STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675757	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Pointe	14655 Preston Rd Dallas, TX 75254

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation, interview and record review the facility failed to post in a form and manner accessible and understandable to residents and resident representatives a list of names, addresses (mailing and email, and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit for 1 of 1 buildings reviewed for postings The facility failed to ensure the number to HHS Long Term Care Regulatory (state survey and certification agency) number for filing grievances, or complaints or suspected violations of state or Federal violations was posted. This failure could place residents at risk of lack of knowledge of who to contact should they require advocacy, investigation, and not knowing their rights, how to exercise their rights, or investigations into violations of their rights.Findings include: An observation throughout the facility on 04/14/26 at 10:40,9:15 AM and 04/15/26 at 9:15 AM, revealed there was a single posting on the 1st floor only, and no HHSC complaint number and statement that the residents may file a complaint with the State Survey Agency posted in any other location of the facility. Further observation revealed all public areas of the facility including, and the dining room, the posting for the abuse number was not posted.During an Observation and interview on 04/16/26 at 11:20 AM SW stated she does the update of the ombudsman and abuse coordinator with paper postings. She stated the facility had an interim ombudsman due to the current one being promoted. She stated as a temporary fix they have posted throughout the facility on all floors, provided contact information for both the Ombudsman and ADMIN. SW stated she does not have access to the glass cabinets displaying the postings but added I would think either the ADMIN or Maintenance supervisor would have the key access to the glass cabinets. The SW stated they have had an issue with the one cabinet located in the elevator. During an interview on 04/16/26 at 11:55 AM ADMIN stated it was important to have this signage posted on each floor. ADMIN stated she did not know why there was no HHSC complaint number and statement that the resident may file a complaint with the State Survey Agency posted in the facility. The ADMIN stated it was important to have this signage posted so residents will know how to file a complaint regarding staff. The Administrator said the risk to the residents would be unreported abuse and neglect.Record review of the facility's policy and procedure on Resident Rights, revised February 2021, reflected: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: Communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection, or advocacy organizations etc.) regarding any matter.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 4 of 12 residents (Residents #4, #9, #74 and #124) reviewed for care plans. The facility failed to ensure Resident #4, #9 and #124's care plan reflected an intervention which included the bed being in the lowest position and fall mat alongside bed. The facility failed to ensure Resident #74's care plan, dated 02/05/2026, included a care plan for suction use due to the resident was unable to expel any secretion. These failures could place residents at risk of their needs not being met. Findings include:Record review of Resident #4's Face Sheet, dated 04/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with lack of coordination and muscle weakness.Record review of Resident #4's Comprehensive MDS Assessment, dated 1/15/26, reflected Resident #4 had a BIMS of 99 (unable to complete the interview). The Comprehensive MDS Assessment indicated the resident had an active diagnosis of muscle wasting.During an observation on 04/14/26 at 12:05 p.m., revealed Resident #4 was lying in bed, which was in its lowest position and a fall mat was placed on the left side of the resident's bed.Record review on 04/14/2026 of Resident #4's Comprehensive Care Plan, dated 4/01/26, for fall prevention reflected no intervention to include the resident's bed being in the lowest position and fall mats being placed on both sides of the bed. Record review of Resident #9's Face Sheet, dated 04/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with lack of coordination and muscle weakness.Record review of Resident #9's Comprehensive MDS Assessment, dated 1/01/26, reflected Resident #9 had a BIMS of 99 (unable to complete the interview). The Comprehensive MDS Assessment indicated the resident had an active diagnosis of seizure disorder.During an observation on 04/14/26 at 11:05 p.m., revealed Resident #9 was lying in bed, which was in a low position and fall mats placed on both sides of the resident's bed.Record review on 04/14/2026 of Resident #9's Comprehensive Care Plan, dated 1/07/26, reflected no plan of care for fall prevention nor interventions to include the resident's bed being in the lowest position and fall mats being placed on both sides of the bed. During an interview and record review on 04/15/26 at 11:13 a.m., RN M was informed by the Surveyor of Resident #9 not having a care plan for fall prevention. He stated the resident required her bed to be in a low position and fall mats on both sides of her bed to reduce the chance of her injuring herself if she fell out of bed. He stated he did not update care plans and was not sure who did.Record review of Resident #124's Face Sheet, dated 04/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Alzheimer's disease.Record review of Resident #124's Initial MDS Assessment, dated 4/08/26, reflected no BIMS score for the resident. The MDS Assessment had no active diagnoses indicated on the assessment.During an observation on 04/14/26 at 11:5 p.m., revealed Resident #124 was lying in bed, which was in a low position and fall mats placed on both sides of the resident's bed.Record review on 04/14/2026 of Resident #124's Comprehensive Care Plan reflected no plan of care for fall prevention nor interventions to include the resident's bed being in the lowest position and fall mats being placed on both sides of the bed. During an interview and record review on 04/15/26 at 11:29 a.m., LVN T was informed by the Surveyor of Resident #124 not being care planned for fall prevention. He stated he was not sure if the resident was care planned for fall prevention. He stated the resident should be care planned because she was a fall risk and it was needed to inform staff of the care plan. During an interview and record review on 04/15/26 at 11:29 a.m., MDS D was informed by the Surveyor of Residents #9 and #124 not being care planned for fall prevention. She reviewed the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's system of record and stated there was no intervention including the residents needing fall mats and the bed being in the lowest position. She stated it should be care planned for staff to know the plan of care for the residents. She stated it was the MDS nurse, ADON, and DON's responsibility to update care plans. She stated Resident #124 had not had his comprehensive assessment completed yet because she was out on vacation and the fall prevention care plan was not triggered.During an interview on 04/15/26 at 12:55 p.m., ADON S was informed by the Surveyor of Residents #4, #9 and #124 not being care planned for fall prevention. She stated Resident #9 was a fall risk because she had fallen before. She stated Resident #124 was a new resident and she was not sure if she had fallen but she leaned in the bed and they were concerned she would fall out, which was why they lowered her bed and placed fall mats on both sides of her bed. She stated it should be care planned for staff to know the plan of care for the residents. She stated it was mainly the MDS nurses' responsibility to update care plans.During an interview on 04/16/26 at 12:45 p.m., the DON was informed by the Surveyor of Residents #4, #9 and #124 not being care planned for fall prevention. He stated leadership completed IDT meetings for the residents and the MDS nurse was responsible for updating their care plans. He stated they were trying to get all care plans updated because it was used to determine the care needed for each resident.Review of Resident #74's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and dysphagia (difficulty in swallowing).Review of Resident #74's Quarterly MDS Assessment, dated 03/19/2026, reflected that the resident was unable to complete the interview to determine the BIMS score. The Staff Assessment for Mental indicated that the resident had memory problem. The Quarterly MDS Assessment did not show that the resident was using a suction machine.Review of Resident #74's Comprehensive Care Plan, dated 02/05/2026, did not reflect that the resident was using a suction machine.Record review of Resident #74's Physician's Order on 04/14/2026 reflected that the resident did not have an order for suctioning.During an observation and interview on 04/15/2026 at 7:14 a.m., revealed a suction machine was on top of the Resident #74's side table. Resident #74 did not reply when asked about her suction machine.During an interview on 04/15/2026 at 7:38 a.m., LVN C said that Resident #74 had been using the suction machine for more than four months. She said the suction was used when there was an accumulation of secretions in the resident's mouth. She said the resident was unable to expel any secretion. During an interview on 04/16/2026 at 6:08 a.m., LVN C said she did not see any care plan for Resident #64's suction use. She said the MDS Nurse was the one doing the care plans.During an observation and interview on 04/16/2026 at 6:29 a.m., MDS Nurse G said if the resident was using a suction machine, then there should be a care plan in place for suctioning so that the staff knew the interventions and goals for the resident pertaining to suction use. She said the purpose of the care plan was to ensure that the residents would receive tailored care specific to their needs, preferences , and goals. She said the care plan also facilitated a consistent care because all the healthcare providers would be in sync in terms of the care of the residents. She checked on Resident #74's care plan and saw that the resident did not have a care plan for suctioning. She said she would audit the resident's care plan and would put a care plan for suctioning. She said she would also audit the care plans of the other residents so that there won't be confusion about their care.During an interview on 04/16/2026 at 6:46 a.m., ADON A said care plans were important because care plans served as the contract between the facility and the resident in terms of what care and services would be provided by the facility. ADON A stated care plans would project the problem lists of the residents and the goals and the interventions pertaining to the said problems. She said without the care plans, needed interventions might not be provided and the needs of the residents would not be met. She said the expectation was all the issues of the residents were care planned. She said she would coordinate with the DON and the MDS Nurse to make sure the residents had appropriate care plans. During an interview on 04/16/2026 at 7:27 a.m., the DON said that the care plans would represent the whole picture of the current condition of the resident and how (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility would provide the care needed to meet the needs of the residents. He said if there were no care plans, the staff might miss the care needed by the residents. He said the care plans also served as a communication tool across the providers so that everyone taking care of the residents would be in the same page. He said the expectation was for all residents to have care plans with regards to their medical issues. He said he would coordinate with the MDS Nurses to audit the care plans of the residents. During an interview on 04/16/2026 at 7:59 a.m., the Administrator said that all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. She said the expectation was for all the residents were care planned accordingly to meet their needs. She said she would coordinate with the DON and the MDS Nurses to make sure all the residents were care planned.Record review of facility's policy, Comprehensive Care Plans, dated 2022, reflected It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide appropriate treatment and services to prevent complications of enteral feeding for three of five residents (Resident #8, #74, and #125) reviewed for feeding tube management.1. The facility failed to ensure LVN D checked Resident #8's g-tube placement before flushing and administering medications on 04/15/2026. 2. The facility failed to ensure LVN C checked Resident #74's residual before flushing and medication administration on 04/15/2026.3. The facility failed to ensure LVN A checked Resident #125's g-tube placement before flushing and administering medications on 04/15/2026. These failures could place residents with g-tubes at risk for tube displacement, clogging, aspiration, and discomfort.Findings included:1. Record review of Resident #8's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy.Record review of Resident #8's Comprehensive MDS Assessment, dated 01/15/2026, reflected that the resident was unable to complete the interview to determine the BIMS score. The Staff Assessment for Mental indicated that the resident had memory problem. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach).Record review of Resident #8's Quarterly Care Plan, dated 04/15/2026, reflected the resident required tube feeding and one of the interventions was to check for tube placement.Record review of Resident #8's Physician Order, dated 09/02/2025, reflected Enteral Feed Order every day shift Check G-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) placement prior to administration of water/formula/med through the tube.During an observation on 04/15/2026 at 1:25 p.m. revealed LVN D was about to administer Resident #8's medications via g-tube. He sanitized his hands, put on a pair of gloves, and sanitized the resident's overbed table. After sanitizing the overbed table, he took off his gloves, and sanitized his hands, and placed a towel on top of the overbed table. He then started to prepare the resident's medications. He put each medication in small plastic cups, crushed them, returned the crushed medications to the small plastic cups, and dissolved them. He also prepared a cup of water. He sanitized the bell of his stethoscope and hang it on his shoulders. He went inside the resident's room bringing with him the medications and the cup of water and placed them on top of the overbed table. He took 60 ml piston syringe from the IV post and placed it also on top of the overbed table. He washed his hands and put on a gown and a pair of gloves. He raised the resident's bed, elevated the head of the bed, turned off the machine, and disconnected the g-tube from the formula. After disconnecting the g-tube, he took his stethoscope and assessed the resident's abdomen by placing the bell of the stethoscope on the upper and lower quadrants of the abdomen. After assessing the abdomen, he attached the syringe to the g-tube, and checked for the residual (amount of formula, water, and secretions left in the stomach) by pulling the plunger of the syringe. He then disconnected the syringe, pulled the plunger, connected the barrel of the syringe to the g-tube, flush the g-tube, and poured the dissolved medications one by one flushing in between medications. He did not check for the placement of the resident's g-tube before flushing and administering the medication. After he was done administering the medications, he flushed the g-tube, detached the syringe, connected the g-tube to the formula, and cleaned the table and the syringe.During an interview on 04/15/2026 at 1:44 p.m., LVN D said he did auscultate (listening to the sounds inside the body using a stethoscope) the abdomen of Resident #8 by placing the bell of the stethoscope on the four quadrants of the resident's abdomen to listen to the bowel sounds. He said, but to check for the placement of the g-tube, he should have used his stethoscope by listening to the whoosh sound when air was introduced. He said the placement of the g-tube should be checked to make sure that the g-tube was not dislodged. He said the dislodged g-tube could cause aspiration. 2. Review of Resident #74's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female admitted (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the facility on [DATE]. The resident was diagnosed with gastrostomy status.Review of Resident #74's Quarterly MDS Assessment, dated 03/19/2026, reflected that the resident was unable to complete the interview to determine the BIMS score. The Staff Assessment for Mental indicated that the resident had memory problem. The Quarterly MDS Assessment showed the resident had a feeding tube. Review of Resident #74's Comprehensive Care Plan, dated 02/05/2026, reflected the resident had a g-tube and one of the interventions was for care staff to monitor aspiration.Review of Resident #74's Physician Order, dated 10/24/2026 reflected every day shift Check residual: if < 100 cc return to stomach and continue with med/formula administration. If residual > 100cc hold medications/formula for 1 hour then reassess. Flush with 15-30 cc tap water and clamp tube.During an observation on 04/15/2026 at 7:19 a.m. revealed LVN C was about to administer Resident #74's medication via g-tube. She sanitized her hands, put on a pair of gloves, and sanitized the resident's overbed table. After sanitizing the overbed table, she took off her gloves, and sanitized her hands, and placed a wax paper on top of the overbed table. She then started to prepare the resident's medications. She put the medications in small plastic cups, crushed them, and returned the crushed medications to the small plastic cups. She then went inside the resident's room bringing with her the medications and placed them on top of the overbed table. She went to the sink to get some water, placed it on top of the table, and dissolved the medications. She also placed the syringe on top of the table. She then sanitized the bell of her stethoscope using an alcohol wipe and placed it also on the table. She washed her hands and put on a gown and a pair of gloves. She raised the resident's bed, elevated the head of the bed, turned off the machine, and disconnected the g-tube from the formula. After disconnecting the g-tube, she took the syringe, pulled the plunger halfway, connected it to the gtube, and checked the placement of the g-tube via auscultation. After checking for the placement, she disconnected the syringe, pulled the plunger out of the syringe, connected it again to the g-tube, and flushed the g-tube. After flushing the g-tube, she poured the dissolved medications one by one and flushed in between medications. She did not check for the residual before flushing and medication administration. After she was done administering the medications, she flushed the g-tube, detached the syringe, and cleaned the table and the syringe.During an observation and interview on 04/15/2026 at 7:38 a.m., LVN C said she did not see an order to check the gastric residual before medication administration. She logged on to her computer and checked Resident #74's orders. She said there was an order to check the residual before administering medications and she missed it. She said the residuals should be checked to make sure that the resident's stomach was functioning properly. She said the residual be checked to see if the content of the stomach was not too much because the resident might throw up if the or might aspirate if the stomach was still full. She said even though there was no order for checking the residuals, the best practice was to check it to prevent any adverse reactions.3. Record review of Resident #125's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status.Record review of Resident #125's Comprehensive MDS Assessment, dated 04/10/2026, reflected the resident's full ARD would be on 04/23/2026.Record review on 04/14/2026 of Resident #125's Baseline Care Plan revealed the resident was not care planned for tube feeding.During an observation on 04/15/2026 at 6:16 a.m. revealed RN A was about to administer Resident #125's medication via g-tube. He put the medication in a small plastic cup, crushed them, returned the crushed medication to the small plastic cup, and dissolved it. He went inside the room and brought with him the medication and a cup of water and put them on the overbed table. He took a 60 ml piston syringe from the resident's IV pole and placed it also on the overbed table. He put on a gown and a pair of gloves, raised the bed, elevated the head of the bed, turned off the machine, and disconnected the g-tube from the formula. After disconnecting the g-tube, he attached the syringe to the g-tube, and pulled the plunger of the syringe to check for the residual. After checking for the residual, he disconnected the syringe, pulled the plunger out of the syringe, attached the barrel of the syringe to the g-tube, and flushed it. After flushing the g-tube, he poured the dissolved medication, (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and flushed it. He did not check for placement of the resident's g-tube before flushing and administering the medication. After he was done administering the medication, he flushed the g-tube, detached the syringe, and cleaned the table and the syringe.During an interview on 04/15/2026 at 6:56 a.m., RN A said every time the g-tube would be used to, like connecting the formula or administering medications, the placement should be checked to make sure the formula and the medication would go to the stomach and that the tube was not displaced. He said he did not know why he forgot to check for placement of the g-tube.During an interview on 04/16/2026 at 6:56 a.m., ADON A said g-tube placement and gastric residual should be checked before introducing water and administering medications. She said g-tube placement should be checked to ensure the g-tube was in the right place and would not cause aspiration. She said even though the residents were on continuous feeding, the placement should still be checked. She said gastric residuals were also checked prior to flushing and medication administration to see if the stomach could accommodate the water and the medications. she said checking for the residual was also one way to assess if the stomach was emptying. She said not checking the residual might cause vomiting and aspiration pneumonia. She said the expectation was for the staff to check for g-tube placement and the gastric residuals before flushing and administering medications. She said they already started an in-service about g-tube placement and residual checks.During an interview on 04/16/2026 at 7:27 a.m., the DON said the placement of the g-tube should be checked before flushing it and before medication administration to ensure the medications and the fluid would enter the stomach. He said checking the placement was a safety step to ensure the tube was not in other parts of the body, like the lungs, esophagus, and cavities inside the body, that could result to aspiration and ineffective feeding because the formula was not delivered to the intended site. He said gastric contents should also be checked to ensure there was no delayed emptying of the stomach. He said another reason the residual should be checked was to make sure the resident was tolerating the amount of formula ordered, and if not, the order could be adjusted. He said the expectation was for the staff to follow the policies and procedures for enteral feeding. He said he already started an in-service for checking g-tube placement and the gastric residuals.During an interview on 04/16/2026 at 7:59 a.m., the Administrator said the expectation was for the staff to check the g-tube placement and the residual content as per orders. She said the DON already started an in-service about g-tube but would still closely coordinate with the DON to monitor the adherence of the staff to the policy about g-tube.Record review of the facility's policy Administering Medications through an Enteral Tube Nursing Services Policy and Procedure Manual for Long-Term Care revised November 2018 reflected Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Steps in the Procedure . 6. Verify placement of feeding tube.Record review of the facility's policy Checking Gastric Residual Volume (GRV) Nursing Services Policy and Procedure Manual for Long-Term Care revised November 2018 reflected Purpose: The purpose of this procedure is to assess tolerance of enteral feeding and minimize the potential for aspiration . Preparation 1. Verify that there is a physician's order for this procedure . General Guidelines 1. Do not use gastric residual volume (GRV) as a routine indicator of proper feeding tube location . Steps in the Procedure . 4. Attach sixty (60) mL syringe to end of catheter tube . 6. Aspirate stomach contents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of twelve (Resident #9, and #74) reviewed for respiratory care. The facility failed to ensure Resident #9 had physician's orders for the use of an oxygen concentrator. The facility failed to ensure Resident #74 had an order for her suction use on 04/14/2026. These failures could place the residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met.Findings included: Record review of Resident #9's Face Sheet, dated 04/15/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy (hole in neck to allow air to pass).Record review of Resident #9's Comprehensive MDS Assessment, dated 1/01/26, reflected Resident #9 had a BIMS of 99 (unable to complete the interview). Record review on 04/14/2026 of Resident #9's Comprehensive Care Plan, dated 1/07/26, reflected no plan of care for oxygen use. Record review of Resident #9's Physician's Order, dated 04/14/26, reflected no physician's orders for oxygen use.During an observation on 04/14/26 at 11:05 p.m., revealed Resident #9 was lying in bed and she was using an oxygen concentrator by way of a nasal cannula. During an interview and record review on 04/15/26 at 11:13 a.m., RN M was informed by the Surveyor of Resident #9 not having a physician's order for the use of an oxygen concentrator. RN M verified the resident did not have physician orders and he stated it was required because it was a medication for the resident. He stated it was needed for the resident's safety. During an interview and record review on 04/15/26 at 12:52 p.m., ADON S was informed by the Surveyor of Resident #9 not having physician orders for the use of an oxygen concentrator. She stated she was informed of this by one of her nurses. She stated the resident required physician orders for the device. She stated the resident had orders for use of the oxygen device but it may have discontinued. She stated physician orders were needed to ensure the resident received the oxygen.During an interview on 04/16/26 at 12:26 p.m., the DON was made aware of Resident #9 not having physician orders for the oxygen device. He stated physician orders were required for the resident. He stated the admitting nurse should ensure the resident had physician orders for particular care. He stated if the resident did not have orders, their care may not be carried out.Review of Resident #74's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and dysphagia (difficulty in swallowing).Review of Resident #74's Quarterly MDS Assessment, dated 03/19/2026, reflected that the resident was unable to complete the interview to determine the BIMS score. The assessment indicated that the resident had memory problem. The Quarterly MDS Assessment did not show that the resident was using a suction machine.Review of Resident #74's Comprehensive Care Plan, dated 02/05/2026, did not reflect that the resident was using a suction machine.Record review of Resident #74's Physician Order on 04/14/2026 reflected that the resident did not have an order for suctioning.During an observation and interview on 04/15/2026 at 7:14 a.m., revealed a suction machine was on top of the Resident #74's side table. Resident #74 did not reply when asked about her suction machine.During an observation and interview on 04/15/2026 at 7:38 a.m., LVN C said that Resident #74 had been using the suction machine for more than four months. She said the suction was used when there was an accumulation of secretions in the resident's mouth. She logged on to her computer and checked if the resident had an order for suctioning. She said she did not see an order for the resident's suctioning and that she did not notice that there was no order for the resident's use of the suction machine. She said there should be an order for the suction machine because the direct staff were using the suction machine to clear the resident's secretions. She said there should be an order for all the treatment being done for the resident. During an interview on 04/16/2026 at 6:56 a.m., ADON A said there should (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be a physician's order for the suction machine use because it was a medical procedure that was used if there was accumulation of secretions in the airway or if there was any sign of respiratory distress. She said the order should reflect the procedure, it's frequency, and the rationale why it was used. She said it was an oversight on the part of charge nurses taking care of Resident #74 because they did not notice that there was no order for suctioning. She said it was also an oversight on her part because she did not audit the resident's orders. She said they already started an in-service about orders.During an interview on 04/16/2026 at 7:27 a.m., the DON said there should be an order for Resident #74 suction use to ensure that the resident was assessed and it was a medical necessity. He said there should be physicians' orders in everything done for the residents to ensure safety, compliance, and coordinated care. He said the physicians' orders were fundamental and served as instructions on how to ensure the residents were receiving proper care. He said he already started an in-service about making sure there was a physician's order on everything done for the residents.During an interview on 04/16/2026 at 7:59 a.m., the Administrator said if the resident had a suction machine, then there should be an order for it because it was a treatment done by the nurses. She said there should be physicians' orders for medications, treatment, diet, and therapies. She said the DON already started an in-service about physician orders but would still closely coordinate with the DON to monitor the adherence of the staff to the policies.Record review of the facility's policy, Medication and Treatment Orders Nursing Services Policy and Procedure Manual for Long-Term Care revised July 2016 reflected Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and Implementation . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . 9. Orders for medications must include . a. name and strength of the drug; b. number of doses, start and stop date, and/or specific duration of therapy; c. dosage and frequency of administration; d. route of administration; e. clinical condition or symptoms for which the medication is prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for four of eighteen residents (Residents #19, #52, #67, and #79) reviewed for medication storage. 1. The facility failed to ensure Resident #52 did not have a muscle cramp foam inside her room on 04/14/2026. 2. The facility failed to ensure Resident #67's did not have a nasal spray and adaptogenic mushroom inside his room on 04/14/2026. 3. The facility failed to ensure Resident #79 did not have a pain relieving gel inside her room on 04/15/2026. 4. The facility failed to ensure Resident #19 did not have a pain relief ointment inside her room on 04/15/2026. These failures could place residents at risk of wrong medication administration, accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1. Record review of Resident #52's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle spasm and chronic pain.Record review of Resident #52's Quarterly MDS Assessment, dated 03/12/2026, reflected that the resident was unable to complete the interview to determine the BIMS score. The Staff Assessment for Mental indicated that the resident had memory problem. The Quarterly MDS Assessment showed that the resident had muscle spasm and chronic pain.Record review of Resident #52's Comprehensive Care Plan, dated 04/15/2026, reflected the resident had chronic pain and one of the interventions was administer analgesic medication.Record review on 04/14/2026 of Resident #52's Assessment Notes reflected the resident did not have an assessment for self-administration of medications.Record review on 04/14/2026 of Resident #52's Physician Order reflected no order for muscle cramp foam.During an observation and interview on 04/14/026 at 9:18 a.m. revealed Resident #52 was in her bed, awake. It was observed that a container of muscle cramps foam was on top of the resident's side table and was on plain view. The resident said the medication was hers but she was not using it.During an observation and interview on 04/14/2026 at 9:26 a.m., RN B said he did not notice that there was a medication inside Resident #52's room. He said if the resident did not have an assessment for safe self-administration, then no medications should be inside their room because the staff would not be able to assess if the resident was using it appropriately or how many times the resident was applying it. He went inside the room, talked to the resident and took the muscle cramp foam. He said he would also check if the resident needed the muscle cramp foam so he could request for an order for it. He said if the medication was ordered, the staff should be the one administering it.2. Record review of Resident #67's Face Sheet, dated 04/16/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with age related cataract (lens of the eyes become cloudy leading to blurred vision and difficulty seeing clearly). Record review of Resident #67's Quarterly MDS Assessment, dated 02/01/2026, reflected the resident was cognitively intact with a BIMS score of 15. Record review of Resident #67's Comprehensive Care Plan, dated 02/14/2026, reflected the resident had impaired visual function and one of the interventions was to ensure appropriate visual aids were available.Record review on 04/14/2026 of Resident #67's Assessment Notes reflected the resident did not have an assessment for self-administration of medications.Record review on 04/14/2026 of Resident #67's Physician Order reflected the resident did not have an order for nasal spray and adaptogenic mushroom (fungi that may help the body manage stress).During an observation and interview on 04/14/2026 at 9:46 a.m. revealed Resident #67 was in his wheelchair inside room. It was observed that a nasal spray and a bottle of adaptogenic mushroom were on top of his drawer that was in line with the resident's door. The resident said those were his medications and he took the adaptogenic mushroom to increase his (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	strength.During an interview on 04/14/2026 at 11:18 a.m., ADON A said residents should not have any medications inside their room because the staff would not be able to monitor the effectiveness of the medications and how often the residents were administering them. She said confused resident might apply the medication every thirty minutes and no one would know. She said she would go to Resident #67's room to check if he still have the nasal spray and the adaptogenic mushroom. She said he did not even know what the effect of adaptogenic mushroom to the resident or its potential interactions with the medications he was taking.3. Record review of Resident #79's Face Sheet, dated 04/16/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and osteoarthritis (a type of arthritis that happens when the cartilage that lines your joints is worn down and your bones rub against each other). Record review of Resident #79's Quarterly MDS Assessment, dated 03/09/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident had dementia, osteoarthritis, and was in pain in the last seven days.Record review of Resident #79's Comprehensive Care Plan, dated 02/19/2026, reflected the resident had was taking an anticoagulant (medication used to prevent blood clotting) and one of the interventions was to monitor for muscle joint pain.Record review on 04/15/2026 of Resident #79's Assessment Notes reflected that the resident did not have an assessment for self-administration of medications.Record review on 04/15/2026 of Resident #79's Physician Order reflected that the resident did not have an order for pain relieving gel.During an observation and interview on 04/15/2026 at 9:53 a.m. revealed Resident #79 was in her bed, awake. It was observed that a pain relieving gel was on top of the resident's side table. The resident said the relieving gel had always been in her side table. she said nobody mentioned to her that she cannot have a pain relieving gel inside her room.During an observation and interview on 04/15/2026 at 10:09 a.m., the WCN said there should be no medications inside the room because residents might use them inappropriately, like consuming them or applying their eyes or nose. She said she would talk to Resident #79 about the medication. She went inside the resident's room, talked to the resident, and took the medication. She said she would give it to the charge nurse. During an interview on 04/15/2026 at 12:07 p.m., LVN H said the WCN told him about the medication inside the Resident #79's room. He said he did not notice the medication when he did his morning round. He said, sometimes family members would bring the medications so they also needed to talk to the family members to let them know if they were bringing any medication for the residents. 4. Record review of Resident #19's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with fibromyalgia. Record review of Resident #19's Comprehensive MDS Assessment, dated 03/29/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had fibromyalgia and was occasionally in pain. Record review of Resident #19's Comprehensive Care Plan, dated 04/07/2026, reflected the resident had chronic pain and one of the interventions was administer analgesia as ordered.Record review of Resident #19's Physician Order, dated 04/12/2026, reflected Biofreeze External Cream 10 % (Menthol (Topical Analgesic). Apply to AFFECTEDAREAS topically every 6 hours as needed for PAIN.Record review on 04/15/2026 for Resident #19's Assessment Notes reflected the resident did not have an assessment for self-administration of medications.During an observation and interview on 04/15/2026 at 12:35 p.m., Resident #19 was in her wheelchair, awake. it was observed that a full cup of green ointment was on top of the resident's overbed table. The resident said she asked the therapist to give her some biofreeze and the therapist handed it to her.During an observation and interview on 04/15/2026 at 12:46 p.m., the WCN said she did not notice the cup with green ointment on top of Resident #19's table. She went inside Resident #19's room, talked to the resident, and took the cup of biofreeze ointment. She said the resident said the green ointment was biofreeze and she asked the therapist to get her some. She said she would let the DON know that a therapist handed over the biofreeze so he could communicate the issue to the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	department of therapy.During an interview on 04/16/2026 at 6:46 a.m., ADON A said the therapist should have not given Resident #19 her biofreeze because the therapist was not authorized to dispense medications. She said the therapist should have called the nurse if the resident requested for it. She said medications should not be inside the residents' rooms because confused residents might use them inappropriately. She said the staff should be mindful that when they check on the residents, they check also if the they have any medications inside their room. She said topical medications could cause harm if applied to the skin too much. She said too much topical medication could cause skin damage. She said even supplements could be harmful if there was no order for it and if nobody knew if the supplement had any effect on the medications being taken by the residents. She they already started an inservice about medications inside the rooms of the resident.During an interview on 04/16/2026 at 7:21 a.m., the DON said he already talked to the DOR regarding a therapist giving Resident #19 her biofreeze. He said the DOR already talked to the therapist and provided an one-on-one in-service regarding not dispensing any medication. He said the therapist should have called a nurse when the resident requested for the biofreeze because the therapist was not authorized to hand-over medications. said medications should not be inside the rooms of the residents because it could cause probable harm such as misuse, overmedication, or allergic reactions. He said the staff did not even know how often the residents were applying the topical medications, the nasal spray, and the supplement. He said the expectation was for the staff to make sure there were no medications inside the room. He said if the resident needed the medications, then the staff should request orders for the medications and the staff should be the one giving the medications to them. He said he also talked to the family members to let them know if they bringing any medications to the facility. He said she had already started an in-service about over-the-counter medications. He said the residents should have an assessment that they could safely administer medications before medications could be left with them. During an interview on 04/16/2026 at 7:59 a.m., the Administrator said the expectation was for the staff to make sure there were no medications inside the residents' rooms the residents might consume them or use them on their eyes causing irritation. She said the DOR already talked to the therapist not to give any medication found inside the room. She said residents could not administer any medication with an assessment that it would be safe for the residents to take the medications by themselves. She said the DON already started an in-service about over-the-counter medications but would still closely coordinate with the DON to monitor the adherence of the staff to the policies.During an interview on 04/16/2026 at 8:26 a.m., the DOR said he already talked to the PRN therapist who handed over a cup of medication to a resident. He said he told the therapist to call the nurses when a resident requested any medication from inside their room. Record review of the facility's policy Medication Labeling and Storage Nursing Services Policy and Procedure Manual for Long-Term Care revised 2023 reflected Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls.Record review of the facility's In-Service OTC Medications and Self-Administration, dated April 15, 2026, reflected Over-the-counter (OTC) medications are not permitted at the bedside unless a self-administration assessment has been completed and the resident has been deemed appropriate . Any unauthorized medications found at bedside must be removed and addressed.

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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 observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's main kitchen and two of two substations, reviewed for food and nutrition services. The [NAME] failed to wear a hair net to properly cover her entire head while food was being prepared.The facility failed to properly seal food stored in the freezer.The facility failed to ensure the ice machine and ice scoop, located in the substation on the 4th floor, was thoroughly cleaned.The facility failed to ensure the microwaves in the dining area of the 3rd and 4th floors were properly cleaned.The facility failed to ensure proper pest control in the dining area of the 4th floorThe facility failed to ensure the trashcan in the main kitchen had a lid on it.The facility failed to ensure the sanitizer bucket (red bucket) in the substation on the 4th floor had the appropriate level of sanitizer fluid in it. These failures placed residents at risk of exposure to food contamination and illness. Findings included:Observations on 04/16/26 from 9:26 a.m. to 9:46 a.m. in the facility's only kitchen revealed: [NAME] M was observed in the kitchen area, while food was being prepared, and she was wearing a ball cap. She had a large ponytail protruding from underneath the ball cap, that was not covered. An ice machine, located in the substation on the 4th floor, had white stains on the inside panel wall and dark stains on the inside metal panel of the ice machine. An ice scoop holder storing an ice scoop, located in the substation on the 4th floor, had a pool of water in it. One large sheet of cake, located in the freezer, was not completely sealed and exposed to air. Two of two microwaves, located in the dining area on the 3rd and 4th floor, had dried food stains along the inside panel walls. A tray of six clean small serving bowls, located in the dining area on the 4th floor, had a German roach crawling between the bowls. A large trashcan in the main kitchen area did not have a lid on it.During an interview and observation on 04/15/26 at 12:30 p.m., revealed [NAME] E was plating food for the residents lunch in the kitchen substation on the 3rd floor. The Dietary Manager stated the sanitizer bucket (red bucket) in the kitchen had the appropriate amount of sanitizer solution in it. The Dietary Manager tested the solution in the container, and the PPM registered at 0, which indicated no sanitizer solution was registered in the mixture. The DM stated he normally tested the buckets throughout the day to ensure it had the appropriate level of sanitizer solution in it. He stated the bucket needed to have the appropriate amount of sanitizer solution in it to effectively clean spills while serving food to residents.During an interview on 04/16/26 at 11:41 a.m., the Plant Operations Supervisor stated when staff observed pests or rodents, they were to chart it into the pest control book and when the pest control came to the facility to treat the facility, they treated the area. He stated the pest control person reviewed the pest control book to determine what area needed to be treated. He stated pest control was scheduled to treat the inside of the facility bi-weekly or if there was an emergency. He stated he was made aware of the roach observed in the dining area on the 4th floor and pest control was notified. He stated pest control was at the facility on 04/15/26 and treated the entire 4th floor. During an interview on 04/16/26 at 12:50 p.m., the Administrator was informed by the Surveyor of the findings in the kitchen area. She stated she expected the Dietary Manager to ensure all kitchen standards were met to avoid any food contamination. She stated she would follow up with the Dietary Manager.During an interview on 04/16/26 at 1:15 p.m., the Dietary Manager was informed by the Surveyor of the concerns observed in the main kitchen and the substations on the 3rd and 4th floor. He stated they had cleaned the ice machine and replaced the dirty microwaves. He stated the ice scoop holder was cleaned. He stated he will ensure the food in the feezer was properly sealed to avoid contanmination. He stated he in-serviced his team on 04/15/26 on wearing the appropriate head coverings. He stated the risk of not addressing the concerns mentioned could result in food contamination. Record Review of the Facility's policy titled Food Storage, dated 2023, revealed, Sufficient storage facilities will be provided to keep food safe, wholesome, and appetizing. Food will (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be stored in an area that is clean, dry, and free from contaminants. Record Review of the Facility's policy titled Employee Hygiene for Food Safety, dated 2023, revealed, All food and nutrition service employees will practice good personal hygiene and safe food handling. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.Record Review of the Facility's policy titled Cleaning and Sanitation of Dining and Food Service Areas, dated 2023, revealed, The food and nutrition staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance written, comprehensive cleaning schedule.Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD.

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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. Based on observations, interviews, and record review, the facility failed to ensure each bed have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains for seven of fifteen residents (Residents #4, #48, 50, #64, #73, #95, and #100) reviewed for privacy and confidentiality.The facility failed to ensure Residents #4, #48, #50, #64, #73, #95, and #100 had privacy curtains for their privacy. This failure could place the residents at risk of not having their personal privacy maintained while care was provided, which could result in the residents feeling uncomfortable during care and having their personal and medical record exposed to unauthorized individuals.Findings included:During an observation on 04/14/2026 at 11:40 a.m., revealed Resident #100's privacy curtain was stuck in the track and could not close.During an observation on 04/14/2026 at 11:53 a.m., revealed Resident #50 had no privacy curtain in a shared room. During an observation on 04/14/2026 at 12:05 p.m., revealed Resident #4 had no privacy curtains and Resident #64 had no privacy curtains for the foot of her bed. During an observation on 04/16/2026 at 8:55 a.m., revealed Resident #95 had no privacy curtains for the foot of her bed in a shared room.During an observation on 04/16/2026 at 8:55 a.m., revealed Resident #73 had no privacy curtains for the foot of her bed in a shared room.During an interview on 04/16/26 at 11:30 a.m., the DON was informed by the Surveyor of Residents #4, #48, #50, #64, #73, #95, and #100 not having the privacy curtains. He stated he and the Administrator had went to the 4th floor and identified the residents' rooms that did not have complete privacy curtains. He stated they corrected some of the rooms but had to order more privacy curtains. He was informed by the Surveyor of CNA S providing incontinent care to Resident #48 and the resident room door was open and the privacy curtain was partially drawn. He stated the resident's door should have been closed and the curtains should have been drawn for the resident's dignity.During an interview on 04/16/26 at 12:00 p.m., ADON S was informed by the Surveyor of Residents #4, #48, #50, #64, #73, #95, and #100 not having the privacy curtains. She stated she was made aware of this by the DON. She stated housekeeping had ordered curtains for the residents. She was informed by the Surveyor of CNA S providing incontinent care to Resident #48 and the resident room door was open and the privacy curtain was partially drawn. She stated the residents needed privacy curtains for their dignity. Record review of the facility's policy, Resident Rights, dated 02/21, reflected Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during personal care and confidentiality of personal and medical records for two of fifteen residents (Residents #48, and #84) reviewed for privacy and confidentiality. The facility failed to ensure Resident #48's door was closed or the privacy curtain was drawn during incontinent care on 04/14/26. The facility failed to ensure that the roommates of residents with AEM had signed consents in the active section of the EHR from Resident #84 or their RP acknowledging the AEM in the shared room since 01/07/2026. These failures could place the residents at risk of not having their personal privacy maintained while care was provided, which could result in the residents feeling uncomfortable during care and having their personal and medical record exposed to unauthorized individuals.Findings included: Record review of Resident #48's Face Sheet, dated 04/14/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle wasting, and lack of coordination.Record review of Resident #48's Comprehensive MDS Assessment, dated 03/19/2026, reflected the resident had an intact cognitive response with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diagnoses of muscle wasting, and lack of coordination.During an observation on 04/14/2026 at 11:29 a.m., revealed CNA S was providing Resident #48 incontinent care while the resident's room door was open, and the privacy curtain was partially drawn. The resident was missing part of his privacy curtain near the foot of the bed. During an interview on 04/14/26 at 11:32 a.m., CNA S stated she was providing incontinent care to Resident #49 and was not aware the resident's roommate had left the room. She stated she was so focused on the resident, and she did not notice the room door had opened. She stated she pulled the privacy curtain alongside the resident's bed but the resident did not have a privacy curtain near the foot of his bed to completely provide the resident privacy. During an interview on 04/14/26 at 11:39 a.m., LVN T was informed by the Surveyor of CNA S providing incontinent care to Resident #48 and the resident room door was open and the privacy curtain was partially drawn. He was informed the CNA stated the resident's roommate had left the room and failed to close the door. He stated the CNA should have closed the door for the resident's privacy and dignity. Record review of Resident #84's admission Record dated 01/07/2026, revealed a [AGE] year-old female who had original admission date of 01/07/2026. Resident #84 was noted to have diagnosis including Chronic Systolic (Congestive) Heart Failure (condition where the heart's left ventricle weakens, becomes enlarged, and cannot contract properly to pump enough blood), Chronic Obstructive Pulmonary Disease (progressive, incurable, yet treatable lung disease that causes chronic airflow constriction leading to severe breathing difficulties) Unspecified Dementia (diagnosis used when symptoms of cognitive decline-severe memory loss, impaired thinking, and reduced social abilities- are present but underlying cause has not been determined), Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life). Record review of Resident #84's quarterly MDS assessment dated [DATE] reflected a BIMS (standardized assessment tool to evaluate cognitive function, specifically memory and orientation) score of 12 indicating moderate cognitive impairment. Record Review of Resident #84's Care Plan, last updated 03/30/2026, revealed no indication of resident being in a room that currently had ongoing AEM.Record review of Resident #107's admission Record dated 02/02/2021, revealed an 87 -year-old female who had original admission date of 02/21/2021. Resident #107 to have a diagnosis including Unspecified Dementia (diagnosis used when symptoms of cognitive decline - severe memory loss, impaired thinking, and reduced social abilities - are present but underlying cause has not been determined), Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), with the diagnoses of type 2 diabetes mellitus with hyperglycemia (a person diagnosed with type 2 diabetes has persistently high blood sugar levels)Record review for Resident #107 revealed a signed consent from the resident/RP dated 02/05/2021; be moved into a room with (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ongoing AEM for roommate.Record review of Resident #107's quarterly MDS dated [DATE], reflected a BIMS (standardized assessment tool to evaluate cognitive function, specifically memory and orientation) score of 7 indicating severe impairment. Record review of resident #107's Care Plan, last updated on 03/10/2026 revealed no indication of resident being in a room that currently had ongoing AEM. Observation on 04/14/2026 at 9:20 AM of the shared room door for Resident #84 and Resident #107 revealed a sign that reflected, This room is being electronically monitored. Further observation revealed a camera placed on Resident #107 side of their room. Observation on 04/15/2026 at 1:25 PM of the shared room door for Resident #84 and Resident #107 revealed a sign at reflected, This room is being electronically monitored.During an interview on 04/16/2026 at 11:18 AM the SW stated she was familiar with the process with AEM. The SW stated the AEM forms are located outside of the SW office. This is if any staff member has observed, been advised or heard about a resident wanting or having a camera placed in their room. The staff member will fill out the form and submit it. The SW stated if staff observed a camera, in a resident's room they would fill out a form, and then the family or patient would sign most circumstances it would be the family signing the form. The SW stated the forms were readily available whether the SW was there or not. The SW stated when the form was completed, they would turn it into the SW office. It is either given to me or medical records department, to be scanned and added to the resident file. The SW stated the signed consent form should be in the miscellaneous or documents tab of the EHR. The SW stated that the risks of not having the signed consent was that there was no evidence the resident or RP was made aware they could possibly be filmed, and that there may be audio recording capabilities as well; that would be a privacy violation and that ultimately the DON was responsible to ensure all consents were obtained and in the EHR. During an interview on 04/16/2026 at 11:55 AM the ADMIN stated the SW handles the AEM forms, and if residents had an AEM signed the SW would get the sign for the room. The ADMIN stated that the risks of not having the signed consent was that there was no evidence the resident or RP was made aware they could possibly be filmed, and that there may be audio recording capabilities as well. That would be a privacy violation, and that ultimately the DON was responsible to ensure all consents were obtained and in the EHR.Record review of the facility's policy, Resident Rights, dated 02/21, reflected Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;Record review of the facility provided policy, dated 09/01/2025, revealed the statement The facility supports the rights of residents to use electronic monitoring devices in their rooms to promote safety, autonomy, and quality of care, in accordance with federal regulations and applicable state laws.Policy Guidelines Consent RequirementsWritten consent must be obtained from: The resident, or The resident's legal representative if the resident lacks capacity. If the room is shared: Consent must be obtained from the roommate or roommate's representative.If consent is not granted, accommodations (e.g., room change, camera positioning) will be explored.Procedure1. Resident/family submits request for electronic monitoring. 2. Facility provides consent forms and reviews policy. 3. Obtain required consents (resident + roommate if applicable). 4. Post required signage. 5. Document in medical record and care plan. 6. Notify staff of monitoring device. 7. Ongoing review for compliance.Documentation RequirementsConsent forms (resident and roommate) Care plan inclusion Progress notes regarding monitoring Any incidents, complaints, or investigations.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of ten residents (Resident #92 and Resident #10) reviewed for abuse and neglect.The facility failed to ensure Resident #10 was free from abuse when Resident #92 hit him on 03/23/2026. This failure could place residents at risk of abuse and emotional stress.The findings include:1.Record review of Resident #92's Face Sheet, dated 01/30/2026, reflected the resident was a [AGE] year-old male who admitted on [DATE]. Resident #92 had diagnosis including Unspecified Dementia (diagnosis used when symptoms of cognitive decline - severe memory loss, impaired thinking, and reduced social abilities - are present but underlying cause has not been determined), Unspecified mood [affective] disorder is a clinical (diagnosis used when mood-related symptoms that cause significant distress but do not fully meet criteria for a specific mood disorder like depression or bipolar disorder.Record review of Resident #92's Quarterly MDS (tool used to assess health status) Assessment, dated 02/23/2026, reflected moderately impaired cognition with a BIMS (screening tool to assess cognitive status) score of 11. Record review of Resident #92's care plan with an initiation date of 03/24/2026 revealed [Resident #92] had a resident to resident and he struck to another resident to the side of his face, with an initiation date of 03/24/26. Resident #92's Comprehensive Care Plan did not indicate behaviors toward staff or other residents. Record review of Resident #92's progress notes dated 03/24/26 revealed Resident #92 was monitored for changes or symptoms. Resident #92 had no emotional distress or changes noted. During an attempted interview on 04/15/26 at 2:40 PM, Resident #92 refused to speak to the surveyor.Record review of Resident #10's Face Sheet dated 02/25/2026, reflected the resident was a [AGE] year-old male who originally admitted on [DATE] and a re-admitted on [DATE]. Had a diagnosis of Acute respiratory failure unspecified whether with hypoxia or hypercapnia, (indicates a critical condition where the lungs cannot adequately exchange gases, leading to insufficient oxygen or excessive carbon dioxide levels). The unspecified nature of the diagnosis means that the specific type of respiratory failure (hypoxemic or hypercapnic) is not clearly defined at the time of diagnosis. Diagnoses of type 2 diabetes mellitus with hyperglycemia (a person diagnosed with type 2 diabetes has persistently high blood sugar levels)Record review of Resident #10's Quarterly MDS (tool used to assess health status) Assessment, dated 02/25/2026, reflected moderately impaired cognition with a BIMS (screening tool to assess cognitive status) score of 12.Record review of Resident #10's care plan with an initiation date of 03/24/2026 revealed [Resident #10] had a resident to resident where he had been struck by another resident to the side of his face. With an initiation date of 03/24/26. Resident #10's Comprehensive Care Plan did not indicate behaviors toward staff or other residents.Record review of Resident #10's progress notes dated 03/24/26 revealed Resident #10 was monitored for changes or symptoms. Resident #10 had no emotional distress or changes noted.During an interview on 04/15/2026 at 2:30 PM Resident #10, was observed lying in bed. Resident #10 stated that he was doing fine and that this was the best care he had received. Resident #10 stated that he had a roommate, but the roommate was put out of his room due to hitting him. Resident #10 stated that his roommate was getting out of bed, attempting to get into his wheelchair, and having difficulty. Resident #10 stated that he told him to call the nurse to help him get into his wheelchair and go where he needed to go. Resident #10 stated that his roommate became upset, came over to his side of the bed, and attempted to hit him in his head with his fist. Resident #10 stated that he told the resident, I will knock your ass out, you are lucky that I cannot get up as quickly as I used to. Resident #10 stated that the roommate picked up his urinal off the bedside table and hit him in his stomach and head. Resident #10 stated that he began to yell for the nurse, the nurse came in along with the CNA to check on him. Resident #10 stated the nurse completed an (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment on him, and he did not have to go to the emergency room. Resident #10 stated that he was happy nothing was in the urinal and that it was plastic. Resident #10 stated that the roommate was normally aggressive with staff and residents. Resident #10 stated the nurse did come in after the incident and completed a head-to-toe assessment. Resident #10 stated he advised the ADMIN and DON that he did not want to press charges. Resident #10 gave staff a statement, and the resident was moved out of his room. Resident #10 stated he does feel safe at the facility, and his call light was within reach but normally just calls out for someone. Resident #10 further stated staff do respond promptly to his needs. Resident #10 stated he does not have any additional concerns.During an interview on 04/16/2026 at 11:12 AM the SW stated she had been a SW for 5 years. SW stated she was advised from the Nursing staff that the residents were arguing with each other. SW stated Resident #92 stated he got his wheelchair stuck on Resident #10's wheelchair. Resident #10 was making some comments about him. Resident #92 stated that he grabbed the plastic bottle off the table and lightly tapped him with it. She stated Resident #92 stated that he understood that any type of physical behavior was not to be tolerated. Resident #92 stated he understood. Resident #10 was upset and stated Resident #92 got his chair stuck on his. He advised him that he should have used the call light to get it undone. At which point Resident #92 grabbed the bottle and struck him. SW stated there was no documented history of aggression by either one of the residents towards each other or towards any other residents. SW stated she asked Resident #10 if he wanted to relocate and he advised yes. Resident #10 stated he felt safe at the facility. Resident #92 was advised he would be moving to another room. SW stated Resident #92 stated he understood but had one request of staff. Which was if he could stay on the same floor due to him liking the nursing staff that takes care of him. Psych was also advised to follow up with them. Neither resident felt upset or other issues with each other. She stated as of now there are no issues with either one of them. SW stated Resident #92 was currently on psych service case load, she did an initial, them Resident #92 would be re-assigned to one of the 3 psych services personnel SW stated the facility had in-service training about abuse and de-escalation and to report any abuse to the Administrator.During an interview on 04/16/2026 at 11:18 AM CNA G stated she had been a CNA for 12 years. She stated Resident # 92 or Resident #10 had no history of aggression towards other residents. She stated she had no issues while she provided care to both residents when they were in the same room. She stated there had been no issues or concerns from either resident since the incident. She stated when she returned to, she had in service training regarding ANE. During an interview on 04/16/2026 at 11:40 AM LVN K stated she has been a Nurse for 2 and half years. She stated neither resident had a history of aggression towards other residents. She stated they got labs immediately afterward the incident for both residents and they were negative for UTI. During the time they were rooming together they never had issues with each other. They have not said anything about the incident afterwards. She stated if ANE was suspected she would notify the ADMIN immediately of the incident. LVN stated there were no other incidents of resident-to-resident altercation with Resident #92 as the perpetrator had occurred since Resident #92's incident on 03/23/26. Record review of the facility's Statement of Resident Rights Revised February 2021 reflected, You have a right to be free from abuse, neglect, misappropriation of property, and exploitation.Record review of the facility's policy titled Resident to Resident Altercations revealed revised September 2022, revealed All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator. Policy Interpretation and Implementation. 1. Facility staff monitors residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, and or staff. 2. Behaviors that may provoke a reaction by residents or other include: b. physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that the transfer or discharge was documented in the resident's medical record for one (Residents #121) of three residents reviewed for transfers and discharges.The facility failed to obtain a signed Against Medical Advice document during Resident #121's discharge on [DATE].This failure could prevent the resident from receiving necessary information about the resident's support needed for further care.Findings included:Review of Resident #121's Face Sheet, dated 04/15/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with joint replacement and seizures. Record review of Resident #121's 's MDS Assessment, dated 02/23/26, did not reflect the resident's BIMS score. The MDS Assessment reflected the resident had active diagnoses of joint replacement and seizures.During a record review on 04/16/26 at 9:40 a.m., revealed Resident #121's progress notes indicated she had discharged from the facility against medical advice. The facility's system of records did not reflect a signed AMA form on file.During an interview on 04/16/26 at 12:45 p.m., the DON was informed by the Surveyor of Resident # 121 not having a signed AMA on file. He stated the discharge nurse on duty should ensure the resident or their RP signed the AMA upon discharge. He stated RN M was the discharge nurse at the time and although the resident had signed a document, she should have signed the AMA form because it educated the resident of the risk of leaving the facility.During an interview on 04/16/26 at 12:55 p.m., RN M stated he had completed the discharge for Resident #121. He stated he was aware the resident had to sign an AMA form but had forgotten and only had her sign the progress notes forms. He stated the AMA had to be signed by the resident because it was making her aware that she was leaving against medical advice.During an interview on 04/16/26 at 12:45 p.m., the Administrator was informed by the Surveyor of Resident # 121 not having a signed AMA on file. She stated the discharge nurse on duty should ensure the resident or their RP signed the AMA upon discharge. She stated RN M should have had Resident #121 sign the AMA form because it educated the resident of the risk of leaving the facility. Record review of facility's policy, Transfer and Discharge, undated, reflected It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the assessments accurately reflected the resident's status for two (Resident #74 and Resident #110) of ten residents reviewed for accuracy of assessments.1. The facility failed to ensure Resident #74's Quarterly MDS assessment dated [DATE] accurately reflected that the resident had an external catheter and received suctioning.2. The facility failed to ensure Resident #110's Quarterly MDS assessment dated [DATE] accurately reflected that the resident had a nephrostomy.These failures could place the residents at risk for not receiving care and services to meet their needs, diminished functions of health, and regression in their overall health.Findings included:1. Review of Resident #74's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support).Review of Resident #74's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 03/19/2026, reflected that the resident was unable to complete the interview to determine the BIMS (screening tool used to assess cognitive status) score. The MDS indicated that the resident had memory problem. The Quarterly MDS Assessment did not show that the resident was using an external catheter (non-invasive device used to manage urinary incontinence) and a suction machine (equipment used to mechanically aspirate pulmonary secretions to clear the airway).Review of Resident #74's Comprehensive Care Plan, dated 02/05/2026, reflected the resident used an external catheter and one of the interventions was for care staff to ensure that suction tubing was connected securely and functioning properly. The care plan did not indicate that the resident was using a suction machine.Review of Resident #74's Physician's Order, dated 10/30/2025, reflected Pure wick (a female external catheter positioned externally to absorb the urine): Insert pure wick female catheter per manufacturer's instruction. Maintain catheter device to low continuous suction per protocol. every shift.Record review on 04/14/2026 of Resident #74's Physician's Order reflected that the resident did not have an order for suctioning.During an observation and interview on 04/15/2026 at 7:14 a.m., revealed a suction machine was on top of the Resident #74's side table. Resident #74 did not reply when asked about her suction machine.During an interview on 04/15/2026 at 7:16 a.m., LVN C said that the machine on top of Resident #74?s side table was a suction machine. She said the resident also had an external catheter and had been using both had been using both for more than four months. She said the external catheter was not suctioning well so the family member took it home. She said she did not know if the family member would have the external catheter repaired or would bring a new one.2. Record review of Resident #110's Face Sheet, dated 04/16/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive and reflux uropathy (a blockage in the urinary tract) and displacement of nephrostomy catheter (a thin tube inserted through the skin into the kidney to drain urine).Record review of Resident #110's Comprehensive MDS Assessment, dated 02/10/2026, reflected that the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 13. The Comprehensive MDS Assessment did not indicate that the resident had a nephrostomy (a surgical procedure that inserts a tube to the kidney to drain urine to a bag outside the body).Record review of Resident #110's Comprehensive Care Plan, dated 04/14/2026, reflected the resident had a nephrostomy tube (a thin tube inserted through the skin into the kidney to drain urine) and one of the interventions was for care staff to provide nephrostomy care every shift.Record review of Resident #110's Physician's Order, dated 10/30/2025, reflected dressing change every day shift every Thu related to DISPLACEMENT OF NEPHROSTOMY CATHETER.During an observation and interview on 04/14/2026 at 9:20 a.m. revealed Resident #110 was in his bed, awake. The resident said he a had a nephrostomy tube on the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left side of the body that he had for approximately a year. He lifted the side of his hospital gown to expose the nephrostomy bag (an external medical device designed to drain urine from the kidney).During an observation and interview on 04/16/2026 at 6:29 a.m., MDS Nurse G said the purpose of the MDS was to collect and record pertinent data about the resident. She said the MDS was used to do a basic assessment of the resident that could be from the documentation from the nurses or through a face-to-face assessment. She said the data collected would be the basis for the residents' care plans. The data collected were the resident's demographics, cognition, behavior, functional abilities, diagnoses, and if the resident was using any kind of special treatment. She turned on her computer and saw that Resident #74 was not coded for her external catheter and suction use. She said she did not know why the external catheter was not coded since the resident was using it since October 2025 and had an order for it. She said since the suction use did not have an order or any documentation, then it was not captured. She then checked Resident #110's MDS and saw that the resident was not coded for his nephrostomy. She said it was an oversight because if the residents were using an external catheter, a suction machine, and had a nephrostomy, then they should be coded for them respectively. She said she would audit the MDS' of the residents and would make sure that everything was coded appropriately. She said if the residents were not properly assessed, the needs would not be met, and there could be confusion in the provision of care and in doing the care plan. During an interview on 04/16/2026 at 6:56 a.m., ADON A said she was not familiar with MDS assessments but if the residents should be coded for an external catheter, suction, and nephrostomy, then the residents' MDS' should reflect the external catheter, suction, and nephrostomy.During an interview on 04/16/2026 at 7:27 a.m., the DON said the MDS Nurse was responsible in making the MDS assessment of the residents. He said the MDS was done upon admission, discharge, or if there was a change in condition. He said the purpose of the MDS was to capture current and significant quality measures that could be basis of residents' care. He said if the residents were using an external catheter, suction, a nephrostomy, then the residents' MDS' should reflect them. He said if the assessment in the MDS was not accurate, the care needed by the resident might not be met. She said the expectation was for the residents to be accurately assessed and coded in the MDS.During an interview on 04/16/2026 at 7:59 a.m., the Administrator said the MDS was done to reflect the current condition of the resident. She said if there was no accurate assessment, there could be a misunderstanding about the care needed by the residents. She said she would coordinate with the MDS Nurses to evaluate and resolve the issue.Record review of the facility's policy Resident Assessments Nursing Services Policy and Procedure Manual for Long-Term Care revised March 2022 reflected Policy Statement: A comprehensive assessment of every resident's needs is made at intervals designated by OBRA (federal law that required nursing homes for a standardized assessment) and PPS (payment used by Medicare to reimburse providers) requirements . 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments . 3. A comprehensive assessment includes . a. completion of the Minimum Data Set (MDS) . 5. The interdisciplinary team uses the MDS form . to conduct the resident assessment . 9. All resident assessments completed . are maintained in the resident's active clinical record.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care to one of eight residents (Resident #125) reviewed for baseline care plan.The facility failed to ensure Resident #125 had a baseline care plan after admission to the facility on [DATE]. This failure could place the resident at risk of not receiving necessary care, treatment, and services upon admission that could result to worsen condition.Findings included:Record review of Resident #125's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Upon admission, the resident was diagnosed with malignant (conditions that are dangerous to health) neoplasm (abnormal growth of tissue in the body) of mandible (Jaw bone), diabetes mellitus (high blood sugar), hypertension (high blood pressure), gastro-esophageal reflux (stomach acid repeatedly flows back into the tube connecting your mouth and stomach), acute kidney failure (kidneys stop working), dysphagia (difficulty in swallowing), aphasia (a language disorder), and gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support).Record review of Resident #125's Comprehensive MDS Assessment, dated 04/10/2026, reflected the resident's full ARD (Assessment Reference Date: last day of the assessment period) would be on 04/23/2026.Record review on 04/14/2026 of Resident #125's Baseline Care Plan revealed the resident was only care planned for enhanced barrier precautions. The resident's baseline care plan did not include the minimum healthcare information necessary to properly care for the resident immediately upon admission. The plan did not address any resident-specific health issues such as dysphagia, diabetes mellitus, neoplasm, kidney failure, aphasia, and gastrostomy; safety concerns such as elopement risk and fall risk; needs for supervision such as the mode of transfer, shower, and dressing; behavioral intervention such as any PASRR (process to determine if an individual mental illness, intellectual disabilities, and developmental disabilities) recommendation. The plan did not reflect any goals and interventions to address his current needs.During an observation and interview on 04/16/2026 at 6:29 a.m., MDS Nurse G said all the residents admitted should have a baseline care plan within 48 hours to be able to meet the immediate needs of the residents. She said if the resident was admitted on [DATE], then there should be a baseline care plan by 04/12/2026. She checked the Resident #125's care plan and said the resident did not have a base line care plan. She said the only focus on the care plan of the resident was only about enhanced barrier precaution and nothing else. She said the base line care plan should, at least, reflect the resident's medical issues. She said the nursing department, the admitting nurse, the ADON, or the DON, should have done the base line care plan. She said she would make the resident's care plan.During an interview on 04/16/2026 at 6:56 a.m., ADON A said if a resident came after office hours or during the weekend, the admitting nurse should do the baseline care plan. She said she was not able to follow-up and it was an oversight on her part. She said she would do the care plan of Resident #125.During an interview on 04/16/2026 at 7:27 a.m., the DON said baseline care plans were important because it would give the providers the minimum healthcare information about the resident that needed to be addressed immediately or upon admission. He said without the baseline care plan, the immediate needs of the resident would not be met. He said he already started an in-service about baseline care plan.During an interview on 04/16/2026 at 7:59 a.m., the Administrator said all the residents must have a baseline care so that the care staff would know how to take care of the residents. She said the expectation was for the admitting nurse to initiate the baseline care plan. she said the DON already started an in-service about baseline care.During an interview on 04/17/2026 at 8:41 a.m., LVN I said she was the one who admitted Resident #125. She said the resident was (continued on next page)

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	675757	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Pointe	14655 Preston Rd Dallas, TX 75254

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted past eight in the evening and she had no time to do the baseline care plan. She said she did know that a base line data should be done upon admission of a resident. She said the computer indicated that a base line care plan should be done 04/12/2026 but it did not occur to her that the date mentioned was the deadline for the baseline care plan. She said she should have initiated the initial plan. She said the next shift should have done the base line care plan. She did not reply when asked if she told the next shift to do the baseline care plan.Record review of the facility's policy Care Plans - Baseline Nursing Services Policy and Procedure Manual for Long-Term Care revised March 2022 reflected Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . Policy Interpretation and Implementation . 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident's environment remained free of hazards as was possible for one of six residents (Resident #73) reviewed for accident hazards. The facility failed to ensure Resident #73 had physician orders for a scoop mattress to ensure it was not a hazard for the resident. This failure could prevent the residents from having an environment that was free from accidents, potential injury, and exposure to toxic chemicals.Findings included: Record review of Resident #73's Face Sheet, dated 04/14/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #73 had diagnoses of muscle wasting, and lack of coordination.Record review of Resident #73's Initial MDS Assessment, dated 1/20/26, reflected the resident had a BIMS score of 3 (severe cognitive impairment). The MDS assessment reflected the resident had active diagnoses of age-related physical debility and lack of coordination.During an observation on 04/14/26 at 11:35 a.m., revealed Resident #73 was lying in bed on a scoop mattress (a scoop mattress features raised sides and a concave center). Record review of Resident #73's Comprehensive Care Plan, dated 10/28/25, reflected the resident being a fall risk, but there was no intervention including the use of a scoop mattress. Record review of Resident #73's Physician's Order, dated 04/14/26, reflected no Physician orders for a scoop mattress. During an interview on 04/16/26 at 11:30 a.m., ADON S was informed by the Surveyor of Resident #73 lying on a scoop mattress, but she did not have a physician's orders for the equipment. She stated she was informed of this by the DON on 04/15/26. She stated they completed an assessment and determined the resident did not need the scoop mattress and they replaced it with an air mattress. She stated the risk of the resident having the mattress could be a form of restraint for the resident. During an interview on 04/16/26 at 12:26 p.m., the DON was informed by the Surveyor of Resident #73 not having a physician's order for the use of a scoop mattress. He stated physician's orders were required. He stated the admitting nurse should ensure the resident had physician's orders for particular care. He stated they conducted a sweep of all residents with scoop mattresses, reassessed the residents, determined the residents did not require them, and had them removed. He stated if the resident did not have orders, their care may not be carried out.Record review of the facility's policy, Resident Rights, dated 02/21, reflected Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;c. be free from abuse, neglect, misappropriation of property, and exploitation;d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms

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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 one of ten residents (Resident #98) reviewed for pharmaceutical services.The facility failed to dispose of Resident #98's expired insulin on 04/15/2026.This failure could place residents at risk of not receiving the medication's full therapeutic benefits and not receiving medications as ordered resulting to adverse effects.Findings included:Record review of Resident #98's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #98's Comprehensive MDS Assessment, dated 01/30/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus. Record review of Resident #98's Comprehensive Care Plan, dated 01/29/2026, reflected the resident had diabetes mellitus and one of the interventions was administer insulin as ordered.Record review of Resident #98's Physician Order, dated 12/14/2025, reflected GLARGIN YFGN INJ 100 U/ML Inject 10 unit subcutaneously (administer under the skin) at bedtime related to Diabetes mellitus due to underlying condition with diabetic nephropathy (nerve damage due to diabetes).During an observation on 04/15/2026 at 11:20 a.m. revealed Resident #98's insulin KwikPen was inside a nurse's cart. It was observed that the insulin had a date opened 03/14/2026 and an instruction to discard after 28 days.During an observation and interview on 04/15/2026 at 11:21 a.m., LVN C said she was not the one administering Resident #98's insulin because the insulin was scheduled at bedtime. She looked at the insulin and said the opening date of the insulin was 03/14/2026. She said the insulin also had an instruction that specified to discard it after 28 days. She said after 28 days, the insulin was already considered expired. She took her cell phone and counted how many days passed from opening date of the insulin. She said the insulin should have been dispose 04/11/2026 and said the insulin was expired for four days. She took the insulin and discarded it. She said expired medications could be less effective or more toxic. During an interview on 04/16/2026 at 6:46 a.m., ADON A said there should not be expired medication inside the carts because expired medications could be less potent and would not be able to provide the full benefit of the medications. She said the nurses were responsible in ensuring there was no expired medications in the carts that they were using. She said she was also responsible in checking and auditing the carts for expired medications. She said the expectation was that the staff would check the carts for expired medications. She said they already started an in-service about insulin storage.During an interview on 04/16/2026 at 7:21 a.m., the DON said the expired insulin should have been disposed of on 04/11/2026 when it was opened 03/14/2026. He said expired medications could be less potent or could cause adverse effects depending on the medication. He said the nurses were responsible in checking their carts for expired medications. He said the ADONs were responsible in going behind the nurses and he was responsible in checking if the ADONs were checking the carts. He said the expectation was the staff would be mindful in checking the expiration dates of the medication. He said he already started an inservice about insulin storage, labeling, and expiration.During an interview on 04/16/2026 at 7:59 a.m., the Administrator said the expectation was for the staff to check for the medications before administering them to prevent any adverse reactions. She said the DON already started an in-service regarding the expired medication but would still closely coordinate with the DON to monitor the adherence of the staff to the policies about expired medication.During an interview on 04/17/2026 at 10:54 a.m., LVN J said it did not occur to her that the insulin for Resident #98 was already expired. She said she saw the date it was opened but thought the expiration date was 04/14/2026. She said expired insulin could lose its (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effectiveness.Record review of the facility's policy Administering Medications Nursing Services Policy and Procedure Manual for Long-Term Care revised April 2019 reflected Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so . 4. Medications are administered in accordance with prescriber orders, including any required time frame . The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.

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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 two of ten residents (Resident #91 and Resident #82) reviewed for infection control. 1. The facility failed to ensure CNA F performed hand hygiene and changed her gloves during Resident #91's incontinent care on 04/14/2026.2. The facility failed to ensure RN B performed hand hygiene before preparing Resident #125's medication on 04/15/2026.These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #91's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #91's Comprehensive MDS Assessment, dated 01/17/2026, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated that the resident was incontinent (unable to control) for bowel and bladder. Record review of Resident #91's Comprehensive Care Plan, dated 02/22/2026, reflected the resident had bowel and bladder incontinence and one of the interventions was to clean peri-area with each incontinent episode.During an observation on 04/14/2026 at 11:24 a.m. revealed CNA F was about to do Resident #91's incontinent care. She went inside the resident's room put on a pair of gloves. She did not wash her hands before putting on her gloves. She took a brief from the resident's drawer, opened it, and placed it at the side of the of the resident. She pulled some wipes and placed it on top of the wipes dispenser. It was observed that some of the wipes fell on the bed. She unfastened the brief and cleaned the resident's perineal area (area between the thighs) using the front to back technique. After cleaning the perineal area, she then assisted the resident to roll to her side, cleaned the resident's bottom, pulled the soiled brief, and threw it in the trash can. After cleaning the bottom, she took the new brief she placed beside the resident and placed it under the resident. She did not change her gloves after cleaning the bottom and before touching the new brief. When she about to roll back the resident, she realized that she did not have the barrier cream she needed to use for the resident's bottom. She removed her gloves, went to the resident's drawer, and looked for some cream. She then went to the bathroom to get a pair of gloves from the wall of the bathroom. She did not do hand hygiene before putting on the new pair of gloves. It was also observed that she used the wipes that fell on the bed.During an interview on 04/14/2026 at 11:41 a.m., CNA F said she was supposed to change her gloves after cleaning Resident #91s' bottom before touching the new brief to prevent using dirty gloves. She said, she did change her gloves at one point but did not sanitize her hands because there was no sanitizer inside the resident's room. she said she had a small one that she used to put in her pocket but maybe it fell because she could not find it. She said she also needed to wash her hands before doing any care, not only before incontinent care. She said it did not occur to her that there was a bathroom inside the resident's room and she could washed her hands if there was no sanitizer in sight. She said she should have thrown the wipes that fell on the bed and did not use them because they were already dirty.2. Record review of Resident #125's Face Sheet, dated 04/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status.Record review of Resident #125's Comprehensive MDS Assessment, dated 04/10/2026, reflected the resident's full ARD would be on 04/23/2026.Record review on 04/14/2026 of Resident #125's Baseline Care Plan revealed the resident was not care planned for tube feeding.During an observation on 04/15/2026 at 6:16 a.m. revealed RN B was about to administer Resident #125's medication via g-tube. He put on a pair of gloves and started to prepare the resident's medication. He did not do hand hygiene before preparing the resident's medication. After preparing the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, he went inside the room, wore a gown and a pair of gloves, and administered the resident's medication. He did not do hand hygiene before administering the medication.During an interview on 04/15/2026 at 6:49 a.m., RN B said he did not know why he forgot to wash his hands or even sanitize his hands before preparing Resident #125's medication and even before putting on the PPE. He said it was important to do hand hygiene to make sure the hands were clean during medication preparation and administration.During an interview on 04/16/2026 at 6:46 a.m., ADON A said hand hygiene should be done before, during, and after doing any care or treatment. She said the hands should be washed or sanitized to prevent cross contamination and probable infection. She said after cleaning the resident's bottom, the gloves should have been changed before touching the new brief to avoid transfer of microorganisms to the new brief that could eventually cause infection. She said every time the staff change their gloves, the hands should be sanitized for the same reason. She said the wipes that fell from the dispenser should have been discarded because they were already dirty. She said the expectation was for the staff to be mindful to be not the cause of the development of any infection. She said they already started an in-service about handwashing and perineal care.During an interview on 04/16/2026 at 7:21 a.m., the DON said staff should do hand hygiene before, during, and after care and treatment. He said hand hygiene was the most effective way to prevent cross contamination that could possibly lead to infection. He said the gloves should have been changed after touching something soiled like the resident's bottom and the soiled brief to make sure there was no transfer of microorganisms to the new brief. He said it should be clean to dirty and not the other way around. He said he already did a one-on-one in-service about perineal care with CNA F and a facility wide in-service about handwashing.During an interview on 04/16/2026 at 7:59 a.m., the Administrator said the expectation was for the staff to wash their hands before any care and treatment, to change their gloves when needed, and to sanitize their hands before putting on their gloves. She said the DON already started an in-service about handwashing and perineal care but would still closely coordinate with the DON to monitor the adherence of the staff to the policies.Record review of the facility's policy Infection Control Guidelines for All Nursing Procedures Nursing Services Policy and Procedure Manual for Long-[NAME] Care revised August 2012 reflected Purpose: To provide guidelines for general infection control while caring for residents . General Guidelines . 3. Employees must wash their hands . Before and after direct contact with residents . d. After removing gloves . After handling items potentially contaminated with blood, body fluids, or secretions . 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub . Before and after direct contact with residents . Before preparing or handling medications . Before moving from a contaminated body site to a clean body site during resident care . After removing gloves.Record review of the facility's In-Service Proper Perineal Care & Infection Control Practices, dated April 14, 2026, reflected Policy and Procedure . pericare must follow clean to dirty technique . gloves must be . removed after contact with contaminated areas, hands must be sanitized.