STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S. Henderson Blvd. Kilgore, TX 75662

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; and the resident's drug regimen was free from unnecessary psychotropic drugs and PRN orders for psychotropic drugs were limited to 14 days for 6 of 12 residents reviewed for unnecessary psychotropic drugs (Resident #3, Resident #5, Resident #53, Resident #10, Resident #25, and Resident #64). 1. The facility failed to ensure a rationale was documented in Resident #3's medical record for extending the PRN lorazepam 0.5mg (a prescription medication used to treat anxiety disorders: feelings of fear, dread, and uneasiness) order duration beyond 14 days. 2. The facility failed to ensure a GDR was attempted for Resident #5's buspirone medication (a medication used to treat anxiety) in February 2026. The doctor did not provide an appropriate rationale for not attempting the GDR. 3. The facility failed to ensure a GDR was attempted for Resident #5's Ambien medication (a medication used for insomnia) in March 2026. The doctor did not provide an appropriate rationale for not attempting the GDR. 4. The facility failed to ensure a GDR was attempted for Resident #53's Seroquel medication (a prescription atypical antipsychotic medication primarily used to treat schizophrenia, bipolar disorder, and major depressive disorder) in May 2026. The doctor did not provide an appropriate rationale for not attempting the GDR. 5. The facility failed to place a 14-day end date to Resident #25's psychotropic medication prescribed as needed for Lorazepam Oral Concentrate 2 milligrams/milliliter. 6.The facility failed to ensure a rationale was documented for Resident #10's Seroquel and no signature or date indicating response on recommendations for unapproved diagnosis of agitation. The doctor did not provide an appropriate rationale for not attempting a GDR. 7. The facility failed to ensure Resident #64's PRN Lorazepam (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or documented a rationale for the continued provision of the medication and heavy psychotropic and anticholinergic medication burden with potential major drug interaction. These failures could put residents at risk of psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: 1. Record review of Resident #3's face sheet, dated 06/15/26, reflected that he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (a progressive, incurable lung disease that blocks airflow and makes breathing difficult). Record review of Resident #3's significant change MDS assessment, dated 05/08/26, reflected that he had a BIMS score of 09, which indicated moderate cognitive impairment. He was able to make himself understood, and he was able to understand others. (continued on next page)

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

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's order summary report, dated 06/15/26, reflected this order: *Ativan oral tablet 0.5mg (lorazepam), give 1 tablet by mouth every 6 hours as needed for anxiety for 30 days. The start date was 06/08/26. The end date was 07/08/26. Record review of Resident #3's medication administration record for the month of June 2026 reflected that Resident #3 was not administered the lorazepam medication during the month of June 2026 as of June 17, 2026. 2. Record review of Resident #5's face sheet, dated 06/15/26, reflected that she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included paranoid schizophrenia (a subtype of schizophrenia marked by intense paranoia, hallucinations, and delusions), major depressive disorder (a serious mental health condition characterized by persistent, pervasive feelings of sadness, hopelessness, and a loss of interest in activities), anxiety disorder (mental health conditions characterized by excessive, persistent, and disproportionate fear or worry about everyday situations), and post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or deeply traumatic event). Record review of Resident #5's quarterly MDS assessment, dated 05/22/26, reflected that she had a BIMS score of 10, which indicated moderate cognitive impairment. She was able to make herself understood and she was able to understand others. Record review of Resident #5's order summary report, dated 06/15/26, reflected the following orders: *Ambien oral tablet 5mg, give 5 mg by mouth at bedtime for insomnia. The start date was 10/14/25. *Buspirone HCL oral tablet 7.5mg, give 1 tablet by mouth two times a day for anxiety. The start date was 10/14/25. Record review of Resident #5's Consultant Pharmacist/Physician Communication, dated 02/17/26, reflected: .Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for a trial dose reduction. Current order: Buspirone 7.5mg BID Recommendation: Buspirone 5mg BID. .This recommendation is to ensure lowest effective dose is utilized. If resident failed previous dose reduction attempt or is clinically contraindicated, please document clinical rationale below. The Physician/Prescriber response section was marked disagree, and no rationale was provided. The communication was signed and dated by the Physician on 02/21/26. Record review of Resident #5's Consultant Pharmacist/Physician Communication, dated 03/16/26, reflected: .Resident is receiving the following psychoactive medications that are due for review. Per CMS (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regulations, please evaluate resident for a trial dose reduction. Current order: Ambien 5mg QHS Recommendation: Ambien 2.5mg QHS. .This recommendation is to ensure lowest effective dose is utilized. If resident failed previous dose reduction attempt or is clinically contraindicated, please document clinical rationale below. The Physician/Prescriber response section was marked disagree, and no rationale was provided. The communication was signed and dated by the Physician on 03/21/26. 3. Record review of Resident #53's face sheet, dated 06/18/26, reflected that she was a [AGE] year-old female, most recently readmitted to the facility on [DATE], and initially admitted on [DATE]. Her diagnoses included schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia with a mood disorder). Record review of Resident #53's annual MDS assessment, reflected that she had a BIMS score of 07, which indicated severe cognitive impairment. She was usually understood and she was usually able to understand others. Record review of Resident #53's Order Summary Report, dated 06/15/26, reflected the following orders: *Seroquel oral tablet, give 100mg by mouth one time a day for schizoaffective disorder. The start date was 12/24/25. *Seroquel oral tablet 400mg, give 1 tablet by mouth at bedtime for schizoaffective disorder. The start date was 10/14/25. Record review of Resident #53's Consultant Pharmacist/Physician Communication, dated 05/08/26, reflected: .Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for a trial dose reduction. Current order: Seroquel 100mg QAM and 400mg QPM Recommendation: Seroquel 100mg QAM and 300mg QPM . .This recommendation is to ensure lowest effective dose is utilized. If resident failed previous dose reduction attempt or is clinically contraindicated, please document clinical rationale below. The Physician/Prescriber response section was marked disagree, and the rationale provided was To to continue Resident Stable [sic]. The communication was signed and dated by the Physician on 05/16/26. 4. Record review of Resident #25's face sheet dated 08/31/24, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #25's diagnoses (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	honored, maintain calm environment, and pharmacy consultation review quarterly and as needed. Record review of a physician order, dated 6/16/2026, indicated Resident #10 was ordered to have Seroquel 50 mg at bedtime for agitation and Zyprexa 5 mg twice daily for mood disorder. The physician order summary also included monitoring for observed behaviors such as hallucinations and delusions. The physician order summary included monitoring for side effects such as dry mouth, constipation, blurry vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, nausea and vomiting, lethargy, drooling, EPS (Extrapyramidal) symptoms such as tremors, gait issues, agitation, restlessness, involuntary movement of mouth and tongue. Record review of Resident #10's MAR dated 5/1/2026-5/31/2026, indicated Resident #10 was prescribed Seroquel 50 mg 1 tablet at bedtime for agitation. Resident #10 was also prescribed Olanzapine 2.5 mg twice daily for psychosis starting on 4/30/2026. Resident #10's dose was discontinued on 5/22/2026. Resident #10 was restarted on Olanzapine 5 mg twice daily on 5/29/2026 for mood disorder and discontinued on 6/17/2026. During an interview on 6/17/2026 1:27 PM, ADON E said Alzheimer's was not the appropriate diagnosis for Seroquel. ADON E said appropriate diagnoses for psychotropic medications were Schizophrenia and behaviors that she could not recall. ADON E said Resident #10 did not have behaviors currently and did not know if Resident #10 had behaviors when she was admitted . ADON E said it should be documented if she was having behaviors. ADON E said Hospice was the one who put the diagnosis in for psychosis. ADON E said Hospice was the one who prescribed Seroquel on 3/30/2026 after Resident #10 was admitted on [DATE]. ADON E said Hospice was signing Resident #10's orders. ADON E said the resident could have a drug interaction with Seroquel and Zyprexa being the same drug. ADON E said it could cause an increase in falls and drowsiness. ADON E said the DON was responsible for the pharmacy consultant's recommendations and Physician communication. During an interview on 6/17/2026 at 2:32 PM, the DON said Resident #10 was not sedated. The DON said Resident #10 was engaged in activities. The DON said she did not think Resident #10 was on too many antipsychotic medications. The DON said Alzheimer's was not an appropriate diagnosis for Seroquel. The DON said Resident #10 was diagnosed with psychosis for Zyprexa and was an appropriate diagnosis. The DON said Zyprexa was discontinued today and Resident #10 was no longer on Zyprexa. The DON said she was responsible for following up on the recommendations for GDRs. The DON did not elaborate on a negative impact on the residents. During an interview on 6/17/2026 at 2:53 PM, the ADM said the nursing (DON or designee) was responsible for reviewing and recommendations and rationale for the use of psychotropic medications. The ADM said a resident could be negatively impacted depending on the resident medical conditions. 6. Record review of Resident #64's Face sheet dated 6/17/2026 indicated an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #64 had diagnoses which included Senile Degeneration of brain (progressive decline in cognitive function, impacting memory), Type II Diabetes (a chronic condition where the body cannot use insulin properly, leading to high blood sugar levels that can damage organs), chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), dementia (a syndrome characterized by a decline in cognitive functioning, affecting memory, thinking, behavior and ability to perform everyday task), depression (a common and serious mood disorder characterized by persistent feelings of sadness, loss of interest and a range of emotional and physical problems), and hypertension (a common condition where the force of blood (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	against the artery walls is consistently too high). Record review of Resident #64's admission MDS dated [DATE] indicated she was usually able to make herself understood and usually understood others. Resident #64 had a BIMS score of 3 indicating she was severely cognitively impaired. Resident #64 required moderate assistance on toileting and bathing and required substantial assistance dressing upper and lower body. The MDS care area indicated Resident #64 was on psychotropic medication. Record review of Resident #64's Care plan, revised on 4/22/2026 indicated Resident #64 had a diagnosis of Dementia/Alzheimer's disease and required a secure unit due to confusion, wandering, and risk for elopement. Interventions included a staff member who will be present on the unit 24/7, baby dolls provided comfort and aromatherapy for relaxation and engage and have supervised activities. The Care plan also included Resident #64 had episodes of anxiety and was at risk for fluctuating moods. Interventions included administer medications as ordered, listen to resident concerns, monitor and document signs and symptoms of adverse effects as well as positive effects of medications, monitor and document signs and symptoms of adverse effects of medications given related to the underlying health problem, monitor and record any abnormal behavior or moods and monitor and report any mental status changes that occur with resident. Record review of a physician order, dated 6/17/2026, indicated Resident #64 was prescribed Lorazepam 0.5 mg 1 tablet every 4 hours as needed for anxiety indefinite per Hospice starting on 5/2/2026. Record review of MAR dated 5/1/2026-5/1/2026, indicated Resident #64 had an order for Lorazepam 0.5 mg 1 tablet every 4 hours as needed for anxiety indefinite per Hospice. Resident #64 was administered Lorazepam 0.5 mg on 5/17/2026. During record review of Pharmacy recommendations dated 4/15/2026 indicated Resident #64 had high-severity inappropriate drug therapy related to heavy psychotropic and anticholinergic medication burden with potential major drug interaction related to prescribed medication doxepin 10 mg BID, meclizine PRN, promethazine PRN, zaleplon, lorazepam PRN and methocarbamol with potential major drug interactions, including serotonin syndrome (excessive serotonin which the body naturally produces builds up in the body) risk with venlafaxine, tramadol, buspirone, mirtazapine, and additive respiratory/CNS (Central Nervous System) depression (a condition in which the brain and spinal cord reduce activity, leading to slower communication between nerves and impaired control over bodily functions) with prescribed medications (morphine PRN, lorazepam, zaleplon) indicating overall regimen likely contributing to falls and functional decline while increasing risk of adverse events in a frail, hospice patient where comfort is priority. The Pharmacy recommendations indicated an immediate review of hospice physician, nursing and family align medications with comfort-focused goals and reduce fall risk. Recommendations also included monitoring watching for sedation, falls, serotonin syndrome signs and hyponatremia (low sodium in the body) and reassess after changes were implemented. The Physician disagreed and signed on 5/20/2026. During an interview on 6/17/2026 at 12:40 PM, ADON E said she would review if there was a reason for Lorazepam to be ordered as needed by Hospice. The ADON E said Lorazepam should not be prescribed indefinite and said it should be for 14 days for anxiety medication. ADON E said the Physician did not want to change the medication regimen. ADON E said Hospice was responsible for the heavy burden of psychotic medication and anticholinergic medication. ADON E said it could cause the residents to be heavily sedated, side effects with all the different medications. ADON E said the (continued on next page)

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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 in the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure the flour container in the dry storage room was in good repair and did not have a hole in it. 2. The facility failed to ensure the fryer was clean and free of grease buildup and food particles. 3. The facility failed to ensure the ice machine did not have a pink substance on the inside of the machine above the ice. These failures could place residents at risk of foodborne illness and food contamination.Findings included: During an observation on 06/15/26 at 09:08 AM, an initial tour of the kitchen was conducted. The following items were observed:1) inside the dry storage room, a container of flour was broken. There was a hole in the side approximately the size of a golf ball and the container was cracked. There was flour inside the container. 2) The fryer was covered with aluminum foil. When uncovered, there were food crumbs all over the fryer. The baskets had grease buildup, and the back of the fryer had grease buildup. 3) The ice machine had a pink colored substance on the inside at the top, directly above the ice. During an interview on 06/17/26 at 08:36 AM, the Dietary Manager said the ice machine should have been cleaned and not have any pink residue. She said the fryer should not have had food particles on it. She said the flour container should not have had a hole in it. She said they used the fryer on Sunday night, and she did not expect the evening shift to clean it after use. She said someone should have noticed the pink residue in the ice machine. She said the risk to the residents was possible foodborne illness or contamination. She said someone should have replaced the flour container. During an interview on 06/17/26 at 02:25 PM, the Administrator said there should not have been a pink substance in the ice maker. She said there should not have been food particles on the fryer or grease buildup. She said there should not have been a hole in the flour container. She said the risk was possible foodborne illness. Record review of the facility's policy, Sanitizing Equipment In-Place, dated 10/01/18, reflected: .Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for cleaning equipment in place in order to ensure that all equipment is thoroughly cleaned and sanitized to minimize the risk of food hazards.Procedure:1. Unplug electrically powered equipment, such as meat slicers and toasters.2. Remove any fallen food particles and scraps.3. Wash, rinse and sanitize removable parts using the manual immersion method.4. Wash the remaining food-contact surfaces, and rinse with clean water. Wipe down with a chemical sanitizing solution mixed according to the manufacturer's directions.5. Wipe down all nonfood contact-surfaces and rinse with clean water. Wipe down with a chemical sanitizing solution mixed according to the manufacturer's directions.6. Re-sanitize the external food-contact surfaces of the parts that were handled during reassembling. Record review of the Facility's policy, Ice Machines, dated 10/01/18, reflected: Policy: The facility will maintain the ice machine, scoop and storage container in a sanitary manner to minimize the risk of food hazards. The ice machine will be cleaned once per month or more often as needed. The scoop and storage container will be cleaned once each day. Record review of the Facility's policy, Ingredient Bins, last revised 06/01/19, reflected:Policy: The facility will maintain the ingredient bins in a sanitary manner to minimize the risk of food hazards. The ingredient bins will be cleaned each time the bin contents are replaced, or more often as needed.

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	675814	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S. Henderson Blvd. Kilgore, TX 75662

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 2 residents reviewed for misappropriation of resident property. (Resident #4) The facility failed to prevent CNA J from stealing Resident #4's debit card and withdrawing $1600 dollars from her account. These failures could place residents at risk for decreased quality of life, misappropriation of property, and dignity.Findings included: Record review of Resident #4's face sheet dated [DATE] indicated Resident #4 was a [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), Type II Diabetes (a chronic condition where the body cannot use insulin properly, leading to high blood sugar levels that can damage organs), severe protein-calorie malnutrition (an imbalance between the nutrients the body needs and the nutrients it gets), dementia (a syndrome characterized by a decline in cognitive functioning, affecting memory, thinking, behavior and ability to perform everyday task), cognitive communication disorder (a condition in which impaired cognitive processes disrupt a person's ability to communicate effectively) and hypertension (a common condition where the force of blood against the artery walls is consistently too high). Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated Resident #4 was usually understood and understood others. The MDS indicated a BIMS score of 7 which indicated severe cognitive impairment. The MDS also indicated Resident #4 had inattention and was easily distracted. The MDS indicated Resident #4 required moderate assistance with bathing, dressing upper body and required substantial assistance with dressing lower body. Record review of Resident #4's care plan revised on [DATE] indicated Resident #4 had paranoid and suspicious behavior related to cognitive impairment. The Care plan indicated Resident #4 would report things stolen but would locate items in room. The care plan indicated Resident #4 kept her debit card with her and would not allow staff to keep it in a safe and often reported it stolen. Interventions included not to invade Resident #4's personal space, establish daily routine and explain procedures such as what, when and for how long and explain why you are entering room and going into closet and cupboards. Record review of hospital records dated [DATE], indicated Resident #4 was hospitalized for acute cystitis with hematuria (a bladder inflammation, often due to bacterial infection, that causes blood in the urine) from [DATE]-[DATE]. Record review of transaction summary dated [DATE], indicated Resident #4 had the following withdrawals from her debit card and withdrawal fees:[DATE] ATM withdrawal of $202XXX[DATE] ATM withdrawal of $202XXX[DATE] Card purchase from convenient store $40XXX[DATE] ATM withdrawal fee $0.85XXX[DATE] ATM Withdrawal $202XXX[DATE] ATM withdrawal fee $0XXX[DATE] ATM withdrawal $202XXX[DATE] ATM withdrawal $ 203XXX[DATE] ATM withdrawal fee $0.85XXX[DATE] ATM withdrawal $200XXX[DATE] ATM withdrawal fee $0.85XXX[DATE] ATM withdrawal $200XXX[DATE] ATM withdrawal fee $0.85XXX[DATE] ATM withdrawal $200XXX[DATE] ATM withdrawal fee $0.85. Record review of a Provider Investigation Report dated [DATE] indicated the ADM requested the Social Worker to obtain resident's bank card code number to get resident cigarettes. Resident #4 was purchased a book (lockbox), and the card was not found, and the card was placed on hold. On [DATE], the social worker contacted Resident #4's RP as she was able to see purchases while Resident #4 was in the hospital ([DATE]-[DATE]). The report indicated the RP had not seen nor had made purchases for Resident #4. The provider investigation report indicated Resident #4 did not have any visitors during the months of May or June. The investigation report indicated the police investigator had met with Resident #4 in private and noted Resident #4 did not know what happened to her card. The Provider Investigation Report indicated a replacement was requested. Resident #4 was to be the direct payee, and a lockbox was purchased for Resident #4's card to be kept in the business office for her use with consent. The (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provider Investigation Report indicated an in-service was provided on misappropriation. The Provider Investigation Report indicated on [DATE], the ADM was made aware an investigator would be taking over the case and was requesting footage from transactions on date known from withdrawal sites. Record review of an in-service topic titled Misappropriation dated [DATE] indicated 14 staff members were in-serviced. The in-service summary provided indicated to be mindful that if a resident has reported a loss of personal item.not use any of the resident's personal property.cannot use resident's phone, money.must protect residents and safeguard their personal.contact the administrator.In the event you have knowledge or feel someone was misusing resident's property.resident having issues protecting their property. Misappropriation of Resident Property Inservice Training indicated. misappropriation of resident property was a serious violation that must be addressed in in-service training to ensure staff understand their legal and ethical responsibilities. Definition and Legal Scope. Federal Regulations define misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. This applies to any individual providing care in a facility that participates in Medicare and Medicaid, including full-time staff, part-time employees, contractors, volunteers, and agency workers. There was no facility policy or sign-in sheet attached to the in-service. The signatures were signed on the summary topic misappropriation. Record review of employee file for CNA J revealed he was a contracted employee. CNA J was an employee of a contracted platform service. There were no previous employee misconduct reports identified on the service platform and CNA J was current with training and licensure. Record review of a Report of Certified Nursing Assistant Misconduct dated [DATE] indicated CNA J had no misconduct. During an interview on [DATE] at 10:24 AM, the Police Investigator met with ADM, Surveyor, and Program Manager. The Police Investigator was able to review footage of an alleged perpetrator from the convenient store. The alleged picture was identified as contracted employee CNA J. The Police Investigator said he was going to get a warrant and contact the alleged suspect, CNA J. During an interview and record review on [DATE] at 10:46 AM, the DON was asked for the employee file for contract employee, CNA J. The record review of the contractor platform indicated the background check was cleared by Texas Department of Public Safety The DON said when she used the contractor platform to schedule a staff member, she said she may never meet the employee. The DON said the contractor platform completed all the background checks for the employee. During an interview on [DATE] at 1:12 PM, the ADM brought the five-day investigation report. The ADM said Resident #4 had her bank card in a lock box in her room. The ADM said she would purchase her cigarettes for Resident #4 using her debit card. The ADM had requested the bank card code number on [DATE] and went to her lock box to obtain the card and the card was not in Resident #4's lockbox. The ADM said Resident #4 was sent to the hospital on [DATE] and admitted on [DATE]-[DATE]. The ADM said purchases were made during and after Resident #4's hospitalization. The ADM said Resident #4's RP voiced that she had not gone to see Resident #4 nor made purchases for Resident #4. The ADM said Resident #4 did not have any known visitors in May or June. The ADM said the Investigator was taking over the investigation and making contact to obtain footage from transactions from ATM. Attempted phone interview on [DATE] at 2:13 PM with RP for Resident #4. Voicemail was full and unable to leave a message. No return call by the end of investigation. During a record review on [DATE] at 11:35 AM, CNA J's background check was completed on [DATE] and expired on [DATE]. CNA J completed a post training test for Abuse, Neglect and Exploitation that expired on [DATE]. Background checks and trainings were completed annually by the independent contractor to remain eligible to bid on shifts. During a phone interview on [DATE] at 4:41 PM, CNA J said he had worked for the platform contractor for 3-4 years. CNA J stated he had worked at the facility but could not recall the last time he worked. CNA J stated he had training annually over Abuse, Neglect, and Exploitation. CNA J refused to answer additional questions and hung up when asked additional questions. During a phone interview on [DATE] at 12:32 PM, the Police Investigator called the ADM while at facility and was placed on speaker phone with his (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility will review each incident.Abuse Coordinator.ensure oversight and accountability.receiving, documenting, and tracking all allegations of abuse, neglect, exploitation, and misappropriation.ensuring immediate protection measures.coordinating and overseeing investigation in collaboration.ensuring timely reporting, maintaining complete investigation files and tracking trends.leading staff education on abuse prevention and reporting requirements.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 1 of 4 residents (Resident #21) reviewed for comprehensive assessments and timing. The facility did not ensure Resident #21's admission MDS assessment was completed within 14 days of admission. Resident #21 was admitted to the facility on [DATE] and her comprehensive care plan was not completed until 6/17/26. This failure could place residents at risk of not having their needs identified and met.Findings included: Record review of Resident #21's face sheet dated 6/17/26 indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of other cerebral artery (a type of ischemic stroke) and unspecified dementia (a clinical or diagnostic classification used when a patient exhibits a clear decline in cognitive abilities such as memory loss or problem-solving). Record review of Resident #21's comprehensive MDS assessment, with an ARD of 6/8/26, indicated in Section A0310 it was an admission assessment (required by day 14). The MDS assessment for Resident #21 indicated in Sections: A0310, A1005, A1010, A1110, A1805, J2000, O0110 and V0200 were incomplete. The MDS assessment in Section Z0500 was not signed and incomplete on 6/17/26, which indicated the MDS assessment for Resident #21 was a day late. During an interview on 6/17/26 at 12:20 PM, the MDS Nurse stated she did the MDS assessments. She stated she was not finished with Resident #21's MDS. She stated she had 14 days from Resident #21's admission date to have the MDS assessments completed. She stated her goal was to have MDS assessments completed that day. She stated yesterday (6/16/26) was the 14th day and she had not completed the MDS assessments for Resident #21. During an interview on 6/17/26 at 1:57 PM, the Administrator stated her expectations were for MDS assessments to be completed accurately and timely. She stated the facility's MDS Nurse was responsible for the MDS assessments. She stated the risk was a possibility of risk with detail. During an interview on 6/17/26 at 2:25 PM, the Director of Nursing stated she expected the MDS assessments to be done timely and accurately. She stated the MDS Nurse was responsible for the MDS assessments. She stated the risk would be inaccurate billing. Review of Certifying Accuracy of the Resident Assessment Policy dated November 2019 revealed Any person completing a portion of the [NAME] Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. 1. Any health care professional who participates in the assessment process is qualified to assess the medical, function and/or psychosocial status of the resident that is relevant to the professional's qualifications and knowledge.4. The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 21 residents reviewed for assessments. (Resident #27) The facility failed to ensure the MDS was appropriately coded for functional limitations in ROM for Resident #27. Resident #27 had bilateral hand contractures. This failure could place residents at risk for decreased quality of care due to inaccuracy of assessments. Findings included: Record review of the face sheet, dated 6/16/26, indicated Resident #27 was an [AGE] year-old female admitted [DATE] and readmitted [DATE]. Record review of the physician's orders, dated 6/16/26, indicated Resident #27 had diagnoses that included: Dementia (decline in mental ability such as thinking, reasoning, and memory severe enough to affect daily life), Aphasia (impaired ability to speak), and Alzheimer's Disease (progressive irreversible brain disorder that slowly destroys memory and thinking skills). Record review of the annual MDS assessment, dated 3/20/26, indicated Resident #27 had short-term and long-term memory problems. The MDS, Section GG0115/Functional Limitations in Range of Motion, indicated Resident #27 had no functional limitation in range of motion in her upper extremities (shoulder, elbow, wrist, hand). The MDS indicated she was dependent on staff for eating, toileting, dressing and personal hygiene. Record review of the undated care plan indicated Resident #27 had cognitive impairment related to a diagnosis of Dementia/Alzheimer's Disease. The care plan indicated, I have contractures and am at risk for skin breakdown, increased pain from affected areas and injuries, mobility impairment related to functional limitation in ROM. Have contractures of bilateral hands. During an observation on 6/15/26 at 9:26 A.M., Resident #27 was in bed. The head of the bed was raised approximately 40-45 degrees. Both hands were contracted. Her hands were clean and fingernails that were visible were trimmed and not jagged. She did not have hand rolls in her hands. Call light was within reach. During an interview on 6/17/2026 at 1:40 PM, ADON E said MDSs should be marked correctly so nurses knew how to care for a resident and so the care plan was correct. She said for example, if a resident was marked for 1 (impairment on one side) or 0, (no impairment) in Section GG0115/Functional Limitations in Range of Motion, she might assume the resident could brush her own teeth. She said the risk for this section being marked wrong was staff might not know what they needed to do for that resident. She said Resident #27 could not move either hand at all, both hands were contracted. She said Resident #27 should have been coded a 2 in Section GG0115 indicating she had impairment on both sides. During an interview on 6/17/2026 at 1:44 PM, the MDS nurse said she marked Resident #27's GG0115/Functional Limitation in Range of Motion wrong. She said she should have marked that section a 2, which indicated impairment on both sides, but she had marked it 0 indicating no impairment. The MDS nurse said she knew Resident #27 had bilateral hand contractures but marked it wrong. She said she would do an MDS correction. During an interview on 6/17/2026 at 1:57 PM, the ADM said her expectations were for the MDSs to be completed accurately and timely. She said the MDS nurse was responsible for the MDS assessments. During an interview on 6/17/2026 at 2:25 PM, the DON said she expected MDSs to be completed timely and accurately. The DON said the MDS Coordinator was responsible for the MDS assessments. She said the risk would be inaccurate billing. Record review of a facility policy titled, Certifying Accuracy of the Resident Assessment, dated November 2019, provided by the ADM indicated: Policy StatementAny person completing a portion of the Minimum Data set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. Policy Interpretation and Implementation 1.Any healthcare professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident that is relevant to the professional's qualifications and knowledge. 2.Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods. 4. The resident assessment coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received appropriate treatment and services to prevent further decrease in ROM for 1 of 21 residents reviewed for rmobility. (Resident #27) The facility failed to ensure Resident #27 had contracture prevention devices in place for treatment of her right-hand and left-hand contractures. These failures could place residents at risk for decrease in mobility and range of motion and contribute to worsening of contractures. Record review of the face sheet dated 6/16/26 indicated Resident #27 was an [AGE] year-old female admitted [DATE] and readmitted [DATE]. Record review of the physician's orders, dated 6/16/26, indicated Resident #27 had diagnoses that included: Unspecified Dementia (decline in mental ability such as thinking, reasoning, and memory severe enough to affect daily life), Aphasia (impaired ability to speak), Alzheimer's Disease (progressive irreversible brain disorder that slowly destroys memory and thinking skills) and Gastrostomy Status (presence of a surgically created opening in the stomach that allows a feeding tube to be inserted directly through the abdominal wall, primarily used for long term nutritional support). There were no physician's orders addressing her bilateral hand contractures. Record review of the annual MDS assessment, dated 3/20/26, indicated Resident #27 had short-term and long-term memory problems. The MDS Section Functional Limitations in Range of Motion indicated Resident #27 had no functional limitation in range of motion in her upper extremities (shoulder, elbow, wrist, hand). The MDS indicated she was dependent on staff for eating, toileting, dressing and personal hygiene. Record review of the undated care plan indicated Resident #27 had cognitive impairment related to a diagnosis of Dementia/Alzheimer's Disease. Further review indicated, I have contractures and am at risk for skin breakdown, increased pain from affected areas and injuries, mobility impairment related to functional limitation in ROM. Have contractures of bilateral hands. An update to the care plan, dated 3/9/26, indicated, Therapy states no change in contracture of hands. I am not appropriate for therapy services. No odor, or moisture, and no further contracture since last OT assessment. An update to the care plan, dated 6/12/26, indicated, Therapy states no change in contracture of hands. I am not appropriate for therapy services. No odor, or moisture, and no further contracture since last OT assessment. The goal for her contractures was, Contracture management will be effective as evidenced by no deterioration in current level of contracture this quarter, pain will be controlled within one hour of intervention and no injuries will occur through next review date. I will have no decline in current level of functional mobility through the next review date. Interventions for contractures included: Encourage use of mobility devices if needed and per MD orders. Apply splints as ordered. Record review of the MAR/TAR, dated May 2026 and June 2026, did not indicate any type of treatment for Resident #27's bilateral hand contractures. Record review of a Multidisciplinary Screening Form, dated 3/9/26, indicated Resident #27 had a quarterly PT, OT, and ST evaluation. The DOR signed the form and indicated, No change in contracture of hands. Patient not appropriate for therapy services. No odor, or moisture, no further contracture than last assessment. Record review of a Multidisciplinary Screening Form, dated 6/12/26, indicated Resident #27 had a quarterly PT, OT, and ST evaluation. The DOR signed and form and indicated, No change in condition. No further contracture. No odor. No therapy needed at this time. During an observation on 6/15/26 at 9:26 A.M., Resident #27 was in bed. The head of the bed was raised approximately 40-45 degrees. Both hands were contracted. Her hands were clean and fingernails that were visible were trimmed and not jagged. She did not have hand rolls(such as a rolled wash cloth to prevent hands from closing further) in her hands. Call light in reach. She had a feeding tube running with Isosource, 1.5 calories at 50 ml/hr (dated 6/15/26), and water dated 6/15/26 with a water flush of 35 ml every hour. Observation indicated the feeding tube syringe was secured in a plastic bag, dated 6/15/26. During an observation on 6/15/2026 at 1:48 PM, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27 was lying in bed. HOB was elevated approximately 40 degrees. She had no hand rolls in either hand. She was not interviewable. During an interview on 06/15/2026 at 3:08 PM, OTA C said the last time Resident #27 had OT was in 2025. OTA C said Resident #27 was discharged in March 2025. She said Resident #27 currently used rolled wash cloths in her hands for contracture management. She said the aides were diligent about putting in the hand rolls for a moisture barrier and staff trimmed her nails. OTA C said Resident #27 was managed care only, and because of that, she only qualified for OT yearly. OTA C said she was not sure why Resident #1 had not received OT in 2026. She said the DOR was not available at this time, but she would be able to answer that question. During an observation on 6/16/2026 at 9:50 A.M., Resident #27 was lying in her bed. HOB was up approximately 40 degrees. Her hands were clean and her nails were trimmed. She had no hand rolls in either hand. During an interview on 6/16/26 at 9:55 A.M., CNA F said she did not put hand rolls in Resident #27's hands and was not responsible for doing that. She said she had not ever seen hand rolls in Resident #27's hands. During an interview on 6/16/26 at 9:58 A.M., LVN G said she cleaned Resident 27's hands and cut her fingernails. She said it had probably been a week since she put hand rolls in Resident #27's hands. She said she did not document when she put the hand rolls in her hands. She said when she did put them in, she would leave them in for 2-3 hours then remove them. She said she clipped her nails as needed and washed her hands each shift or as needed. LVN G said the CNAs did not put hand rolls in residents' hands, only the nurses. She said the risk of not using rolls in Resident #27's hands were that the contractures could get worse, but they had not. She said she knew the contractures had not gotten worse because she saw her, cleaned her hands and was familiar with her. She said the last time she cut Resident #27's fingernails was Sunday (6/14/26). She said she did not document when she cut her fingernails or cleaned/washed her hands. During an interview on 6/16/2026 at 10:05 A.M., the DOR said they followed the MDS schedule when screening residents for therapy; therefore, screenings were done quarterly. The DOR said the MDS nurse gave her a list of MDS's that were due and she evaluated the residents on that list. She said she provided evaluations for Resident #27, dated 3/9/26 and 6/12/26. She said Resident #27 was not appropriate for therapy. She said therapy had a meeting with nurses (DON) in March of 2026. She said she thought she remembered that they (DON and DOR) decided no hand rolls were needed due to her contractures not changing. She said the results of the meeting was what was in her care plan indicating she did not currently need hand rolls or therapy. During an interview on 6/16/2026 at 10:50 A.M., the DON said in March of 2026 therapy reviewed Resident #27's evaluations, and it was determined by therapy, her contractures had not declined, and hand rolls were not needed. She said no one at this time was supposed to be putting hand rolls in Resident #27's hands. During an interview on 6/16/2026 at 11:21 A.M., the DON said they had a care plan meeting on 3/26/26 and there were no changes with Resident #27's bilateral hand contractures. She said there was no need for hand rolls or therapy at that time. She said therapy evaluated her quarterly and if there were any changes they would look at it again. The DON said she agreed with the care plan. During an observation on 6/17/2026 at 8:27 A.M., Resident #27 was in bed with HOB up approximately 40 degrees. Her hands were clean and her fingernails were trimmed. There were no hand rolls in her hands. During an interview on 6/17/2026 at 8:35 A.M., RN D said if a resident had contractures, it was important to keep rolls in their hands to prevent contractures from getting worse. She said not having rolls in a resident's hands could cause the contractures to worsen, or cause the resident's fingernails to dig into their hands and break the skin, which could cause wounds. During an interview on 06/17/2026 8:49 A.M., the ADM said the policy she provided was the only one they had regarding contractures. During an interview and observation on 6/17/2026 at 10:17 A.M., ADON E said if a resident had contractures and therapy indicated they needed hand rolls to prevent contractures from getting worse they should have them. However, she said if a nurse felt like a resident needed hand rolls for contractures, that nurse should care plan it so that all staff knew to put hand rolls in. She said she wanted to look at Resident #27's hands. ADON E went to Resident #27's room and she assessed Resident #27's hands. ADON E said (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27 should have hand rolls in her hands because they were closed all the way and there was a risk of the contractures getting worse and also a risk of wounds if her fingernails dug into her skin. During an interview on 6/17/2026 at 10:23 A.M., the ADM said per the care plan, hand rolls had not made a difference for Resident #27. She said therapy evaluated her quarterly and if there were any changes in her contractures, they would address it. The ADM said it would make sense that the contractures would get worse if not treated but not with Resident #27, because her hands were not changing and they were evaluated by therapy. Record review of the facility policy titled, Resident Mobility and Range of Motion Policy, dated 2001, provided by the ADM indicated: Policy Statement 1.Residents will not experience an avoidable reduction in range of motion (ROM).2.Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM.3.Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Policy Interpretation and Implementation 1.As part of the resident's comprehensive assessment, the nurse will identify the resident's:a.current range of motion of his or her joints.c.limitations in movement or mobility;d.opportunities for improvement; ande.previous treatment and services for mobility. 2. As part of the comprehensive assessment, the nurse will also identify conditions that place the resident at risk for complications related to ROM and mobility, including:a.pain;b.skin integrity issues;c.muscle wasting and atrophy.e.contractures; [NAME].other complications that could cause or contribute to immobility, impaired ROM. 3.During the resident's assessment, the nurse will identify the underlying factors that contribute to his or her range of motion or mobility problems, if any, including:a.immobilization (bedfast, chair or wheelchair usage);b.neurological conditions cerebral palsy, cerebral-vascular accident , etc.);c.conditions in which movement may lead to pain;and/ord.conditions that limit or immobilize movement of limbs or digits (e.g. splints). 4. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. 5. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.8.Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs.

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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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 18 residents (Resident #7) reviewed for infection control. The facility failed to ensure CNA B sanitized her hands after removing dirty gloves and applying clean gloves while providing catheter care and incontinent care for Resident #7 on 6/16/26. This failure could place residents at risk for cross contamination and the spread of infection.Findings included: Record review of Resident #7's face sheet, dated 6/16/26, reflected a [AGE] year-old female, admitted [DATE] and readmitted [DATE]. Resident #7 had diagnoses which included: chronic diastolic (congestive) heart failure (occurs when the heart's main pumping chamber (left ventricle) becomes stiff and cannot relax to fill with blood properly), retention of urine (the inability to fully empty the bladder) and need for assistance with personal care and chronic kidney disease stage 3B (the kidneys have moderate to severe damage, operating at roughly 30% to 44% of their normal capacity). Record review of Resident #7's comprehensive MDS assessment, dated 4/6/26, reflected Resident #7 was understood and understood others. Resident #7's BIMS score was a 10, which indicated moderately impaired cognition. Resident #7 was dependent on staff for ADLs. Resident #7 was always incontinent of bowel and had a catheter for urinary continence. Record review of Resident #7's care plan, revised dated 6/2/26, reflected Resident #7 required assistance with ADLs. Resident #7 was transferring herself without assistance. The intervention included staff would assist Resident #7 with all ADL's unable to be performed independently. Record review of Resident #7's care plan, dated 6/2/26, reflected Resident #7 required enhanced barrier precautions related to one or more of the following: indwelling catheter and wound. The interventions included to gather all needed supplies and material, clean hands correctly, and put on a gown and gloves. Record review of Resident #7's care plan, dated 6/2/26, reflected Resident #7 had bladder incontinence with the presence of catheter indwelling for the following diagnosis: urinary retention. Resident #7 manipulated her catheter and would drag it on the ground versus using her privacy bag. The intervention included providing catheter care per Medical Director orders. Record review of Resident #7's physician's order summary report, dated 6/16/26, reflected urinary catheter care every shift, dated 3/31/26. Record review of CNA B's Hand Washing and Perineal Care Competency Assessments, dated 12/18/25, indicated she was checked off on all skills and signed by ADON H. During an observation on 6/16/26 at 11:14 A.M., CNA B was accompanied by RN A for catheter care and incontinent care for Resident #7. CNA B performed catheter and incontinent care for Resident #7. CNA B removed her dirty gloves and applied clean gloves without sanitizing her hands, then she proceeded to apply a clean brief and clean pants to Resident #7. During an interview on 6/16/26 at 11:28 A.M., CNA B stated she knew she forgot to sanitize her hands between glove change. She stated she had the sanitizer on the table, but she was nervous. She stated when going from dirty to clean she was supposed to sanitize her hands between glove changes. She stated gloves could have permeation(the process by which a substance (like a gas, liquid, or vapor) penetrates, spreads through, or passes completely through a solid material or space), because there were many things that could be transferred through gloves that could not be seen by the naked eye. She stated improper hand hygiene could cause cross contamination. During an interview on 6/16/26 at 11:32 A.M., RN A stated when performing catheter care and incontinent care she expected the CNAs to change their gloves and sanitize their hands when going from dirty to clean. She stated she observed CNA B when she failed to sanitize her hands after removing the dirty gloves, but she had already started the next step before she could intervene. She stated she was not sure who was responsible for ensuring the staff were checked off for proficiency. She stated a negative effect of improper hand hygiene was cross contamination. During an interview on 6/17/26 at 1:45 PM, ADON E (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she expected the staff to their sanitize hands when going from dirty to clean and after a glove change. She stated it was the infection prevent list and she was responsible for staff using proper hand hygiene. She stated the risk of improper hand hygiene was infection and the spread of bacteria. During an interview on 6/17/26 at 1:57 PM, the Administrator stated her exceptions were for staff to sanitize their hands between glove changes when going from dirty to clean. She stated the risk was possible infections. During an interview on 6/17/26 at 2:25 PM, the Director of Nursing stated she expected staff to sanitize when going from dirty to clean and between gloves changes, during incontinent and catheter care. She stated the Infection Preventionist was responsible for ensuring staff were using proper hand hygiene techniques. She stated the risk was infection. Record review of the facility's policy titled, Handwashing/ Hand Hygiene, dated December 2025, indicated. Hand hygiene is the primary means for preventing healthcare-associated infections (HAIs) and the transmission of multidrug-resistant organisms (MDROs). This facility requires strict adherence to evidence-based hand hygiene practices (as described in this policy) for all personnel, including licensed, contracted, therapy, dining, housekeeping: volunteers, and students. 1. All personnel are provided with hand hygiene training upon hire and annually thereafter. Hand hygiene competency of staff is measured, including through return demonstrations to verify technique. 1. Hand hygiene is indicated: h. after glove removal. Record review of the facility's policy titled, Perineal Care, dated February 2018, indicated. The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider when an antibiotic was used despite criteria, to determine the the appropriate use of an antibiotic for 1 of 5 residents reviewed for antibiotic use (Resident #32). The facility failed to ensure Resident #32 did not receive Bactrim 800-160mg (an antibiotic used to treat a variety of bacterial infections) for prophylactic antibiotic use. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections.Findings included: Record review of Resident #32's face sheet, dated 06/17/26, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills) and multiple sclerosis (a chronic autoimmune disease of the central nervous system). Record review of Resident #32's quarterly MDS assessment, dated 05/08/26, reflected that she had a BIMS score of 09, which indicated moderate cognitive impairment. She was usually able to make herself understood and she was able to understand others. Record review of Resident #32's Order Summary Report, dated 06/16/26, reflected the following order:*Bactrim oral tablet 800-160 mg, give 1 tablet by mouth one time a day for prophylactic indefinitely. The start date was 03/12/26. There was not an end date. During an interview on 06/17/26 at 11:22 AM, ADON E said they were giving Resident #32 the Bactrim medication for a UTI preventative. She said they had to keep putting her on IV antibiotics to treat recurrent UTIs. She said they did not follow any criteria for that, but they just followed the doctor's order. She said they did not have a documented rationale for the antibiotic, and they did not document other things they had tried. She said it had not been brought up in a pharmacy consultant review. During an interview on 06/17/26 at 02:11 PM, the DON said Resident #32 had recurrent UTI's. She said she did meet the McGeer's criteria (standardized definitions used for infection surveillance in long-term care and nursing facilities) for having a prophylactic antibiotic. During an interview on 06/17/26 at 02:25 PM, the Administrator said she expected the nursing staff to follow orders. She said the risk to Resident #32 was a possibility of change of condition. Record review of the Facility's policy, Antibiotic Stewardship - Orders for Antibiotics, last revised December 2016, reflected: .3. Appropriate indications for use of antibiotics include:a. criteria met for clinical definition of active infection or suspected sepsis; andb. pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending).