TV room.2. The facility failed to ensure Resident #232's eye drops and arthritis pain cream, located at his bedside, was clinically appropriate to self-administer medications.These failures could place residents at risk of not receiving the therapeutic benefit of medication or an adverse drug reaction.Findings include:1. Record review of Resident #102's quarterly MDS, dated [DATE], reflected Resident #102 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #102 had a BIMS score of 07, which indicated his cognition was moderately impaired. Resident #102's diagnoses included asthma (chronic respiratory disease that causes inflammation, swelling, and tightening of the airways, often resulting in coughing, wheezing, shortness of breath, and chest tightness) and (COPD) Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs). Record review of Resident #102's order summary, dated 06/26/25, reflected the following: - Atrovent 17 mcg hfa (hydrofluoroalkane) inhaler (ipratropium bromide) puffs inhalation four times a day 08:00 am, 12:00 pm, 04:00 pm, 09:00 pm for z99.81 dependence on supplemental oxygen 2 puffs inhalation four times a day [time: 08:00 am, 12:00 pm, 04:00 pm, 09:00 pm] start date 06/26/25. Record review of Resident #102's March 2026 MAR reflected Residnet#102 was receiving Atrovent 17mcg HFA Inhaler 4 times a day 08:00 am,12:00 pm, 04:00 pm, 09:00 pm with a start date of 07/22/25. Record review of Resident #102's records reflected there were no determinations from the IDT included regarding self-administration. Observation and interview on 03/08/26 at 12:35 PM, revealed Resident #102 had an inhaler at the TV room. Resident #102 said one of the staff gave him the inhaler to keep. He could not identify which staff. Resident#102 stated he used the inhaler during shortness of breath. He could not tell how often he used the inhaler in a day, but he said he used it daily .He was not asked whether he requested to self-administer the medication. Interview on 03/08/2026 at 3:47 PM, with LVN I, who was the charge nurse for Residnet#102, revealed he was not aware Resident #102 had an inhaler to administer to himself. LVN I stated the inhaler should be stored in the mediation cart and Resident#102 had orders for four times a day. LVN I, stated a physician's order was required for Resident #102 to self-administer and also self-administration assessment was supposed to be done. LVN I stated allowing residents to have medications without a self-administration assessment placed residents at risk of over-using medication. Interview on 03/10/2026 at 5:25 PM, the DON revealed the facility did not have residents who self-administered medications. She stated in order for residents to have medication with them, a self-administration assessment was supposed to be done and the care plan updated. The DON stated residents who had medications in their rooms put them at risk of overmedicating and other residents (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting the medications. 2. Record review of Resident #232's admission MDS, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #232 had a BIMS of 6. which indicated severe cognitive impairment. Resident #115's vision was adequate. Resident #232 required partial/moderate assistance with upper body dressing, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfer, toilet transfer and tub/shower transfer. Active diagnoses included Radiculopathy (pinching of a nerve root in the spinal column), lumbar region, low back pain, wedge compression fracture of unspecified thoracic vertebra, subsequent encounter for fracture with routine healing, Wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing. Record review of Resident #232's, undated, Baseline Care Plan did not address Resident #232's need or use of medications at his bedside. Record review of Resident #232's clinical records reflected no assessment was completed to indicate if Resident #232 was able to self-administer medication. Record review of Resident #232's records reflected there were no determinations from the IDT included regarding self-administration. Record review of Resident #232's physician's order report reflected the following: 1. Eye Drops .055 percent solution for Dry Eyes start ([02/24/26 08:00] 1 gtt OU Ophthalmic Twice a day [Time: 08:00 AM, 09:00 PM]) 2. Voltaren 1 percent Gel/Jelly (Diclofenac Sodium) for Pain ([Start 02/24/26 08:00] apply QID Topically Four times a day [Time: 08:00 AM, 12:00 PM, 04:00 PM, 09:00 PM]) Observation and interview on 03/08/26 at 3:57 PM, revealed Resident #232 had a bottle of eye drops and arthritis pain cream at his bedside. Resident #232 stated he had the medication since being admitted from the hospital. Resident #232 stated he kept the medication at his bedside to use the eye drops as he needed for dry eyes and the pain cream due to pain on his left side lower back area. Resident #232 stated he was not sure if staff knew he had the medication, but they never took them away from his bedside. Interview and observation on 03/08/26 at 4:17 PM, LVN I stated he was not aware of any resident with an assessment to self-administer their own medications. LVN I entered Resident #232's room and observed eye drops and arthritis pain cream located at the resident's bedside table and nightstand. LVN I stated Resident #232 had these same medications on the cart to be administered by nursing staff. LVN I stated all medications were to be kept on the medication carts. LVN I asked Resident #232 if he could remove the mediation, and store them on the medication cart for use, LVN I stated [Resident #232's] family must have brought in the medication for him to use as needed. LVN I stated it was all staff's responsibility to address and remove medications found in resident rooms, not doing so placed residents at risk of overdosing. Interview on 03/10/26 at 12:19 PM, ADON J revealed there were no residents able to have medications at their bedside or self-administer medications due to risk of overdosing. ADON J stated she was not notified by staff that Resident #232 had eye drops or pain cream at his bedside. ADON J (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she expected nursing staff to remove any medication found in resident rooms, contact the family to pick it up or store the medication on the nursing carts. ADON J further stated the physician should be called to notify them medication was found at the bedside and consult for a prescription to administer to the resident from the nursing cart. Interview on 03/10/26 at 1:15 PM, the DON revealed she had no residents who could self-administer any medication. She stated residents were not allowed to keep medications at the bedside unless a physician order had been obtained and the resident had been assessed to self-administer. She stated the potential risk of keeping medications at the bedside would be someone else could get the medication or the resident using the medication without staff knowledge. Record review of the facility's Bedside Medication storage policy, dated January 2024, reflected Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the nursing care center's interdisciplinary resident assessment team. 1. The interdisciplinary team (IDT) will review and approve resident competencies and understand prior to permission of bedside storage of medications as established in the nursing care centers policies and procedures. 2. A written order for the bedside storage of medication is present in the residents' medical record. 3. Bedside storage of medications is indicated on the resident medication administration record (MAR) for the appropriate medications. (See state regulations as some states restrict types of medications that may be kept at the resident's bedside).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review the facility failed to ensure the resident had the right to a safe, clean, comfortable and homelike environment, including but not limited to Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 35 residents (Residents #147) reviewed for environmental conditions.The facility failed to ensure Resident #147's ceiling plaster was not hanging from the ceiling.This failure could place residents at risk for injury and a decreased quality of life. Findings include: Observation and interview on 03/08/26 at 12:50 PM, revealed Resident #147 room ceiling plaster was peeling and hanging from the ceiling and able to see the drywall. Resident #147 stated a couple of days ago it rained, it started to peel off, and it was getting bigger. Resident #147 stated she was not sure if anyone was going to fix it. Resident #147 stated she could not recall if she notified anyone about it. Interview on 03/10/26 at 10:59 AM, CNA PP revealed she was not aware of Resident #147's ceiling. She stated she had just noticed it, and the resident had not reported anything to her. She stated the resident's bed was on the maintenance logbook but was not sure if the ceiling was documented or if maintenance was aware of it. She stated the Maintenance logbook was kept at the nurses station. Interview on 03/10/26 at 11:05 AM, RN MM revealed she was the nurse assigned to Resident #147. She stated she was aware of the ceiling and thought it was being fixed. She stated there was no water damage due to the rain. RN MM stated it was the resident's right to have every piece of equipment in good condition. Interview on 03/10/26 at 3:42 PM, the Maintenance Supervisor revealed he was not aware of Resident #147's ceiling. He stated he reviewed the Maintenance Logbook once a week. He stated it was the responsibility of the staff to notify him when something was not working properly, so he could get it fixed as soon as possible. He stated if the ceiling plaster was peeling off it could cause something to fall. Interview on 03/10/26 at 5:08 PM, the Administrator revealed the facility had a maintenance logbook located at each nurse's station. He stated he was not aware of Resident #147's ceiling. He stated the expectation was for staff to document any environmental concerns in the maintenance logbook. He stated maintenance staff was responsible for checking the logbook daily. The Administrator stated it was the residents right to have everything functioning in their rooms. Record review on 03/10/26 at 11:02 AM of the facility's Maintenance Logbook revealed there was no request for ceiling repair. Record review of the facility's Resident Room Cleaning policy, revised 01/2026, reflected the following: To provide a clean, attractive, and safe environment for residents, visitors, and staff.

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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 to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 2 of 16 residents (Resident #54, #36) reviewed for care plans.1.The facility failed to develop a care plan for Resident #54's use of a feeding tube for nutrition or his noncompliance with physician orders which indicated Resident #54 to have nothing to eat or drink by mouth.2. The facility failed to ensure Resident #36's care plan addressed antibiotic treatment via CVC line (used to deliver medications and other treatments directly to the large central veins near heart). These failures could place residents at risk of not receiving the care required to meet their individual needs.1. Record review of Resident #54's admission MDS assessment, dated 02/23/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #54 was dependent on staff for eating and oral hygiene. Resident #54 had diagnoses which included cancer and malnutrition. Resident #54's MDS did not indicate his use of a feeding tube. Record review of Resident #54's baseline care plan, dated 02/17/26, reflected: IV Therapy, to deliver medications with goals to complete medication which required IV and met daily nutritional requirements. Resident #54's care plan did not address his wishes to have food or drink by mouth. Record review of Resident #54's order summary report reflected the following: 1. Osmolite 1.5 Cal 0.06 gram-1.5 kcal /mL oral liquid Q 12-hour shift [Time: from 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM] Osmolite 1.5k cal at 70 ml/hr start 03/05/26. 2. Peg -Tube Residual Q 12-hour shift [Time: form 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM]Check residual Q shift. Hold if greater than 100cc , hold feeding and notify physician. 3. Aspiration Precaution Q 12-hour shift [Time: from 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM] 4. DIET: Order - NPO Observation and interview on 03/08/26 at 1:13 PM, revealed Resident #54's tube feeding bag labeled Osmolite 1.5 and water bag labeled H20 03/08/26 was hanging. Resident #54 grabbed his cup at his bedside and drank from the straw, when asked about drinking and eating Resident #54 pointed to the corner where he advised he had snacks and things he liked to eat. Resident #54 then pointed to the small fridge to his left and advised he stored cold drinks. Resident #54 further advised he enjoyed some foods from the facility at least 3 times a day. Interview and observation on 03/08/26 at 4:17 PM with LVN I revealed Resident #54 laid in bed, Resident #54's tube feeding bag labeled Osmolite 1.5 and water bag labeled H20 03/08/26 was hanging. LVN I reported he was aware Resident #54 had a feeding tube and that was something that should have been documented on the care plan . LVN I stated he was not aware of Resident #54's desire to have food and drink by mouth, however, that was something that needed to be updated on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his care plan as well. According to LVN I, care plans were generated upon admission so nursing staff were able to provide adequate care. RN C stated care plans were updated by the MDS Coordinator. Interview on 03/10/26 at 5:27 PM with ADON J revealed she was not aware Resident #54's care plan was not updated with his use of a feeding tube. ADON J stated Resident #54's care plan should have been updated by his admitting nurse or the MDS Coordinator. ADON J stated the care plan included important information for use and care, without it Resident #54 was at risk for malnutrition, over feeding, aspiration, improper care, and infection. Interview on 03/10/26 at 5:25 PM with the DON revealed she was unaware Resident #54 did not have his care plan updated with his use or care of a feeding tube. The DON stated Resident #54 had orders for NPO, however was non-complaint and wanted to eat and drink by mouth, and of course this was something that needed to be care planed. The DON stated MDS Coordinators were responsible for ensuring all resident care areas were entered upon admission. The DON stated Resident #54 not having an updated care plan placed Resident #54 at risk of nutritional issues and aspiration. Interview on 03/10/26 at 5:38 PM with the MDS Coordinator revealed she was not aware Resident #54's care plan did not include his use of a feeding tube or his desire to have food and drink by mouth. The MDS Coordinator said Resident #54 had recently been out to the hospital, nurses were responsible for ensuring the order was entered so the care plan could reflect proper care for residents. The MDS Coordinator said the purpose of the care plan was to notify all staff of resident's care needs. The MDS Coordinator said if something was missing from the resident's care plan, it placed residents at risk and there could be miscommunication regarding the resident's care. 2. Record review of Resident #36's admission MDS Assessment, dated 02/08/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #36had diagnoses which included metabolic encephalopathy (brain disease), bacterial infection (harmful bacteria enter your body and multiply), chronic kidney disease (gradual loss of kidney function), essential hypertension (high blood pressure) and Alzheimer's disease (brain condition that slowly damages your memory, thinking, learning and organizing skills). Resident #36's BIMS score was 06, which indicated severe cognitive impairment. Section O – Special Treatments, Procedures, and Programs reflected the resident had an IV Access -Central line for IV Medications – Antibiotics. Record review of Resident #36's care plan, dated 03/10/26, did not address the use of antibiotics or having a CVC line. Record review of Resident #36's March 2026 physician orders reflected the following: IV-Midline dressing change on Day Shift [Frequency: Weekly on Wednesday Time: Shift 1] or when it becomes, damp, loose, soiled or if the patient develops problems at the site that requires further inspection. Assess the site for redness, drainage, swelling, and pain. Order dated: 02/09/26. Daptomycin In Sodium Chloride (Daptomycin/Sodium Chloride 500 MG/50 ML – 0.9% Solution) Daptomycin 7 MG/KG (500 MG) IV piggyback Q 48 HRS for Acute and subacute infection endocarditis for preventative 1 Intravenous Evening Shift [Frequency: Every 2 days, starting 02/20/26 Time: Shift 2] Stop Date: 03/07/26]. Order dated: 02/20/26. Observation and interview on 03/08/26 at 2:06 PM revealed Resident #36 was in his room, lying in bed. He was observed to have a CVC line on his right side of his chest; it had a dressing that was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peeling off with a date of 03/01/26. No signs of redness or drainage observed. Resident #36 denied any pain and stated he could not recall when the last time he received his antibiotic medication. The intravenous medication bag was hanging on the pole and the IV tubing was not labeled with the date, time, and initials. Interview on 03/10/26 at 5:17PM, RN MM revealed antibiotic therapy should be in the care plan. She stated Resident #36 was receiving antibiotics and had the central line. RN MM reviewed Resident #36's care plan and stated he was not care planned for being on antibiotics and having a central line. She stated it was the responsibility of upper management to update care plans. Interview on 03/10/26 at 5:48 PM, the DON revealed residents who had PICC/CVC lines or receiving antibiotics should not be care planned. She stated Resident #36's tunneled central line should had not be care planned because it was being removed. Interview on 03/10/26 at 6:18 PM, MDS Coordinator KK revealed any resident receiving antibiotic treatment should be care planned and it was the responsibility of the MDS Coordinator to update care plans. She stated she was not sure why it was not care planned. She stated there was no potential risk of not care planning; however, it was important to care plan antibiotic treatments so staff were aware of residents' plan of care. Record review of the facility's Resident Assessment policy, revised January 12, 2020, reflected the following: Purpose: To assess each resident's strengths, weaknesses, and care needs. To use this assessment data to develop a person-centered comprehensive plan of Care for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and well-being as possible. Record review of the facility's Care Plan – Process policy, reviewed 03/27/23, reflected the following: The interdisciplinary team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required time frames .6.The Plan of Care identifies the: Date; Problem; Goals, measurable and realistic; Time frames for achievement; Interventions, discipline specific services, and frequency; Resolution/Goal analysis; Discharge option.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers for 2 of 13 residents (Resident #54 and #229) reviewed for feeding tubes .1.The facility failed to ensure Resident #54's formula and water bag was properly labeled with the resident name, name of formula, feeding rate, date, time his formula and water was administered along with the nurse's initials.2. The facility failed to follow physician's orders of providing Resident #229 with his 22-hours of feeding intake and failed to ensure the formula bag was changed on 03/08/26. These failures could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care.Finding include: 1. Record Review of Resident #54's admission MDS assessment, dated 02/23/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #54 was dependent on staff for eating and oral hygiene. Resident #54 had diagnoses which included cancer and malnutrition. Resident #54's MDS did not indicate his use of a feeding tube. Record review of Resident #54's baseline care plan, dated 02/17/26, reflected: IV Therapy, to deliver medications with goals to complete medication requiring IV and meet daily nutritional requirements. Antibiotic Therapy, reason for antibiotic was Sepsis (the body responds improperly to an infection), with goals to be free of bacterial infection and have no discomfort or adverse side effects. Record review of Resident #54's order summary report reflected:1. Osmolite 1.5 Cal 0.06 gram-1.5 kcal/mL oral liquid Q 12-hour shift [Time: from 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM] Osmolite 1.5k cal at 70 ml/hr start 03/05/26. 2. Peg -tube Flush 120 Cubic centimeter Q 12-hour shift [Time: from 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM] Use water 120 ml every 2 hours. 3. Peg-Tube Residual Q 12-hour shift [Time: form 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM]Check residual q shift. Hold if greater than 100cc , hold feeding and notify physician. 4. Aspiration Precaution Q 12-hour shift [Time: from 06:00 AM to 06:00 PM, from 06:00 PM to 06:00 AM] 5. DIET: Order - NPO Observation and interview on 03/08/26 at 1:13 PM, revealed Resident #54's tube feeding bag labeled Osmolite 1.5 and water bag labeled H20 dated 03/08/26 was hanging. Resident #54 grabbed his cup at the bedside and drank from the straw, when asked about drinking and eating Resident #54 pointed to the corner where he advised he had snacks and things he liked to eat. Resident #54 then pointed to the small fridge to his left and advised he stored cold drinks. Resident #54 further advised he enjoyed some foods from the facility at least 3 times a day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 03/08/26 at 4:17 PM with LVN I revealed Resident #54 was lying in bed, Resident #54's tube feeding bag labeled Osmolite 1.5 and water bag labeled H20 , dated 03/08/26 was hanging. LVN I reported he was aware Resident #54 had a feeding tube, LVN I stated the overnight shift hung the formula and water bags prior to the end of their shift. LVN I stated when he entered on his shift at 6:00 AM he was responsible for completing his assessment, administering medications and starting the machine for feeding. LVN I stated he did not notice the bags were without proper labels. LVN I stated nurses were responsible for ensuring both formula and water bags were labeled with the resident name, feeding rate, date or time hung along with staff initials. LVN I stated not doing so placed Resident #54 at risk of having improper feeding times, expired formula, or upset stomach. Observation on 03/09/26 at 10:15 AM revealed Resident #54 lying in bed, with a tube feeding running at 70 mL per hour. The formula and water bag were not labeled with the resident name, feeding rate, date or time hung along with staff initials. Observation and interview on 03/10/26 at 5:25 PM revealed ADON J stated Resident #54's formula and water bag should be properly labeled and dated. ADON J stated her expectation was that nursing staff hanging formula and water bags should have documented on the bag the resident's name, feeding rate, date, time of administering the formula and add their initials. ADON J stated not providing this information placed residents at risk of having the wrong feeding formula, feeding rates, or malnutrition. Interview on 03/10/26 at 5:30 PM with the DON revealed she expected her nursing staff to follow physician orders and follow the five rights of medication administration ensuring staff had the right resident, right drug, right dose, route and time. The DON stated not doing so placed Resident #54 at risk of not having his feedings as ordered. 2. Record review of Resident #229's face sheet, dated 03/10/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #229 had diagnoses which included unspecified dementia (loss of cognitive functioning), Type 2 diabetes mellitus (high blood sugar level), cerebral infarction (stroke), hyperlipidemia (high cholesterol), essential hypertension (high blood pressure) Dysphagia (difficulty swallowing), adult failure to thrive (physical and mental decline) mild, protein-calorie malnutrition. Record review of Resident #229's Entry MDS Assessment, dated 03/01/26, reflected Resident #229's Entry MDS assessment was completed; however, it did not address the resident's BIMS score, or Special Treatments, Procedures, and Programs the resident was receiving. Record review of Resident #229's Admit Baseline Bare Plan, dated 03/01/26, reflected Special Treatments/Procedures: G-Tube. Cognition/Communication/Vision: Severely Impaired. Record review of Resident #229's March 2026 physician orders reflected: Glucerna 1.2 @ 55ml/hr x 22 hours 1320 ml/day. Down Time 8AM -10AM Order state 03/06/26. Observation on 03/08/26 at 12:48 PM, revealed Resident #229 was not in his room. The g-tube formula bag was hanging on the pole, it was labeled with a date of 03/06/26 at 7:40 PM at a rate of 55ML. The formula bag still had about 200ML of formula inside. Observation on 03/08/26 at 2:46 PM, revealed Resident #229 was in the common area sitting in his wheelchair. An attempt was made to interview Resident #229; however, he would only respond with (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	okay. Observation on 03/08/26 at 3:30 PM, revealed Resident #229 was in the common area sitting in his wheelchair. Interview on 03/08/26 at 3:40 PM, LVN JJ revealed she was the nurse assigned to Resident #229. She stated she arrived at her shift at 3PM, the morning nurse was ADON J. LVN JJ observed the formula bag and stated the date on the formal bag was 03/06/26. LVN JJ stated the formula bag should have been changed every 24 hours. She stated whoever hung the formula bag might have wrote the wrong date, since the syringe was changed and dated 03/08/26. LVN JJ reviewed Resident #229's physician orders and stated the resident should have been connected at 10AM. She stated Resident #229's orders were changing often due to residual and feedings placed on hold; however, ADON J did not notify her of any changes. LVN JJ reviewed documentation and stated she could not locate any new orders since 03/06/26 or any documentation of why Resident #229 was not connected at 10AM. She stated the potential risk of not changing formula bag would be food poising. LVN JJ stated the potential risk of not following physician orders for enteral feedings could lead to malnutrition. Interview on 03/08/26 at 4:09 PM, ADON J revealed she was the morning nurse assigned to Resident #229. She stated Resident #229 was not connected to his feeding when she arrived for her shift around 8:30-9:00 AM. She stated LVN II was the one who disconnected Resident #229 from the g-tube machine. She stated after reviewing Resident #229's orders the resident should have been reconnected at 10AM. She stated she thought Resident #229 was on a bolus feeding. She stated she provided a bolus feeding at 11AM and then at 1:30 PM. ADON J stated she did not review the physician orders or followed the MAR. She stated she was not aware the physician orders had changed and she was going by the original order which were feedings from 6AM-6PM and then bolus feeding during the day. She stated she had not yet documented that she provided Resident #229's bolus feeding. ADON J stated she did not observe the formula bag in the room, she stated she only observed the syringe. She stated she was not aware the formula bag was not changed. She stated the formula bag should be changed every 24 hours. She stated the potential risk of not following physician orders for enteral feedings could lead to malnutrition. She stated the potential risk of not changing the formula bag could cause the resident to get sick . Interview on 03/08/26 at 4:25 PM, LVN II revealed she was not the morning nurse assigned to Resident #229; however, around 8:10 AM a CNA came to her and informed her she was going to get Resident #229 out of bed and needed him to be disconnected from his g-tube. LVN II stated she disconnected Resident #229 from his feeding around 8:15 AM. She stated ADON J came into her shift around 9AM. LVN II stated ADON J should have connected Resident #229 back up at 10AM, but she did not. She stated she only gave report to ADON J that she disconnected Resident #229. She stated ADON J thought Resident #229 was bolus feedings. LVN II stated she did not observe the formula bag, she stated the night shift was responsible for changing out the formula bags. She stated the potential risk of not following physician orders for enteral feedings could lead to nutrition deficiency and not getting enough calories. She stated the potential risk of not changing the formula bag could cause the resident to get sick. An attempted interview was made to contact the overnight nurse, LVN OO by phone on 03/08/26 at 4:37 PM; however, there was no response. Interview on 03/09/26 at 9:54 AM, the DON revealed formula bags should be changed and dated after every feeding. She stated Resident #229 recently admitted with the g-tube and physician orders were changed and adjusted. She stated Resident #229 received bolus feeding during the day. She stated (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the expectation was for nurses to follow physician orders. She stated the potential risk of not changing formula bags could cause the resident to get sick. Interview on 03/10/26 at 3:59 PM, Dietitian LL revealed Resident #229 received g-tube feedings. She stated Resident #229's physician orders were changing almost every day due to resident having residual (the amount of fluid in the stomach). She stated nurses were communicating with her regarding the residents residual, so they've been trying to adjust his orders. Dietitian LL stated nurses should be following physician orders and if the order indicated to reconnect the resident at 10AM, the resident should be reconnected to his feedings. She stated there was no potential risk since they were adjusting his enteral feeding orders. Record review of the facility's Irrigating a Feeding Tube policy, reviewed 04/21/24, reflected the following:Staff will use appropriate methods for irrigation of a feeding tube within standard practice guidelines.Change irrigation bottle every 24 hours.Reconnect tube to pump and set the prescribed rate if a pump is utilized.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 2 residents (Resident #36 and Resident #227) reviewed for intravenous medication. 1. The facility failed to ensure Resident #36, and Resident #227's intravenous medication bag and tubing were labeled with the date, time, and initials.2. The facility failed to change and maintain the integrity of Resident #36's CVC line (used to deliver medications and other treatments directly to the large central veins near heart) dressing per professional standards.3. The facility failed to follow physician orders for administering medications to Resident #227 when LVN Q administered Cefazolin 2gm intravenous medication used to treat infection.These failures could place residents at risk for medication error, delay in medication administration, infections and cross-contamination. Findings include: Record review of Resident #36's admission MDS Assessment, dated 02/08/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #36 had diagnoses which included metabolic encephalopathy (brain disease), bacterial infection (harmful bacteria enter your body and multiply), chronic kidney disease (gradual loss of kidney function), essential hypertension (high blood pressure) and Alzheimer's disease (brain condition that slowly damages your memory, thinking, learning and organizing skills). Resident #36's BIMS score was 06, which indicated severe cognitive impairment. The MDS Section O – Special Treatments, Procedures, and Programs reflected the resident had an IV Access -Central line for IV Medications – Antibiotics. Record review of Resident #36's care plan, dated 03/10/26, did not address the use of antibiotics or having a PICC/CVC line. Record review of Resident #36's March 2026 physician orders reflected the following: IV-Midline dressing change on Day Shift [Frequency: Weekly on Wednesday Time: Shift 1] or when it becomes, damp, loose, soiled or if the patient develops problems at the site that requires further inspection. Assess the site for redness, drainage, swelling, and pain. Order dated: 02/09/26. Daptomycin In Sodium Chloride (Daptomycin/Sodium Chloride 500 MG/50 ML – 0.9% Solution) Daptomycin 7 MG/KG (500 MG) IV piggyback Q 48 HRS for Acute and subacute infection endocarditis for preventative 1 Intravenous Evening Shift [Frequency: Every 2 days, starting 02/20/26 Time: Shift 2] Stop Date: 03/07/26]. Order dated: 02/20/26. Observation and interview on 03/08/26 at 2:06 PM revealed Resident #36 was in his room, lying in bed. He was observed to have a CVC line on his right side of his chest; it had a dressing that was peeling off with a date of 03/01/26. No signs of redness or drainage were observed. Resident #36 denied any pain and stated he could not recall when the last time he received his antibiotic medication. The intravenous medication bag was hanging on the pole and the IV tubing was not labeled with the date, time, and initials. Interview on 03/08/26 at 3:35 PM, LVN II revealed she was the nurse assigned to Resident #36. She stated Resident #36 was on antibiotics, she stated he was receiving it every 48 hours. She stated she believed Resident #36 completed his treatment. She stated the IV tubing and medication bag were (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to have the correct, date, and initials of the nurse administering the medications. She stated she was not the one who hung the bag, she came on at 6AM and the resident was already disconnected. She stated the potential risk of not dating and labeling the medication bag and tubing would be staff not knowing when the medication was last given and they did not give it again. Observation and interview on 03/09/26 at 4:30 PM, revealed Resident #36's CVC line insertion site with LVN M revealed Resident #36 had a CVC line in his right side of his chest, dressing was not attached to skin, it had peeled off and was dated 03/01/26. LVN M stated Resident #36's PICC Line dressing was all wrong. He stated he was aware the dressing was supposed to be changed every 7 days and as needed if loose. LVN M stated the PICC line insertion site revealed it was clean with no signs of infection. He stated dressing changes were completed by the Wound Care Nurse. He stated the potential risk of not changing dressing could lead to infection. Interview on 03/09/26 at 5:05 PM, the DON revealed Resident #36 completed his antibiotic treatment and the intravenous medication bag and tubing should've been taken out of the room and thrown out. She stated it was the responsibility of the ADON to check after the nurses and ensure labelling was done. She stated the importance of labeling would help staff know when the resident last received the medication and when to take it down. Interview on 03/10/26 at 3:16 PM, the Wound Care Nurse revealed the assigned nurse was responsible for changing PICC line dressings. He stated he was not responsible for changing them unless he was the nurse assigned to the resident. He stated the potential risk of not changing PICC line dressing would be infection. He stated it was the responsibility of the ADON to monitor the PICC line dressing to ensure they were completed. Interview on 03/10/26 at 3:21 PM, ADON J revealed she expected staff to date and initial the medication bag and tubing when administering the medications. She stated PICC line dressings should be changed every 7 days. She stated it was the responsibility of the ADONs to monitor PICC lines to ensure it's being done. She stated the memory care unit did not have an ADON at the moment. She stated the potential risk of not changing the dressing would be possible infections. Follow up interview on 03/10/26 at 5:48 PM, the DON revealed she expected the nurses to change PICC line dressings every seven days and as needed to prevent infection. She stated it was not the responsibility of the Wound Care Nurse to change PICC line dressings, but the nurses assigned to the resident. She stated it was the responsibility of the ADONs to ensure it was being completed. She stated the potential risk of not changing the dressing would be infection. Record review of the facility's Medication – Administration of IV Fluids and Medications policy, revised 01/12/23, reflected the following: Staff will administer IV fluids and medications in accordance with standard practice guidelines. Dressing change or site change/date and initial. The policy did not address labelling with date, initials and time. Record review of the facility's Vascular Access Devices and Infusion Therapy Procedures - Dressing Change for Vascular Access Devices policy, dated 10/24, reflected the following:Purpose To prevent local and systemic infection related to the IV catheter. Central venous access device and peripheral midline dressings are changed every 7 daysand immediately if the integrity of the dressing is compromised, if moisture, drainage orblood is present, or for further assessment if infection is suspected. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #227's Face sheet, dated 03/09/26, reflected the resident was a [AGE] year-old female who was admitted to facility originally on 03/06/26 and readmission on [DATE]. Resident #227 had a diagnosis of intraspinal abscess and granuloma (critical conditions involving bacterial infection (often Staphylococcus aureus) or chronic inflammation within the spinal canal, leading to epidural, subdural, or intramedullary pus collection. Her BIMS score was not completed, and she was newly admitted her MDS was not completed. Record review of Resident #227's physician's orders dated 03/06/26 reflected an order for: Cefazolin 2 gm Powder for Solution (Cefazolin) for Intraspinal abscess and granuloma ([start 03/06/26 08:00] 2 g intravenous twice a day [time: 08:00 am, 09:00 pm] [stop 03/15/26 08:00]).) Record review of Resident #227's Care Plan Report, initiated 03/08/26, reflected Resident #227 had problem: -Infection. Goals: - No signs or symptoms of Infection. Interventions: -Administer medications and treatments as ordered. Monitor side effects of medication and report to doctor and adverse reactions. Observation on 03/08/25 at 01:43 PM,revealed Resident #227 in her room, lying in bed. She was observed to have a PICC line dated 03/06/26. The intravenous medication bag was hanging on the pole half administered and was not connected to Resident #227. The IV bag was not labeled with the date, time, and initials to indicate when it was hung. Resident not interviewed since it was not clear whether she had unhooked herself during the observation. Observation and interview on 03/08/26 at 02:39 PM, LVN Q revealed Resident #227 was in bed and intravenous bag was still hanging on the pole and not connected to Resident#227 and it was half administered. The bag was not labeled with date, initial and time. LVN Q stated she was not the one who hung the bag. She stated when she came on duty in the morning at 06:30AM she saw Residnet#227 connected to the IV. It was hung by the 06:00 PM-06:00 AM nurse. LVN Q stated the IV was supposed to run for 30 minutes. She stated she forgot to go check on Resident #227 until later when another nurse notified her Residnet#227 disconnected IV and was outside the facility door. LVN Q stated she was not familiar with Resident#227, and she did not attempt to hook her back on the IV again. She stated she could see Resident#227 outside the facility door on her wheelchair until lunch time when she came back to her room and slept. She stated she did not notify management or the doctor regarding Resident#227 unhooking the IV and she did not get the whole dose. She stated failure to administer the whole bag/dose to Resident#227 could lead to resistance and medication error. She said the IV bag and the tubing were supposed to have the correct resident's name, date, time and initial of the nurse administering the medications. She stated failure to put the date, time, and initials that could make Resident #227 miss the next dose or get an overdose. She stated failure to label the tubing with the date and time could lead to infections because the tubing was only good for 24 hours. LVN Q was requested for interview and she was giving excuses. ADON and DON were notified and this surveyor was notified that LVN Q had clocked out to solve personal issues and was to be back later. Interview on 03/08/26 at 3:43 PM, LVN I revealed he was the one, who reported to LVN Q that Residnet#227 had disconnected herself from the IV pole. He did not know whether LVNQ went to assess Resident# 227. He stated as he was passing down the hall after breakfast, he saw the IV pole was low than usual and he went to the room checked and the medication was half administered, and the resident was not in the room. He stated the risk of Resident#227 disconnecting self, leaving the facility and not completing the dose could lead to PICC line being clogged, risk of infection, and medication error. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/09/26 at 3:10 PM, the ADON revealed she expected staff to date and initial intravenous bags and tubing when administering intravenous medications to prevent infection and medication error. She stated her expectation was when LVN Q noted Resident#227 had not completed the dose to notify the doctor for further instructions. She stated the risk of resident disconnecting and not completing the dose would be medication error and not getting required therapy. She stated she had done training with staff on labeling and putting initials on bags and tubing and nurses had done skill checks. Record revealed LVQ was not in attendance she was newly hired. Attempt to call the night shift nurse RN OO on 03/09/26 at 03:38 PM no response. Interview on 03/10/26 06:40 PM, the DON revealed her expectation was staff to date and initial intravenous bags and tubing when administering intravenous medications. She stated she expected LVN Q to encourage Resident#227 to go back to her room and finish the IV and notify the doctor. She stated risks of not labelling the bag and tubing and not completing the dose of antibiotic were missing a dose and also infection. She stated she had done training with staff on labeling and putting initials on bags and tubing and, she had done skill checks with the nurse on 08/29/25 and LVN Q was not provided since she was newly employed. Record review of the facility's Medications, administration of iv fluids and medications policy, revised January 12, 2023, reflected the following: . Staff will administer IV fluids and medications in accordance with standard practice guidelines. Policy did not address labelling with date, initials and time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 medication carts (Halls 600 B nurse medication cart), 1 of 2 medication rooms (600 Hall medication room), and 1 of 5 residents (Resident #54) reviewed for labeling of drugs and biologicals.1. The facility failed to ensure expired medications were removed from the Hall 600 B medication cart and Hall 600 medication room.2. The facility failed to ensure LVN Q administered all morning medication to Resident #54. This failure could place residents at risk of not receiving the therapeutic benefit of medication or an adverse drug reaction. Findings included: 1.Observation on 03/09/2026 at 3:30 PM, of the Hall 600 B nurse medication cart with LVN M revealed one bubble pack of ibuprofen 400mg (used to treat pain) with an expiry date of January 2025 and Buspirone 7.5mg (treat generalized anxiety disorder) with an expiry date of 2/26/26. Interview on 03/09/2026 3:40 PM, LVN M revealed the unit manager was responsible for checking the cart for expired medications. He stated failing to remove the expired medication could result in the medications being administered which could cause reactions, or the residents would not get the required therapy. Observation / interview on 03/09/2026 at 3:42 PM, of the Hall 600 medication room and refrigerator with RN MM revealed.2 bottles of multivitamins with an expiry date of 11/05/25 and a bag of Daptomycin 500mgs (used to treat serious gram-positive infections) with an expiry date of 03/04/26. RN MM stated nurses are responsible of checking the cart for expired medications. She stated the risk of having expired medication if administered they will not be effective. Interview on 03/09/2026 at 3:45 PM, ADON G revealed her expectation was for nurses to check their cart for medication labeling and to look for expired medications. She stated the unit manager was responsible for checking behind the nurses monthly. She stated she could not tell when she last checked the carts and the refrigerators. She stated the risk of having expired medications on the cart was that if they were administered, they would not be effective. Interview on 03/10/2026 at 5:35 PM, the DON revealed her expectation was all nurses were responsible of checking the carts, medication rooms and refrigerator to ensure expired medications were removed for destruction. She stated it was the responsibility of ADON to monitor and ensure the nurses were labelling and discarding the expired medications, monthly. She stated if the staff was not checking carts for expired medications, it would place residents at risk of having reactions like the medication being ineffective since they could not tell of the potency. She was not asked how often they should check the carts and medication room. 2. Review of Resident #54's MDS assessment, dated 02/23/26, reflected was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had a BIMS score of 10 indicating moderate cognitive impairment. Resident #54's diagnoses included anemia (iron deficiency), cancer (complex group of diseases) and malnutrition (when the body lacks a variety of needed nutrients), Multidrug-Resistant Organism (a germ that is resistant to many antibiotics), Human Immunodeficiency Virus (a virus that attacks the body's immune system). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #54's baseline care plan dated 02/17/26 revealed: IV Therapy, to deliver medications with goals to complete medication requiring IV and meet daily nutritional requirements. Antibiotic Therapy, reason for antibiotic was Sepsis, with goals to be free of bacterial infection and have no discomfort or adverse side effects. Review of Resident #54's order summary report reflected: 1. DOVATO (Dolutegravir/lamivudine 50 MG – 300 MG tablet) for B20. Human Immunodeficiency virus [HIV] disease ([start 03/06/26 08:00] 1 tab Enteral Tube One time daily [Time: 08:00 AM])2. OMEPRAZOLE 20 MG capsule, delayed release (Omeprazole) for GERD ([start 03/06/26 08:00] 1 tab Enteral Tube Twice a day [Time: 08:00 AM, 09:00 PM])3. HYDROmorphone HCL 1 MG/1 ML solution (HYDROmorphone hydrochloride) for Malignant neoplasm of anal canal 4 ml Enteral Tube Every 6 hours [Time: 01:00 AM, 07:00 AM, 02:00 PM, 07:00 PM]4. METHADONE 5 MG tablet (Methadone Hydrochloride) Malignant neoplasm of anal canal 1 tab Enteral Tube Every 8 hours [Time: 08:00 AM, 03:00 PM, 11:00 PM]5. Thiamine 100 MG oral tablet for supplement ([start 03/0626 08:00] 1 tab Enteral Tube One time daily [Time: 08:00 AM]) 6. Amoxicillin/Clavulanate potassium 875mg-125mg tablet for Gram-negative sepsis, ([Start 03/06/26 08:00] 1 tab Enteral Tube Twice a day [Time: 08:00 AM, 09:00 PM] [Stop 03/21/26 08:00])7. Apixabn [Eliquis] 5 mg oral tablet for Acute embolism and thrombosis of unspecified deep veins of left lower extremity ([Start 03/06/26 08:00] 1 tab Enteral Tube Twice a day [Time: 08:00 AM, 09:00 PM]) Record review of Resident #54's MAR dated 03/10/26 revealed 8:00 AM missed doses for Dolutegravir 50mg-300, Omeprazole 10 mg, Hydromorphone solution 4mg, Thiamine 100 mg oral tablet, Amoxicillin/Clavulanate potassium 875mg-125mg, Apixaban [Eliquis] 5 mg and two missed doses for Methadone hydrochloride 5mg 08:00 AM, 03:00 PM. Interview on 03/10/26 at 1:13 PM, Resident #54 stated he had not been given his morning medications. Resident #54 stated someone had given a dose of pain medications however he was supposed to have several other medications that his nurse had not given. Resident #54 stated he was not sure who his nurse was for the day and did not know who gave him the pain medication. Interview on 03/10/25 at 5:21 PM, LVN Q revealed she had not worked with Resident #54 today (03/10/26). According to LVN Q she was unaware that she was to provide Resident #54 with care and medications during her shift. LVN Q stated no one had made it clear to her that she was to provide care for Resident #54. LVN Q stated she worked the back end of the hall, which her cart did not include any medications for Resident #54. LVN Q stated there was a nurse for the front half of the hall, therefore Resident #54 was not at risk of missing his medications. Interview and record review on 03/10/26 at 5:25 PM, ADON J revealed she was not aware that Resident #54 had missed any medications. ADON J stated LVN Q was responsible for care and medication administration for Resident #54. ADON J stated all nursing staff had been notified to pick up Resident #54 when LVN QQ was working, because she was not allowed to work with Resident #54. ADON J reviewed Resident #54's MAR and confirmed Resident #54 missed his morning medications. According to ADON J nursing staff were responsible for ensuring all residents received proper care and their medications, not doing so placed residents at risk of missing their medications and treatments. Interview on 03/10/26 at 5:53 PM, the DON revealed LVN Q was aware that LVN QQ was not allowed to work with Resident #54 and she would provide care to Resident #54. The DON stated all nursing staff had been notified and informed prior to the shift on 03/10/26. The DON stated she expected all (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675756	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	941 Scotland Dr Desoto, TX 75115

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff to ensure they are following physician orders, not doing so placed residents at risk of decline in general health and well being, uncontrolled pain, and further infections. The DON stated the ADON was responsible for following up to ensure the physician was notified of the missed doses and further instructions. Interview on 03/10/26 at 5:55 PM, with LVN QQ revealed she was not able to provide care for Resident #54 due to family request, which was told to her prior to Resident #54's return back to the facility on [DATE]. LVN QQ stated all staff had been educated to pick up Resident #54 when she worked. LVN QQ stated she also informed LVN Q that Resident #54 required her to provided his care because she was not allowed to enter his room. Record review of facility's Medication Storage dated 01/20/21 reflected: . 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal (Refer to Section 5 -Disposal of Medications, Syringes and Needles), and reordered from the pharmacy (Refer to Section 3.2 - Ordering and Receiving Non-Controlled Medications), if a current order exists Record review of facility's policy titled Physician Orders reviewed November 27, 2023 revealed The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician. Record review of facility Medication -Guidelines on Clinical Practice policy, revised January 12, 2020, reflected the following: Staff will provide medications in accordance with standard practice guidelines

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident was free of any significant medication errors for 1 of 7 residents (Resident #54) reviewed for medications. The facility failed to ensure LVN Q administered Resident #54 with his morning medications resulting in significant medication errors. These failures placed residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician, which could result in exacerbation of conditions. Findings included:Review of Resident #54's MDS assessment, dated 02/23/26, reflected a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had a BIMS score of 10 indicating moderate cognitive impairment. Resident #54's diagnoses included anemia (iron deficiency), cancer (complex group of diseases) and malnutrition (when the body lacks a variety of needed nutrients), Multidrug-Resistant Organism (a germ that is resistant to many antibiotics), Human Immunodeficiency Virus (a virus that attacks the body's immune system). Review of Resident #54's baseline care plan dated 02/17/26 revealed: IV Therapy, to deliver medications with goals to complete medication requiring IV and meet daily nutritional requirements. Antibiotic Therapy, reason for antibiotic was Sepsis, with goals to be free of bacterial infection and have no discomfort or adverse side effects.Review of Resident #54's order summary report reflected the following: 1. DOVATO (Dolutegravir/lamivudine 50 MG - 300 MG tablet) for B20. Human Immunodeficiency virus [HIV] disease ([start 03/06/26 08:00] 1 tab Enteral Tube One time daily [Time: 08:00 AM])2. HYDROmorphone HCL 1 MG/1 ML solution (HYDROmorphone hydrochloride) for Malignant neoplasm of anal canal 4 ml Enteral Tube Every 6 hours [Time: 01:00 AM, 07:00 AM, 02:00 PM, 07:00 PM]3. METHADONE 5 MG tablet (Methadone Hydrochloride) Malignant neoplasm of anal canal 1 tab Enteral Tube Every 8 hours [Time: 08:00 AM, 03:00 PM, 11:00 PM]4. Amoxicillin/Clavulanate potassium 875mg-125mg tablet for Gram-negative sepsis, ([Start 03/06/26 08:00] 1-tab Enteral Tube Twice a day [Time: 08:00 AM, 09:00 PM] [Stop 03/21/26 08:00])5. Apixabn [Eliquis] 5 mg oral tablet for Acute embolism and thrombosis of unspecified deep veins of left lower extremity ([Start 03/06/26 08:00] 1-tab Enteral Tube Twice a day [Time: 08:00 AM, 09:00 PM])Record review of Resident #54's MAR dated 03/10/26 revealed 8:00 AM missed doses for Dolutegravir 50mg-300, Hydromorphone solution 4mg, Amoxicillin/Clavulanate potassium 875mg-125mg, Apixaban [Eliquis] 5 mg and two missed doses for Methadone hydrochloride 5mg 08:00 AM, 03:00 PM.Interview on 03/10/26 at 1:13 PM, Resident #54 stated he had not been given his morning medications. Resident #54 stated he was supposed to have pain pills and several other medications that his nurse had not given. Resident #54 stated he was not sure who his nurse was for the day. Interview on 03/10/25 at 5:21 PM, LVN Q revealed she had not worked with Resident #54 today (03/10/26). According to LVN Q she was unaware that she was to provide Resident #54 with care and medications during her shift. LVN Q stated she worked the back end of the hall, which her cart did not include any medications for Resident #54. LVN Q stated there was a nurse for the front half of the hall, therefore Resident #54 was not at risk of missing his medications. Interview and record review on 03/10/26 at 5:25 PM, ADON J revealed she was not aware that Resident #54 had missed any medications. ADON J stated LVN Q was responsible for care and medication administration for Resident #54. ADON J stated all nursing staff had been notified to pick up Resident #5 4 when LVN QQ was working, because she was not allowed to work with Resident #54. ADON J reviewed Resident #54's MAR and confirmed Resident #54 missed his morning medications. According to ADON J nursing staff were responsible for ensuring all residents received proper care and their medications, not doing so placed residents at risk of missing their medications and treatments. Interview on 03/10/26 at 5:53 PM, the DON revealed LVN Q was aware that LVN QQ was not allowed to work with Resident #54 and she would provide care to Resident #54. The DON stated all nursing staff had been notified and informed prior to the shift on 03/10/26. The DON stated she expected all nursing staff to ensure they are following physician (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders, not doing so placed residents at risk of decline in general health and wellbeing, uncontrolled pain, and further infections. The DON stated the ADON was responsible for following up to ensure the physician was notified of the missed doses and further instructions.Interview on 03/10/26 at 5:55 PM, with LVN QQ revealed she was not able to provide care for Resident #54 due to family request, which was told to her prior to Resident #54's return back to the facility on [DATE]. LVN QQ stated all staff had been educated to pick up Resident #54 when she worked. LVN QQ stated she also informed LVN Q that Resident #54 required her to provided his care because she was not allowed to enter his room. Record review of facility's policy titled Physician Orders reviewed November 27, 2023 revealed The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician. Record review of facility Medication -Guidelines on Clinical Practice policy, revised January 12, 2020, reflected the following: Staff will provide medications in accordance with standard practice guidelines

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 7 residents (Residents #107 and #125) reviewed for infection control.The facility failed to ensure MA NN disinfected the blood pressure cuff between blood pressure checks for Residents #107 and #125 during medication administration.These failures placed residents at risk of cross contamination and the spread of infection.Findings included: 1. Record review of Resident #107's Comprehensive MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE]. The resident's cognition was severely impaired with a BIMs of 6, and she had a diagnosis of hypertension (high blood pressure).Record review of Resident #107's care plan dated 09/29/25 reflected: Problem: Cardiac diagnosis. Goal: Improvement or maintenance of cardiac status. Interventions: administer cardiac medication as ordered. Monitor vital signs as ordered and as neededRecord review of Resident #107's March 2026 physician orders reflected an order for amlodipine besylate oral tablet 2.5 mg once a day and metoprolol 25mg 1 tablet by mouth twice daily.2. Record review of Resident #125's Comprehensive MDS assessment, dated 01/02/26, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The resident's cognition was severely impaired with BIMS of 3, and he had a diagnosis of essential hypertension (high blood pressure).Record review of Resident #125's care plan dated 12/11/2023 reflected: Problem: resident is at risk for elevated blood pressure rule out hypertension. Goal: [Resident #125] will have no signs and symptoms, no episode of blood pressure. Interventions: administer medication as ordered.Record review of Resident #125's March 2026 Physician Orders reflected an order for lisinopril 5mg 1 tablet by mouth one time a day. Hold for pulse less than 60.Observation on 03/09/2026 at 8:36 AM, revealed MA NN performing morning medication pass, during which time MA NN checked Resident #107's blood pressure. MA NN did not disinfect the blood pressure cuff after using it on Resident #107. MA NN put the blood pressure cuff on top of the medication cart after use. Observation on 03/09/2026 at 9:16 AM, revealed MA NN continued to perform morning medication pass, during which time she checked the blood pressure of Resident #125. MA NN used the same blood pressure cuff, she did not disinfect the blood pressure cuff before using it on Resident #125. She placed the blood pressure cuff on top of the cart.Interview on 03/09/2026 at 9:25 AM, MA NN revealed reusable equipment, like blood pressure cuffs, should be disinfected with wipes between each resident-use (before and after use on each resident) to prevent transmitting of infection from one resident to another. MA NN stated she did not have wipes on her cart. MA NN stated failure to disinfect blood pressure cuff could lead to contamination and infection.Interview on 03/10/2026 at 5:19 PM, the DON stated her expectation was for staff to disinfect the blood pressure cuffs between residents. She stated the potential risk of not putting on PPE and disinfecting the blood pressure cuffs between residents would be spread of infection. She stated the facility had done training on infection control and disinfecting of equipment.Record review of Competency Check off on Blood Pressure, dated 08/27/25, reflected After obtaining reading using blood pressure cuff and stethoscope, record both systolic and diastolic pressures. Disinfect equipment according to facility policy. MA NN was in attendance.Record review of the facility's Disinfecting and Sterilizing Resident Care Equipment policy, revised March 2025, reflected: .3. Non-critical items are those that either do not ordinarily touch the residents or touch only intact skin. Such items include crutches, bed boards, blood pressure cuffs, and other medical accessories. These items rarely transmit diseases. However, it is imperative that these items are clean. Depending on the piece of equipment or item, washing with a detergent or disinfectant detergent, rinsing and thorough drying may be sufficient.