STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675879	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrell Healthcare Center	204 W Nash Terrell, TX 75160

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record review, the facility failed to designate an Infection Preventionist that was qualified by education, training, experience, or certification, and who completed specialized training in infection prevention and control, for one of one facility. The facility did not designate a qualified Infection Control Preventionist.This failure could place residents at risk for cross contamination and infection.Findings included:During an interview on 04/03/26 at 2:27 PM the ADON stated she was the in charge of infection control but did not have the certificate to be the infection control preventionist. The ADON stated the MDS nurse had certification for infection control preventionist. The ADON stated she was working on her certification of being the Infection Control Preventionist.During an interview 04/03/26 at 11:33 AM the MDS nurse said she does have her Infection Preventionist certification, but she no longer oversees anything with infection control. During an interview on 04/03/26 at 4:26 PM the DON said the MDS nurse had her certification for infection preventionist. The DON said the ADON was over logging the infections and tracking and trending and all that has to do with infection control. The DON said the ADON was not certified but she should have been certified as an infection preventionist. The DON said the failure placed a risk for something to be missed as far infection control. During an interview on 04/03/26 at 4:53 PM the Administrator said he knew the ADON should have had her certification completed to be the infection preventionist. The Administrator said the failure placed a risk for the ADON not following the infection control protocols correctly. Review of the ADON's personnel file reflected the ADON was hired on 02/01/26.Record review of the facility policy, reviewed 03/03/26, Infection Prevention and Control Program indicated 5. Coordination and Oversighta. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist).Refer to Appendix PP.The regulatory requirements for the IP with tips on how to ensure compliance are listed below. See CMS's State Operating Manual Appendix PP updated 2-03-23 for F882 Infection Preventionist pages 801-806. Infection preventionist. The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must:(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; (2) Be qualified by education, training, experience or certification; (4) Have completed specialized training in infection prevention and control.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of medical records for 9 of 12 (Resident #19) residents reviewed for privacy and confidentiality.1.The facility failed to ensure LVN K logged out of her computer and protected Resident#19's Medication Administration Record. 2. The facility did not ensure residents had the right to promptly receive mail on Saturdays. This failure could place residents at risk for low self-esteem, loss of dignity, and decreased quality of life due to medication administration records being accessible to others.Findings included: 1.Record review of Resident #19's face sheet, dated 04/03/26, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included wound infection, heart failure, stroke, and high blood pressure. Record review of Resident #19's quarterly MDS assessment, dated 03/30/26, indicated Resident #19 sometimes understood and was sometimes understood by others. Resident #19's BIMS score was 10, which meant he was moderately cognitively impaired The MDS indicated he took antibiotic medication during the 7-day look-back period. Record review of Resident #19's care plan dated 03/27/26, indicated Resident #19 was on intravenous medications related to wound infection. The intervention was for staff to monitor/document/report as needed of any signs and/or symptoms of leaking at the IV site: Edema at the insertion site, taut, shiny or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of I.V. fluid out of the insertion site. Record review of Resident #19's physicians orders dated 04/01/26 indicated, Cefepime Intravenous Solution Reconstituted 2GM (Cefepime HCl) Use 2 gram intravenously every 8 hours for infection until 04/12/2026 for wound healing. During an observation and interview on 04/01/26 at 4:41 p.m., LVN K stepped away from the medication cart and entered Resident #19's room to remove his intravenous antibiotic. LVN K left the computer screen (on top of the medication cart) unlocked where the medication administration record of Resident#19 was clearly displayed. While LVN K was in the room unknown staff and residents were observed walking by the unlocked computer screen. LVN K said she left the computer screen open for Resident #19 because she was in a hurry. She said she should have closed the MAR before entering Resident #19's room. She said it was a HIPAA violation to keep the MAR open where others could see Resident #19's personal information. During an interview on 04/03/26 at 3:36 p.m., the DON said she expected the nurses and med aides to provide full visual privacy and confidentiality of information for all residents. She said if the staff left the MAR open anyone could walk up to it and see personal information. The DON said failure not to protect the residents' information could cause poor self-esteem and embarrassment for the residents. During an interview on 04/03/26 at 5:32 p.m., the Administrator said he expected the MAR to be always closed when unattended because of resident information and privacy. 2. During a confidential group interview at an undisclosed date and time, 8 residents stated they did not always receive their mail on Saturdays. The residents stated they had to wait until Monday when (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility allowed the Activity Director to pass it out. During an interview on 04/01/26 at 11:42 a.m., the Activity Director stated there were times she delivered mail to residents from Saturday on Monday that was given to her by the Business Office Manager. The Activity Director stated it was important residents received their mail because it was their right. During a telephone interview on 04/01/26 at 6:08 p.m., Dietary Aide E stated she had a key to the mailbox that was left in the Dietary Manager office for her to check the mail. Dietary Aide E stated the Business Office Manager told her to check the mail on Saturdays and place it under her door. Dietary Aide E stated she was never told to pass out mail to residents on Saturdays. Dietary Aide E stated it was important for the residents to get their mail because it was their right. During an interview on 04/02/26 at 2:39 p.m., Dietary Aide D stated she checked the mail on Saturdays and if there was personal mail such as a letter or a package, she gave it to the residents and the other mail she put at the nursing station to be stored until Monday for the Business Office Manager. Dietary Aide D stated it was discussed in an all-staff meeting that she could not recall the date the dietary staff should check the mail on Saturdays and give it to the residents. Dietary Aide D stated it was important for the residents to get their mail because it was their right. During an interview on 04/03/26 at 3:30 p.m., the Business Office Manager stated the locked mailbox was located outside. The Business Office Manager stated the weekend dietary staff were responsible for checking the mailbox and distributing mail on the weekends. The Business Office Manager stated she did obtain mail from Saturdays and give the Activity Director the residents' mail to distribute. The Business Office Manager stated she was aware of the requirements for the residents to have access to their mail on Saturdays. The Business Office Manager stated it was important for residents to receive their mail because it was their right. During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected mail to be delivered on Saturdays. The DON stated she was unsure who was supposed to monitor and oversee residents getting their mail on Saturdays. The DON stated this failure was a resident rights issue. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected mail to be delivered on Saturdays. The Administrator stated dietary staff were responsible for distributing mail to residents on Saturdays. The Administrator stated there was not a system in place to ensure residents receive their mail on Saturdays. The Administrator stated this failure could affect their rights. Record review of the facility's policy titled Statement of Resident Rights (Texas), undated, indicated, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate, or retaliate against you for exercising your rights. #6. privacy, including privacy during visits and telephone calls.#8. have facility information about you maintained as confidential. #17 receive unopened mail.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate with the appropriate, State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition received care and services in the most integrated setting appropriate to their needs for 4 of 6 residents (Resident #41, Resident # 25, Resident #11, and Resident #9) reviewed for PASRR. 1.The facility failed to coordinate with the appropriate state authority to ensure Resident #41 who had a mental disorder received a PASRR meeting (to see if she would qualify for other care and services) after she was positive on her PE on 01/12/26. 2. The facility failed to provide documentation of Resident #25's habilitation coordination and independent living skills services as requested in the PCSP Form.3.The facility failed to ensure the local authority was notified of Resident #11's Medicaid eligibility on 04/01/25 to ensure her PASRR services were started. 4. The facility did not ensure Resident #9's PASARR screening was completed to indicate a diagnosis of post-traumatic stress disorder.These failures could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings included: 1.Record review of Resident #41's face sheet, dated 04/03/26 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, schizophrenia disorder (a serious mental health condition that affects how people think, feel and behave), and depression (a feeling of sadness). Record review of Resident #41's admission MDS assessment, dated 12/30/25, indicated Resident #41 understood and was usually understood by others. Resident #41's BIMS score was 15, which indicated her cognition was intact. The MDS indicated Resident #41 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS reflected Resident #41 had an active diagnosis of Schizophrenia disorder. Record review of the PASRR Level 1 Screening form, dated 12/23/25, reflected Resident #41 had a mental illness. Record review of the PASRR Evaluation Screening form, dated 01/12/26, reflected Resident #41 had a mental illness. Record review of Resident #41's medical record did not indicate a PCSP meeting had occurred after receiving the positive PE. Record review of Resident #41's comprehensive care plan, dated 01/19/26, indicated, Resident #41 used an antidepressant medication. The intervention was for staff to give medication as ordered. Record review of Resident #41's Physician order dated 03/12/26 indicated Fluoxetine HCl Oral Solution 20 MG/5ML (Fluoxetine HCl) Give 15 ml via(through) gastrostomy (a medical tube inserted directly through the abdominal wall into the stomach to deliver nutrition, fluids, and medications) tube one time a day related to depressive disorder. During an interview on 04/03/26 at 11:28 a.m., the MDS Coordinator said she was responsible for ensuring the PCSP meeting was held. She said she had been told that Resident #41 had refused PASRR service by an unknown staff member. She said she did not ask Resident #41 if the information (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was true or reach out to the local authority to validate the information. During a phone interview on 04/03/26 at 1:11 p.m., the Local Authority said she did Resident #41's PE on 01/12/26. She said she was deemed with a mental illness and qualified for PASRR service. She said she did not talk to the normal MDS Coordinator but did let an unknown staff member know that Resident #41 was reluctant to receive PASRR services but said she never refused services. She said generally the facility would coordinate the PCSP meeting with the local authority. She said she could not see in her system where a PCSP meeting had occurred for Resident #41. During an interview on 04/03/26 at 3:08 p.m., Resident #41 said she would be interested in learning more about PASRR services. During an interview and record review on 04/03/26 at 3:28 p.m., the MDS Coordinator looked in Resident #41's medical records and did not see a PCSP meeting. She said she had not set up the PCSP meeting because usually the local authority set up the meetings. She said she did not reach out to the local authority once they had not contacted her for the meeting. She said she failed to follow up on the meeting. She said a risk could be that Resident #41 may not receive extra services that she may benefit from such as therapy, specialized wheelchair, or additional outside activity. During an interview on 04/03/26 at 3:39 p.m., the DON said she had attended 1 or 2 PCSP meetings in the past but was not familiar with the process. She said she expected the MDS Coordinator to complete the necessary paperwork for the process. She said she knew the PASRR service offered extended services but could not remember which kind. During an interview on 04/03/26 at 5:32 p.m., the Administrator said the MDS was responsible for the PCSP meetings. He said they should meet quarterly. He said if Resident #41 was positive on her PE, then the resident could qualify for services that could benefit her. 2. Record review of Resident #25's face sheet, dated 04/03/26, reflected Resident #25 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included Paranoid Schizophrenia (severe psychiatric disorder is characterized by persistent delusions of persecution, unwarranted suspicion, and often vivid hallucinations, anxiety (excessive worry), and delusional disorder (a fixed false belief based on an inaccurate interpretation of an external reality). Record review of Resident #25's quarterly MDS assessment, dated 01/02/26, reflected Resident #25 understood others, and made himself understood. Resident #25 BIMS score was 15, which reflected his cognition was intact. Record review of Resident #25's comprehensive care plan, revised 03/25/26, reflected Resident #25 had identified that he was in need of specialized services due to mental illness. The care plan interventions included: follow up with agency representative to ensure recommendations are fully implemented. Record review of the PCSP meeting dated 12/09/25 reflected that habilitation coordination and independent living skills services were recommended for Resident #25. Record review of Resident #25's EMR dated 04/01/26 reflected no documentation of habilitation coordination or independent living skills training notes. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 04/02/26 at 10:37 a.m., the Habilitation Coordinator stated she came to the facility monthly to get a report from Resident #25 to ensure his needs were met. The Habilitation Coordinator stated she did not leave any documentation for the monthly visits at the facility. The Habilitation Coordinator stated she followed up with the nurses after each visit to see if there were any concerns with his care. During a telephone interview on 04/03/26 at 11:24 a.m., the Skill Trainer Community Advocate stated he came to the facility once a week on Mondays to visit Resident #25. The Skill Trainer Community Advocate stated he did not leave any documentation for the facility nor spoke with anyone after each visit. The Skill Trainer Community Advocate stated his documentation was left at the local authority office. During an interview on 04/03/26 at 11:28 a.m., The MDS Coordinator stated she was responsible for ensuring visits were conducted by the habilitation coordinator and skill trainer. The MDS Coordinator stated she was not aware when the skill trainer came to visit but the habilitation coordinator came every three months. The MDS Coordinator stated she did not coordinate with them after their visits. The MDS Coordinator stated it was important documentation was received after every visit to ensure they were receiving services. During an interview on 04/03/26 at 4:04 p.m., the DON stated she could not recall the exact services Resident #25 should be receiving but she expected some type of documentation to be provided after every visit to show the habilitation coordinator and skill trainer were in the building. The DON stated she did not know when the habilitation coordinator and the independent skill trainer came to the facility until she received an email from the habilitation coordinator to schedule the quarterly meeting. The DON stated she was not aware how often they came until the state surveyor intervention. The DON stated it was important to ensure documentation was provided for continuity of care. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he did not know what services Resident #25 was receiving until the state surveyor intervention. The Administrator stated he had not received recommendations to know how often Resident #25 should be seen. The Administrator stated in his experience that if the facility ever needed documentation, they would ask that provider to provide the documentation. The Administrator stated there was not a system in place to monitor the MDS Coordinator oversight of needs. The Administrator stated it was important to ensure documentation was provided to ensure Resident #25 was receiving his PASRR services. 3.Record review of Resident #11's face sheet dated 04/02/26 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses which included bipolar disorder (a chronic mental health condition characterized by extreme mood swings, ranging from high energy mania to deep depression), Post Traumatic Stress Disorder (a mental health condition triggered by experiencing or witnessing terrifying or life-threatening, traumatic events), acute respiratory failure (critical condition where the lungs cannot transfer oxygen to the blood or remove carbon dioxide causing breathing problems), and muscle weakness. Record review of Resident #11's annual MDS dated [DATE] indicated she was considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition with a diagnosis of a serious mental illness and an intellectual disability. The MDS also indicated Resident #11 made herself understood and understood others and she had a BIMS score of 15 which meant she was cognitively intact. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's comprehensive care plan dated 03/25/25 indicated she had a PASRR level 2 assessment completed related to mental illness of bipolar and anxiety. She should have been receiving habilitation coordination through PASRR services with interventions in place to follow up with agency representative to ensure that recommendations were fully implemented, assist the case worker with obtaining any needed information, and to ensure the local authority for PASRR was notified of any changes that may need further interventions. Record review of Resident #11's PASRR Comprehensive Service Plan Form dated 06/26/25 indicated her Medicaid eligibility was undetermined, but she was supposed to receive medication training, routine case management, and counseling services from PASRR. Record review of Resident #11's undated client/inquiry information form indicated Resident #11's eligibility for Medicaid began on 04/01/25. During an interview on 04/02/26 at 11:30 a.m., the MDS nurse said she was unsure if Resident #11 had Medicaid eligibility or not. She said the Local Authority representative was responsible for ensuring the meetings were held for positive PASRR residents and the Social Worker and herself should have kept up with it when the Local Authority representative emails the dates sent. The MDS nurse said the failure placed Resident #11 at risk of not getting any of the services that she had requested. During an interview on 04/02/26 at 4:40 PM Resident #11 said she still wanted the services from PASRR but she was unsure of what had happened. Resident #11 said she was not sure what all she chose. During an interview on 04/02/26 at 5:51 p.m., the Business Office Manager said she did not know who was responsible for PASRR services, but she knew Resident #11 had been approved for her Medicaid a while back about a month or two after she admitted . During an interview on 04/03/26 at 4:29 p.m., The DON said she had just heard about Resident #11's admitting Medicaid pending and then she was approved of Medicaid at some point and the Medicaid services back dated to the day they approved her. The DON said she was unsure of any dates, but the facility department heads about talked payor changes daily in the morning meetings. The DON said she expected the MDS nurse or Social Worker to have notified the Local Authority for PASRR when they were aware of the Medicaid being approved. The DON said the failure placed Resident #11 at risk of not receiving services and it was her right to receive the services she requested. During an interview on 04/03/26 at 5:21 p.m., the Administrator said Resident #11's Medicaid was approved about a month after she admitted . The Administrator said 2 months ago the interdisciplinary team discussed the positive PASRR residents, and to his understanding the meeting for her PASRR services to begin was set up at the time. The Administrator said he would make sure with the MDS nurse who was responsible for ensuring the meeting for PASRR services to begin was set up. The Administrator said the failure placed Resident #11 at risk of not receiving her PASRR services and affected every service she wanted because she was PASRR positive. 4. Record review of Resident #9's face sheet dated 4/3/26, reflected Resident #9 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included chronic kidney disease, stage 5 (Kidneys function at less than 15% capacity, causing severe buildup of waste, fluid, and toxins, which necessitates treatment like dialysis or a kidney transplant to sustain life), major (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), hallucinations (sensory experiences—seeing, hearing, smelling, tasting, or feeling things—that appear real but are created by the mind in the absence of external stimuli). and post-traumatic stress disorder (a mental health condition that's triggered by a terrifying event, either experiencing it or witnessing it). Record review of Resident #9's admission MDS assessment dated [DATE], reflected Resident #9 made himself understood and understood others. Resident #9's BIMS score was 15 which indicated the resident's cognition was fully intact. The MDS assessment reflected Resident #9 had an active diagnosis of post-traumatic stress disorder. Record review of Resident #9's Pre-admission Screening and Resident Review screening dated 1/23/26, indicated no diagnosis or history of post-traumatic stress disorder or any other mental illness. Record review of Resident #9's Social History Form- Trauma Informed Care dated 1/29/26 indicated the resident had a previously documented diagnosis of mental disorder and history of trauma. The form indicated the resident did have a diagnosis of post-traumatic stress disorder. The form indicated Resident #9 had experienced a serious accident and physical assault and had been in a situation that was extremely frightening as well as witnessed an extremely frightening situation. The Trauma Informed Care form indicated Resident #9 had triggers of loud noises, specific smells, restraints, and large crowds. The form indicated removing stimuli and medications prescribed for the trauma related diagnosis helped to alleviate the triggers. Record review Resident #9's base line care plan dated 1/31/26 revealed the resident had no mental health needs, no behavioral concerns, and no interventions for post-traumatic stress disorder. Record review of Resident #9's orders dated 4/3/26 indicated no monitoring for traumatic stress behaviors or triggers. In an interview on 4/1/26 the MDS Nurse stated she made a mistake by not doing a correct screening. The MDS Nurse stated she should have done a form 1012 to correct it. The MDS Nurse stated she just learned about the form for filing a correction. She stated it was important to screen and evaluate correctly so residents got the services they need and qualify for. In an interview on 4/3/26 at 4:40 pm, the DON stated the Social Worker was responsible for ensuring the diagnosis of post-traumatic stress disorder triggers trauma informed care on the resident's chart. The DON stated it is important to be aware if a resident requires trauma informed care to be able to provide the best possible care by avoiding triggers. In an interview on 4/3/26 at 5:55 pm, the Administrator stated he expects all residents with a diagnosis of post-traumatic stress disorder to have trauma informed care. The Administrator stated he expects all admission screenings to be done in the appropriate amount of time and all services available be offered. The Administrator stated the Social Worker was responsible for the trauma assessment, but the ADON and DON were also responsible for knowing of the diagnosis and proceeding accordingly. The Administrator stated it is important to care for residents with a post-traumatic stress disorder diagnosis appropriately for the safety of the residents and the staff. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/3/26 at 6:15 pm the Social Worker stated the trauma assessment was part of the initial admission assessment. The Social Worker stated she was responsible for that assessment. The Social Worker stated that Resident #9 did trigger for trauma informed care, but Resident #9 did not have issues. The Social Worker stated it was important to ensure a resident with post-traumatic stress disorder have trauma informed care so that the resident can get needs met and be most comfortable at the facility. Record review of the facility's undated policy titled PASRR Rationale, indicated, All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), (mental retardation (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident's method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State. Planning for Care: The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State. The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition. The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination, and the evaluation report should be addressed in the plan of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide appropriate treatment and service of care for 3 of 3 residents (Residents #8, #23, and #70) reviewed for indwelling catheter. 1. The facility failed to ensure Resident #8's foley catheter (tube inserted into bladder) was secured on 03/31/26. 2.The facility failed to ensure Resident #23 had his catheter secured on 03/31/26 and 04/01/26. 3.The facility failed to have an appropriate diagnosis or indication for the use of the indwelling catheter for Resident #70. These failures could place residents at risk for urinary tract infections and a decreased quality of life. Findings included: 1. Record review of Resident #8's face sheet, dated 04/03/26, reflected Resident #8 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included bladder neck obstruction (blockage at the base of the bladder that prevent it from opening properly) and retention of urine (inability to completely or partially empty the bladder). Record review of Resident #8's significant change in status assessment dated [DATE], reflected Resident #8 made himself understood and understood others. Resident #8 had a BIMS score of 13, which reflected his cognition was intact. Resident #8 had an indwelling catheter. Record review of Resident #8's comprehensive care plan, revised 04/01/26, reflected Resident #8 had an indwelling catheter 16 fr related to bladder outlet obstruction, retention and catheter should be secured with a leg strap at all times. The care plan interventions included: monitor and document for pain/discomfort due to catheter. Record review of Resident #8's physician order summary report dated 04/03/26, reflected an active physician's order to check foley leg strap placement and change PRN every shift for foley catheter with a start date 05/05/25. During an observation and interview on 03/31/26 at 12:32 p.m., Resident #8 was sitting in his wheelchair with his catheter tubing not secured. The state surveyor asked Resident #8 how long his catheter has not been secured, Resident #8 replied, a few weeks. During an interview on 03/31/26 at 12:36 p.m., LVN O stated Resident #8 catheter did not have to be secured because he was able to move the catheter bag easier from his wheelchair to keep the bag from getting in his way of his legs when he went back to bed. During an observation on 03/31/26 at 1:10 p.m., Resident #8 was sitting in his wheelchair with his catheter tubing not secured. During an interview on 03/31/26 at 1:12 p.m., LVN A stated Resident #8's catheter should always be secured. LVN A stated initially the nurse that placed the catheter should have made sure the catheter tubing was secured but if the device comes off the nurse should replace it, or the aide should report it to the nurse. LVN A stated he just noticed today (03/31/26) that his catheter was not secured LVN A stated it was important to ensure the catheter was secured to prevent trauma to the perineum area. During an interview on 03/31/26 at 1:23 p.m., CNA C stated she drained Resident #8's catheter bag this morning (03/31/26) but did not see if it was secured or not. CNA C stated she was not sure why (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the catheter should be secured. 2.Record review of Resident #23's face sheet dated 04/01/26 indicated he was a 68-yer-old male who re-admitted to the facility on [DATE] with the diagnoses which included major depressive disorder (a serious, common mental health condition characterized by low mood, loss of interest in activities, and low energy), paraplegia (a medical condition involving the loss of voluntary movement and/or sensation in the lower half of the body), heart failure (a chronic condition in which the heart becomes too weak to pump blood), retention of urine, and high blood pressure. Record review of Resident #23's quarterly MDS assessment dated [DATE] indicated he made himself understood and he was understood by others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated Resident #23 required total assistance from staff for transfers, bed mobility, bathing, and he required setup assistance for eating. The MDS also indicated Resident #23 had an indwelling catheter. Record review of Resident #23's comprehensive care plan revised 12/08/25 indicated he had renal insufficiency related to retention of urine and had a suprapubic catheter in place with interventions to monitor for signs and symptoms of pain or discomfort. Record review of Resident #23's order summary report as of 04/01/26 indicated he had an order for: Check foley leg strap for placement and change as needed every shift for foley catheter with a start date of 07/31/25 and no end date. During an observation and interview on 03/31/26 at 11:21 a.m., Resident #23 was in his electric wheelchair with shorts on and had a piece of tape on his right leg for his catheter that was not attached to the catheter. Resident #23 said the facility did not have any supplies. During an observation and interview on 04/01/26 at 8:56 a.m., Resident #23 was in his bed with tape on his right leg but not attached to his catheter tubing. Resident #23 said he needed the actual securement device for his catheter because not having the device was making his stoma sore related to the catheter tubing moving around. During an observation and interview on 04/02/26 at 10:14 a.m., Resident #23 was in his bed and had his catheter securement device on his right leg. LVN K said Resident #23 was supposed to have his catheter always secured. LVN K said at times the facility runs out of the securement devices, but she always kept a stash of the securement devices to ensure her residents had one in place. LVN K said she applied Resident #23's securement device for his catheter on 04/02/26. During an interview on 04/03/26 at 3:17 p.m., the ADON said Resident #23 should always have a catheter strap on. The ADON said the failure placed a risk for him having catheter dislodgment or discomfort. During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected catheters to always be secured by the charge nurse. The DON stated CNA C should have looked to see if Resident #8 catheter was secured and if she noticed it was not secured, she should have reported it to the nurse. The DON stated she monitored catheter securement by random rounds. stated it was important to ensure the catheter was secured to prevent dislodgment and caused trauma to the perineal area. 3.Record review of Resident #70's face sheet, dated 04/03/26 indicated she was a [AGE] year-old (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	female admitted to the facility on [DATE] with diagnoses which included, Chronic obstructive pulmonary disease also known as COPD (lung and airway diseases that restrict your breathing), diabetes (a condition that happens when your blood sugar (glucose) is too high), and high blood pressure. Record review of Resident #70's medical records did not indicate a MDS assessment had been completed because it was not yet due. Record review of Resident #70's baseline care plan dated 03/27/26, indicated she had an indwelling catheter. No interventions were listed. Record review of Resident #70's physician's orders dated 03/27/26, indicated an indwelling catheter of 18 French with a 30 ml bulb, to be changed as needed. There was no indication for the catheter on the physician's order. Record review of Resident #70's medication administration records, dated 03/01/26 through 03/31/26, revealed the ordered indwelling catheter was still in place in the resident's bladder. Record review of Resident #70's medical record did not reveal an appropriate diagnosis for the catheter or any assessment for the resident's ongoing use of the catheter. During an observation and interview on 03/31/26 at 1:17 p.m., Resident #70 was lying in her bed. She had an indwelling catheter. Resident #70 said she did not know why she had the indwelling catheter but said she had it for an unknown time. During an observation on 04/01/26 at 9:28 a.m., Resident #70 was lying in bed with her oxygen set at 5 liters per nasal cannula. During an interview and record review on 04/02/26 at 2:20 p.m., RN G said he was Resident #70's nurse. He said he did not know why Resident #70 had an indwelling catheter. He looked at Resident #70's orders and did not see a diagnosis for the indwelling catheter. He said Resident #70's diagnosis should have been listed on her orders. He said she was admitted with the indwelling catheter from home, but he would see if he could find the diagnosis. He said it was important to know the diagnosis to see if she needed the indwelling catheter or not. During an interview on 04/03/26 at 3:36 p.m., the DON said the nurses were responsible for ensuring they received diagnosis for residents who admitted or received an indwelling catheter. The DON confirmed the indwelling catheter should not be in place without appropriate rationale and/or diagnosis for use. She said staff should be aware why a resident had an indwelling catheter for the risk of infection. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected catheters to be always secured. The Administrator stated anyone that had a catheter should have an order. The Administrator stated the aide should have checked to see if the catheter was secured and report it to the charge nurse. The Administrator stated the nurse was responsible for ensuring the catheter was secured, an order was placed in PCC. The Administrator stated the DON, or designee, was responsible for monitoring and overseeing catheter securement. The Administrator stated it was important to ensure the catheter was secured to prevent trauma in the perineal area and infection. The Administrator stated it was important an order was placed in the resident's chart to follow the MD (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders. Record review of the facility's policy titled, Catheter Care, Urinary, Policy, undated, indicated, Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. Changing Catheters: 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 medication room (hall 100) refrigerator for 2 of 2 residents (Resident #54 and Resident #39), 1 of 3 medications carts(hall 300) for 1 of 3 residents (Resident #5), and for 2 of 24 residents (Resident #16 and Resident#23) reviewed for medication storage.1.The facility failed to ensure Resident #54's Lorazepam (antianxiety medication) and Morphine (pain medication) were secured behind two locks2.The facility failed to ensure Resident #39's Morphine (pain medication) was secured behind two locks.3.The facility failed to ensure an insulin pen was dated when opened on the 300-hall medication cart.4.The facility failed to ensure wound cleanser was not left in Resident #16's room on 03/31/26. 5 The facility failed to ensure Resident #23 did not have triad hydrophilic wound paste, triple antibiotic and hydrocortisone cream in his bedside dresser.These failures could place residents at risk of not receiving prescribed medications as ordered, therapeutic medication, drug diversions and injury. Findings included: 1.Record review of Resident #54's face sheet, dated 04/03/26, indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included dementia, (memory loss), depression (sadness), stroke, and high blood sugar. Record review of Resident #54's admission MDS assessment, dated 03/28/26, indicated Resident #54 sometimes understood and was sometimes understood by others. Resident #54's BIMS score was 00, which meant he was severely cognitively impaired. The MDS indicated Resident #54 required help with toileting bed mobility, dressing, transfers, personal hygiene, and eating. The MDS indicated he took anxiety medication during the 7-day look-back period. Record review of Resident #54's care plan dated 03/31/26, indicated Resident #54 was on hospice. The intervention was for staff to observe residents closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Record review of Resident #54's physician order dated 03/20/26 indicated, Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.5 ml by mouth every 6 hours as needed for anxiety/agitation. Record review of Resident #54's physician order dated 03/20/26 indicated, Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) Give 0.25 ml by mouth every 1 hour as needed for shortness of breath/pain. Record review of Resident #54's narcotic sheet for lorazepam and Morphine did not indicate any missing medication. During an observation on 04/02/26 at 2:39 p.m., Resident #54 had 1 open bottle of Lorazepam and 2 unopened bottles of Morphine Sulfate in hall 100 medication room refrigerator door. These medications were not double locked in the refrigerator. 2.Record review of Resident #39's face sheet, dated 04/03/26, indicated a [AGE] year-old male who (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was admitted to the facility on [DATE] with diagnoses which included dementia, (memory loss), depression (sadness), and stroke. Record review of Resident #39's quarterly MDS assessment, dated 02/16/26, indicated Resident #39 understood and was understood by others. Resident #39's BIMS score was 09, which meant he was moderately cognitively impaired. The MDS indicated Resident #39 required help with toileting bed mobility, dressing, transfers, personal hygiene, and eating. Record review of Resident #39's care plan dated 01/27/26, indicated Resident #39 had chronic pain The intervention was for staff to monitor/record/report to nurse any signs or symptoms of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Record review of Resident #39's physician order dated 02/11/26 indicated, Morphine Sulfate Oral Solution 20 MG/1ML (Morphine Sulfate) Give 0.25 ml by mouth every 1 hour as needed for shortness of breath/pain. Record review of Resident #39's narcotic sheet for Morphine did not indicate any missing medication. During an observation on 04/02/26 at 2:39 p.m., Resident #39 had 1 open bottle of Morphine Sulfate in the hall 100 refrigerator door. This medication was not double locked in the refrigerator. During an observation and interview on 04/02/26 at 2:40 p.m., the DON saw the Resident #54's Lorazepam and Morphine and Resident #39's Morphine in the refrigerator not doubled locked. She said she was not aware of the bottles being in the refrigerator door. She said she thought if they were locked by the medication room and the refrigerator door it was considered double locked. She said the risk could be drug diversion. 3.Record review of Resident #5's face sheet, dated 04/03/26, reflected Resident #5 was a [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis which included diabetes (high blood sugars), dementia (memory loss), depression (sadness), and muscle weakness. Record review of Resident #5's admission MDS assessment, dated 01/30/26, reflected Resident #5 made himself understood, and was understood by others. Resident #5's BIMS score was 15, which reflected his cognition was intact. The MDS indicated he received insulin during the 7-day look back period. Record review of Resident #5's care plan revised date of 07/18/25, indicated he was diabetic and received Lispro, Glargine, and metformin. The interventions were to give medications as ordered. Record review of Resident #5's physician ordered dated 01/24/26, indicated, Insulin Glargine Subcutaneous Solution (Insulin Glargine), Inject 30 units subcutaneously at bedtime related to diabetes. During an observation on 04/02/26 at 9:15 a.m., the 300-hall medication cart revealed 1 insulin pen in top drawer opened with no date with Resident #5's name handwritten on it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/03/26 at 9:40 a.m., RN G saw the insulin pen in the drawer without a written date of being opened. He said the insulin pen should have been dated when opened to ensure the resident would not receive expired medication. During an interview on 04/03/26 at 2:47 p.m., LVN K said when Resident #5 was moved to her floor (unknown date) the Glargine pen was already open with his name on it. She said she was not sure of the date of opening and said it was good for 28 days. She said she was sure it was not older than 28 days, but she could not prove when it was opened. She said the risk could be receiving expired medication. She said the nurse who opened the insulin should have dated it. 4 Record review of Resident #16's face sheet, dated 04/03/26, reflected Resident #16 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included dementia (memory loss), depression (sadness), and muscle weakness. Record review of Resident #16's quarterly MDS assessment, dated 01/27/26, reflected Resident #16 made herself understood, and was understood by others. Resident #16's BIMS score was 14, which reflected her cognition was intact. Record review of Resident #16's comprehensive care plan, revised 03/02/26, indicated, Resident #16 was at risk for increase in falls/injury due to use of personal safety device related to motorized wheelchair. Resident #16 had an actual wound (laceration) to her left shin. The intervention was for staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or firm surface. Record review of Resident #16's physician order, dated 03/27/26 indicated, wound #3 cleanse with wound cleanser, apply xeroform and bordered dressing. every other day for wound care. During an observation and interview on 03/31/26 at 12:05 p.m., Resident # 16 had a bottle of wound cleanser on her nightstand table. She said unknown staff had left it in her room. During an interview on 04/03/26 at 9:55 a.m., RN G said he was Resident #16's nurse. He said wound cleanser should not be in a resident's room because they could drink it. During an interview on 04/03/26 at 3:39 p.m., the DON narcotic medication should be always stored under double lock including medications in the refrigerator. She said the nurses should be counting the narcotics each shift. She said if they were not counting medication some could be missing or have a drug diversion. She said she was doing random checks and saw no omits in the narcotic sign out sheets but would change the process of checking narcotics. The DON said the nurses were responsible for ensuring they removed any products (chemicals or medication) brought into the room with them and then stored them in a medication cart or in a medication room. She said wound cleanser should not be left in the room because it contained chemicals and a resident could ingest it. The DON said insulin pens should be dated when they were opened, and when to discord them. She said failure to date the insulin pen could cause residents to receive expired medication. She said this could affect the effectiveness of the medication. She said they did not have an effective system for checking the medication carts and rooms for undated or expired medications. During an interview on 04/03/26 at 5:32 p.m., the Administrator said the nurses should make sure the narcotic medication kept in the refrigerator were always in the locked box. He said the nurses should be counting narcotics every shift. The Administrator said the DON was responsible for monitoring and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	overseeing by rounding. He said if the nurses were not counting the medications there could be a discrepancy, or missing medications. The Administrator said wound cleanser should not be left in a resident's room for risk of swallowing. He said the nurses were responsible for ensuring they removed wound cleanser before exiting a resident's room. The Administrator said all items opened should have an open date written on it. He said the potential negative outcome could be not knowing how long the medication had been on the cart and it may not work how it should. 5.Record review of Resident #23's face sheet dated 04/01/26 indicated he was a 68-yer-old male who re-admitted to the facility on [DATE] with the diagnoses which included major depressive disorder (a serious, common mental health condition characterized by low mood, loss of interest in activities, and low energy), paraplegia (a medical condition involving the loss of voluntary movement and/or sensation in the lower half of the body), heart failure (a chronic condition in which the heart becomes too weak to pump blood), retention of urine, and high blood pressure. Record review of Resident #23's quarterly MDS assessment dated [DATE] indicated he made himself understood and he was understood by others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated Resident #23 required total assistance from staff for transfers, bed mobility, bathing, and he required setup assistance for eating. Record review of Resident #23's comprehensive care plan revised on 02/17/26 indicated he had sacral region moisture associated skin damage with an order to cleanse with wound cleanser, apply triad hydrophilic wound paste and leave it open to air as well as notify medical director, nurse practitioner, and responsible party of and wound development. Record review of Resident #23's order summary report indicated he had an order to apply triad to sacrum every evening shift for sacrum with a start date of 12/26/25 and no end date. The order summary report did not indicate an order for hydrocortisone cream nor triple antibiotic ointment. During an observation on 04/01/26 at 10:05 a.m., Resident #23 had triad hydrophilic wound paste wound care medications in his bedside drawer and had a tube of triple antibiotic ointment and 2 tubes hydrocortisone cream 1% on bedside table in a clear opened storage container. During observation and interview on 04/02/26 at 2:56 p.m., Resident #23 continued to have two tubes of hydrocortisone cream 1% and a tube of triple antibiotic ointment in a clear storage container on the bedside table by his door in his room. LVN K said she attempted to remove the two tubes of hydrocortisone cream and the triple antibiotic ointment, but Resident #23 had a fit, would not let her take it, and said he bought that over the counter, and she could not take his belongings. LVN K said she reported the incident to DON and Administrator. During an interview on 04/02/26 at 2:59 p.m., Resident #23 said he did not see why he could not have his creams in his room that he needs because he hates having to wait on the nurse for things. During an interview on 04/02/26 at 5:08 p.m., LVN K said she was aware of them having the barrier cream for his buttocks, but she said she thought the triad was discontinued so she was unsure why the triad was in Resident #23's bedside drawer. LVN K said Resident #23 should not have any medications in his room. LVN K said the reason the medications needed to be removed was because it was dangerous and any residents could get a hold of the medications and take them. LVN K said she removed the triad but Resident #23 would not let her remove the hydrocortisone cream nor the triple antibiotic ointment because he bought it himself. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/26 at 4:09 p.m., LVN A said the triad hydrophilic wound dressing paste was what the nurses had an order for to use for Resident #23's buttocks. LVN A said the triad hydrophilic wound dressing paste should not have been in the resident room and the failure placed a risk for safety because any resident could have taken the medications and misuse or ingest the medications. LVN A said he thought Resident #23 bout the medication himself but Resident #23 could not have hydrocortisone cream or the triple antibiotic ointment in his room either. During an interview on 04/03/26 at 3:17 p.m., the ADON said there should be no medications in Resident #23's room on his bedside table. The ADON said all medications should be stored on the nurse's cart. The ADON said the failure placed a risk for the patient self-medicating without the nurse knowing. The ADON also placed a risk for wandering residents getting the medications and misusing. During an interview on 04/03/26 at 4:29 p.m., the DON said Resident #23 should not have had any medications in his room. The DON said she would retrieve the medications and get orders for the nurse to administer, and the facility should have had a self-administration assessment completed if Resident #23 was going to keep his medications in the room safely. The DON said the medications should have been stored in the nurse's cart and the failure placed a risk for another resident to get a hold of the medications and self-administer and possibly ingest it. During an interview on 04/03/26 at 5:16 p.m., the Administrator said the medications should have been kept with the nurse in the medication room or nurse's cart. The Administrator said the DON was responsible for ensuring there were no medications in residents' rooms. The Administrator said the failure placed a risk for residents self-medicating against MD orders and staff or other residents getting a hold of medications and using the medication. Record review of the undated facility policy, Controlled Substances, indicated, Policy Statement The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Dispensing and Reconciling Controlled Substances 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.7. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. Record review of the facility's policy titled, Storage of Medications, undated, indicated, Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation:2. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.11. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurse's station or other secured location. Medications are stored separately from food and are labeled accordingly.12. Only persons authorized to prepare and administer medications have access to locked medications.13. Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Security access to controlled medication 14. Access to controlled medications is limited to authorized personnel. Personnel access to controlled medications is recorded. Record review of the facility's policy titled, Insulin Administration, undated, indicated, Purpose: To (continued on next page)

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	675879	A. Building B. Wing	04/03/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 2. Check blood glucose per physician order or facility protocol.3. Remove insulin vial from storage point. 4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date, and time on the vial (follow manufacturer recommendations for expiration after opening) .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 8 of 8 confidential residents, and 1 of 1 meal was reviewed for palatability, attractiveness, and appetizing. The facility failed to provide food that was palatable and at an appetizing temperature for 8 confidential residents for lunch on 4/1/26. These failures could place residents at risk of decreased food intake, hunger, and unintended weight loss.Findings Included:In a Resident Council Meeting on 4/1/2026 at 10:00 am, 8 of 8 residents said the food was bland and served warm. During an observation on 4/1/26 at 12:48 pm the last food temperature was checked on the warming table, trays prepared, and service began at 12:52 pm. The test tray was prepared at 12:59pm. During an observation on 4/1/26 at 1:08pm the tray cart with the test tray left the kitchen preparation area, was checked by the nurses and went to hall 300. The test tray arrived to the conference room at 1:14pm. During a test tray interview with Dietary Manager by State Surveyors on 4/1/26 at 1:15 pm, the Dietary Manager stated the fried pork chops with white gravy could be warmer. It was not over seasoned or under seasoned. The dietary manager stated the candied yams were ok, but he would add more butter and sugar because they were kind of bland. The dietary manager stated the cauliflower with cheese sauce was nice and warm and had an ok flavor. The Dietary Manager stated the lemon pudding could be cooler. The Dietary Manager stated that overall, the flavor was ok, but it could be warmer. Observation of the plate of food revealed the food was unattractive. During an interview on 4/2/26 at 2:02 pm, the Dietary Manager stated he was responsible for ensuring the food was palatable and was hot when the resident received his or her meal tray. The Dietary Manager stated he has had complaints about the food in the last three months. The Dietary Manager stated it was important for the food to be presented in an appealing manner, be palatable, and the proper temperatures for residents to get the needed nutrition and prevent weight loss. During an interview on 4/2/26 at 5:55 pm, the Administrator stated he expected the food to appear appetizing, taste good, and be delivered hot. The Administrator stated the dietary manager was responsible for the residential dining experience. The Administrator said the food should look appetizing because a person eats with his or her eyes first. The Administrator stated it was important to serve palatable meals so the residents avoid weight loss and have adequate nutrition. Record review of the food temperature log, dated 4/1/26, indicated the regular meat's temperature at the time of serving was 183 degrees Fahrenheit, the white gravy was 170 degrees, the candied yams were 183 degrees, the cauliflower with cheese sauce was 145 degrees, the cornbread was 114 degrees, and the lemon pudding was 60 degrees. Record review of Food and Nutrition Services policy dated 10/2022 and revised 6/23/25, revealed each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The policy also stated the food will appear palatable and attractive, and it is served at a safe and appetizing temperature.

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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 grease in the fryer was fresh and free of burnt food particles floating in it. 2. The facility failed to ensure the bags of food in the refrigerator were used or disposed of by the expiration date according to facility policy. 3. The facility failed to ensure the juice nozzle had no black film inside per facility policy. 4. The facility failed to ensure employees in the kitchen wore hair nets according to facility policy.5. The facility failed to ensure employees in the kitchen wore beard guards according to facility policy. These failures could place residents at risk of foodborne illness and food contamination.Findings include: During the initial tour of the kitchen on 3/31/26 at 10:25 am, upon entry to the kitchen, the dietary manager was not wearing a hair net or a beard cover. [NAME] R was not wearing a beard cover, and Dietary Aid D was not wearing a hair net. The microwave had a red sticky substance splattered on the walls and top. There were two bags of unopened shredded carrots with the expiration date of 3/18/26 stored in the refrigerator. The grease in the deep fryer was dark brown and had burnt food particles floating on the top. The inside of the juice nozzle was covered in a black film. During an interview on 3/31/26 at 10:30am, the Dietary Manager stated his hair and beard were less than one inch long and he did not need a hair net. He stated he was responsible for ensuring he and his staff are wearing hair restraints. He stated it was important to prevent food contamination. The Dietary Manager stated the microwave was to be cleaned as needed. The Dietary Manager stated that all kitchen staff are responsible for noticing and removing out-of-date and expired items in the refrigerator. He stated he was responsible for ensuring this was done. The Dietary Manager stated the deep fryer grease was changed four or five days ago and that it needed to be cleaned out. The Dietary Manager stated old grease made the food not taste as good. The Dietary Manager stated the juice nozzle was dirty and needed to be cleaned. The Dietary Manager stated it is important to remove out-of-date food and keep kitchen equipment clean to prevent food borne illnesses. In an interview on 3/31/26 at 11:00am, [NAME] R stated he did not know he needed a cover for his beard. He stated it was important to cover all hair so that no hair got in the food. [NAME] R stated he did not see the out-of-date food in the refrigerator. [NAME] R stated everyone was responsible for cleaning the kitchen equipment as they used it, and making sure the food in the refrigerator is good. [NAME] R stated dirty kitchen equipment and expired food can make people sick. In an interview on 3/31/26 at 11:05 am, Dietary Aid E stated she forgot she needed a hair net. Dietary Aid E stated it was important to wear a hair net to prevent hair from getting in the food. Dietary Aid E stated everyone was responsible for cleaning the kitchen equipment and checking the food in the refrigerator. Dietary Aid E stated it was important for equipment to be clean and food to be in date to prevent food borne illness. In an interview on 4/3/26 at 5:45 pm, the Administrator stated he expected anyone who entered the kitchen to wear proper hair restraints. The Administrator stated that he expects the kitchen equipment to be cleaned on a regular basis, and the deep fryer grease to be fresh and free of floating food particles from previous use. The Administrator stated he expects there to be no out-of-date or expired food anywhere in the kitchen. The Administrator stated the Dietary Manager was responsible for all these things. The Administrator stated wearing hair nets, clean kitchen equipment, no expired food, and clean deep fryer grease were important to protect residents from food borne illnesses. Record review of the facility policy titled Kitchen and Equipment Cleaning and Sanitation dated 12/2020 stated the kitchen and dining service equipment and food contact services shall be maintained in a clean and sanitized condition. Record review of the Food and Drug Administration Food Code 2022, dated 1/18/23, Chapter 2 Part 4 states Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident were treated with respect, dignity, and care in a manner and in an environment, that promotes maintenance or enhancement of her quality of life, for 1 of 6 residents reviewed for dignity issues (Resident #70).The facility failed to ensure they had a privacy bag for Resident #70's indwelling catheter.This failure could place residents at risk of feeling uncomfortable, increase anxiety and loss of dignity.Record review of Resident #70's face sheet, dated 04/03/26 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, Chronic obstructive pulmonary disease also known as COPD (lung and airway diseases that restrict your breathing), diabetes (a condition that happens when your blood sugar (glucose) is too high), and high blood pressure.Record review of Resident #70's medical records did not indicate a MDS assessment had been completed because it was not yet due.Record review of Resident #70's baseline care plan dated 03/27/26, indicated she had an indwelling catheter. No interventions were listed.Record review of Resident #70's physician's orders dated 03/27/26, indicated an indwelling catheter of 18 French with a 30 ml bulb, to be changed as needed. There was no indication for the catheter on the physician's order.Record review of Resident #70's physician's orders dated 03/27/26, indicated a privacy bag or covering over urine collection bag for dignity every shift.Record review of Resident #70's medication administration records, dated 03/01/26 through 03/31/26, revealed the ordered indwelling catheter was still in place in the resident's bladder.Record review of Resident #70's medication administration records, dated 03/01/26 through 03/31/26, revealed the order for privacy bag was signed every shift indicating the privacy bag was intact.During an observation and interview on 03/31/26 at 1:17 p.m., Resident #70 was lying in her bed. She had an indwelling catheter hanging with no privacy bag. Resident #70 said she did not realize her indwelling catheter bag was not covered.During an observation on 04/01/26 at 9:28 a.m., Resident #70 was lying in bed with her oxygen set at 5 liters per nasal cannula. She had her indwelling catheter exposed without a cover.During an interview and record review on 04/02/26 at 2:20 p.m., RN G said he was Resident #70's nurse. He said he did not know why Resident #70 privacy bag was not on her indwelling catheter. He said he put a new privacy bag on Resident #70 indwelling catheter on 04/01/26. He said Resident #70 should have had a privacy bag for her indwelling catheter. He said sometimes when staff move a resident from chair to bed or bed to chair, they forget to reapply the privacy bag. He said the risk of no privacy bag could be a dignity issue.During an interview on 04/03/26 at 3:36 p.m., the DON said all residents who had indwelling catheters should have a privacy bag for dignity issues and all nursing staff were responsible for ensuring the privacy bag was in place. During an interview on 04/03/26 at 4:49 p.m., the Administrator said anyone that had a catheter should have an order and privacy bag. The Administrator said the nurse was responsible for ensuring the catheter was secured, an order was placed in PCC, and the resident had a privacy bag. The Administrator said the DON, or designee was responsible for monitoring and overseeing catheters. The Administrator staid it was important an order was placed in the resident's chart to follow the MD orders and a privacy bag was over the catheter bag to prevent dignity issue.Record review of the facility's policy titled, Catheter Care, Urinary, Policy, undated, indicated, Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. Changing Catheters: 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh).

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident had the right to be informed of and participate in his or her treatment for 1 of 6 residents (Resident #9) reviewed for consents. The facility failed to obtain informed consent from Resident #9 for the antipsychotic Zyprexa (Olanzapine) to be administered starting on 1/25/26. The facility's failure to obtain and document informed consent for antipsychotic medication places the resident at risk for unnecessary chemical restraint, adverse side effects, and violation of the resident's rights to make informed decisions regarding their care and treatment. Findings included: Record review of Resident #9's face sheet dated 4/3/26, reflected Resident #9 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and hallucinations (sensory experiences-seeing, hearing, smelling, tasting, or feeling things-that appear real but are created by the mind in the absence of external stimuli). Record review of Resident #9's admission MDS assessment dated [DATE], reflected Resident #9 made himself understood and understood others. Resident #9's BIMS score was 15 which indicated the resident's cognition was fully intact. The MDS assessment reflected Resident #9 was taking an antipsychotic and there was an indication noted for medication in this drug class. Record review of the order summary report dated 4/3/26 , reflected Resident #9 was ordered one Olanzapine oral tablet 5 mg by mouth two times a day for hallucinations on 1/25/26. Record review of the Medication Administration Review dated 4/3/26 indicated Resident #9 was administered Olanzapine tablet 5mg by mouth two times a day at the 8:00 am medication pass and at the 8:00 pm medication pass daily since 1/25/26. Record review of Resident #'s EMR accessed on 4/2/26 at 3:30pm revealed no consent form signed by the resident. Record review of the Pharmaceutical Review dated 1/31/26 indicated the recommendation to please ensure signed consent form is scanned into PCC for the following medication: Olanzapine (on Texas form 3713). Point Click Care (PCC) is an electronic medical record platform. Record review of Resident #9's EMR accessed 4/3/26 at 5:00 pm revealed Texas Health and Human Services Form 3713 titled Consent for Antipsychotic or Neuroleptic Medication Treatment signed by Resident #9 and the medical director and dated 4/3/26 for the medication Olanzapine. In an interview on 4/2/26 at 5:42 pm, the Executive Director stated all consents should be in the EMR. The Executive Director stated the ADON and the DON were responsible for ensuring consents for all medications that needed consent to be completed and uploaded into the chart prior to administration. The Executive Director stated it was important for residents to be informed of the side effects of the medications, and have the right to chose to take it. In an interview on 4/3/26 at 4:30 pm, the DON stated the nurses were responsible for getting the proper consents prior to administering the medication. The DON stated she is responsible for monitoring the charts to ensure all the necessary consents were present. The DON stated it was important to obtain the informed consent so residents were informed of risks versus benefits. In an interview on 4/3/26 at 5:25 pm, the Administrator stated that he expected all consents to be obtained prior to the administration of medications that require one. The Administrator stated that it was the ADON and the DON's responsibility to ensure consents are obtained. The Administrator stated it was important to obtain consent prior to administration because a resident should know about the side effects and be able to make the choice to take it or not. Record review of the facility's policy titled, Psychotropic/ Psychoactive Medication Policy last reviewed 6/24/25, indicates all residents have full rights to participate or refuse treatment. Before initiating or increasing psychotropic medication the resident and or responsible party must be notified of and have the right to participate in their treatment, including the right to accept or decline the medication. The risk and benefits should be clearly explained. Consent needs to be completed and signed by the Resident or Responsible party. Explain the medication, why it is administered, what are side effects, and black box warning.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure the resident had a right to reasonable accommodations of resident needs for 1 of 8 residents (Resident #64) reviewed for accommodations of needs for call light availability. The facility failed to ensure Resident #64's call button was within reach.This failure could place residents at risk of a delay in assistance and decreased quality of life, self-worth, and dignity.Findings included:Record review of Resident #64's face sheet, dated 04/03/26 indicated Resident #64 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (memory loss), depression (sadness), and muscle weakness.Record review of Resident #64's quarterly MDS, dated [DATE], reflected Resident #64 understood others and made herself understood. Resident #64's BIMS score was a 13, which reflected her cognition was intact. Resident #64 required total assistance with toileting, personal hygiene, transfer, and bathing, and maximal assistance with eating. Record review of Resident #64's comprehensive care plan dated 03/15/21 reflected Resident #64 was a risk for falls related to deconditioning, psychoactive drug use, and unaware of safety needs. The intervention was for staff to anticipate and meet Resident #64's needs. Be sure the call light was within reach and respond promptly to all requests for assistance.During an observation and interview on 03/31/26 at 11:10 a.m., Resident #64 was in bed with her eyes open. Her call light was noted on her bedside table, not in reach. Resident #64 said she usually had to holler out if she needed assistance.During an observation and interview on 03/31/26 at 3:53 p.m., Resident #64 was in bed with her eyes closed. Her call light was noted on her bedside table, not in reach. CNA H entered the room and verified Resident #64's call light was not in reach. She said all residents should have their call lights in reach in case they needed something. She said Resident #64's call light cord was not long enough but placed her call light on her bed. During an observation and interview on 04/01/26 at 4:25 p.m., LVN K said she was the charge nurse for Resident #64. She looked and said Resident #64 does have a call light but because the pull cord was not long enough for the resident, she would not be able to reach it. LVN K said Resident #64 could move her right and left hand a little related to her contractures but could benefit from the push pad call light. She said the risk of not having a call light could be Resident #64 would not get the help she needed in a timely manner. She said she would get a push pad call light system for Resident #64.During an observation on 04/02/26 at 11:00 a.m., Resident #64 was in bed with a push pad call light system in reach.During an interview on 04/03/26 at 3:39 p.m., the DON said all staff should be checking on the residents and ensuring they had a call light within reach. She said she was not aware Resident #64 did not have a call light she could use. She said she expected call lights to always be within reach of residents. The DON said failure to have or keep call lights within reach could cause a resident to fall, receive a bump, bruise, or even a fracture.During an interview on 04/03/26 at 5:32 p.m., the Administrator said he expected call lights to work, have a string long enough for the residents to use and if they needed a special call light then they should have it. He said if call lights were not in reach of residents, then their needs would not be met, and it could place them at a greater risk of falling. He said all staff were responsible for ensuring residents had call lights.Record review of the facility's policy titled, Call System, Residents, dated 09/22, indicated, Policy Statement: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation: Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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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 interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 24 residents (Resident #48) reviewed for MDS assessment accuracy. The facility failed to code Resident #48's quarterly MDS dated [DATE] with the primary language of Spanish. This failure could place residents at risk of not receiving care and services to meet their needs. Findings include: Record review of Resident #48's face sheet, dated 04/03/26, reflected Resident #48 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included the progressive loss of cognitive function and brain tissue associated with aging. Record review of Resident #48's quarterly MDS assessment, dated 01/10/26, reflected Resident #48's preferred language was English and did not need/want an interpreter to communicate with a doctor or health care staff. Resident #48 made herself understood and understood others. Resident #48 had a BIMS score of 4, which reflected her cognition was severely impaired. Resident #48 could repeat 3 words after first attempt. Record review of Resident #48's comprehensive care plan, revised on 11/05/24, reflected Resident #48 had a communication problem related to Language barrier-Spanish speaking and did not speak English well and got embarrassed in group settings. The care plan interventions included: anticipate/meet needs and discuss with resident/family concerns or feelings regarding communication difficulty. Record review of the facility's undated/untitled form reflected Resident #48 spoke in a non-dominant language. During an interview on 04/02/26 at 3:10 p.m., The MDS Coordinator stated she was responsible for Resident #48's quarterly MDS assessment. After reviewing Resident #48's electronic medical records, the MDS Coordinator stated her primary language should have been coded Spanish instead of English and a translator was needed to communicate with facility staff. The MDS Coordinator stated she had not had an in-depth conversation but was able to make her needs known. The MDS Coordinator stated a communication board or translator would be effective communication. The MDS Coordinator stated it was important to ensure the assessment was coded correctly because it painted the picture of the resident on how to ensure her needs were being met. During a telephone interview on 04/03/26 at 1:43 p.m., the Regional MDS Coordinator stated she came to the facility at least quarterly but was available anytime the MDS Coordinator needed her. After reviewing Resident #48's electronic medical records, the Regional MDS Coordinator stated according to her care plan she was Spanish speaking only and her MDS assessment should have stated her primary language was Spanish. The Regional MDS Coordinator stated the MDS Coordinator and Social Worker were responsible for ensuring that it was correctly coded. The Regional MDS Coordinator stated she monitored by random audits but had not particularly looked at Resident #48's assessment. The Regional MDS Coordinator stated it was important to ensure the correct primary language was coded for Resident #48's quarterly MDS assessment to provide accurate and good care to the residents to meet all their needs. During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected Resident #48's quarterly MDS assessment to state her primary language was Spanish. The DON stated she had never had a full conversation with Resident #48. The DON stated in passing Resident #48 would say hello in Spanish. The DON stated the MDS Coordinator was responsible for coding the assessment correctly. The DON stated the [NAME] MDS Coordinator was responsible for monitoring. The DON stated it was important to code the assessment correctly to ensure she received proper care. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected the MDS assessment to be coded accurately. The Administrator stated the care plan and the MDS should reflect whatever the situation of the resident is. The Administrator stated he had not had a full conversation with Resident #48. The Administrator stated he had spoken to staff, and they stated Resident #48 spoke English and Spanish. The Administrator stated the MDS was responsible for ensuring the assessment was coded correctly and the Regional MDS Coordinator should be monitoring assessments for accuracy. The Administrator (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it was important to code the assessment correctly to get a clear pic of who the resident was and their needs. Record review of the undated facility's policy titled MDS Coding, reflected. the facility affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately.Record review of the Resident Assessment Instrument 3.0 Manual, dated 10/2025, reflected .1. Ask the resident's preferred language.3. If the resident-even with the assistance of an interpreter is unable to respond a family member, significant other, and/or guardian/legally authorized representative should be asked.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the services provided or arranged by the facility, as outlined by the comprehensive care plan were provided by qualified persons in accordance with each resident's written plan of care for 1 of 6 residents sampled (Resident #23). The facility failed to ensure CNA B did not apply triad hydrophilic wound dressing paste (a medication cream to manage chronic wound, pressure ulcers, and dermal lesions) to bilateral buttocks of Resident #23 without qualifications to do so. This failure could place residents at risk for not receiving appropriate care and treatment outlined in their comprehensive care plan.Findings include:Record review of Resident #23's face sheet dated 04/01/26 indicated he was a [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses which included major depressive disorder (a serious, common mental health condition characterized by low mood, loss of interest in activities, and low energy), paraplegia (a medical condition involving the loss of voluntary movement and/or sensation in the lower half of the body), heart failure (a chronic condition in which the heart becomes too weak to pump blood), retention of urine, and high blood pressure. Record review of Resident #23's quarterly MDS assessment dated [DATE] indicated he made himself understood and he understood by others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS also indicated Resident #23 required total assistance from staff for transfers, bed mobility, bathing, and he required setup assistance for eating. Record review of Resident #23's comprehensive care plan revised on 02/17/26 indicated he had sacral region moisture associated skin damage with an order to cleanse with wound cleanser, apply triad paste and leave it open to air as well as notify medical director, nurse practitioner, and responsible party of any wound development. Record review of Resident #23's order summary report indicated he had an order to apply triad to sacrum every evening shift for sacrum with a start date of 12/26/25 and no end date. During an observation and interview on 04/01/26 at 10:05 AM CNA B provided catheter care to Resident #23 using infection control practices but applied Triad hydrophilic wound dressing paste, that he retrieved from Resident #23's nightstand drawer, to Resident #23's bilateral buttocks prior to putting on his clothes. CNA B said he used the triad daily for Resident #23, but he said he thought Resident #23 had an order for it as well as another order for butt paste. CNA B said the nurse usually handed the CNAs the barrier cream to apply to the residents in a clear medication cup. During an interview on 04/02/26 at 4:09 PM LVN A said the triad hydrophilic wound dressing paste was what the nurses had an order for to use for Resident #23's buttocks. LVN said the CNA cannot place the triad hydrophilic wound dressing paste on the resident's buttocks because it was out of their scope of practice and the nurse should have placed the triad hydrophilic wound dressing paste in order to assess the area and see the progress. During an interview on 04/02/26 at 10:14 AM LVN K said she was aware of Resident #23 having a wound to his bottom and left foot. LVN K said CNAs should not have applied the triad cream to Resident #23's buttocks because it was out of their scope of practice. During an interview on 04/03/26 at 1:16 PM CNA B said he thought the triad cream that was in Resident #23's nightstand drawer was the cream that the charge nurse usually handed him in a clear medication cup. CNA B said he was not a nurse and should not have applied the triad cream to Resident #23's buttock. CNA B said he did not know what the risk was. During an interview on 04/03/26 at 3:18 PM the ADON said CNAs should not have been applying prescription medications to residents. The ADON said administering the triad was in the nurse's scope of practice because they should have been assessing the area during each treatment. The ADON said the failure placed a risk of not having a good assessment, not knowing what side effects to look for, and CNAs practicing out of their scope of practice. During an interview on 04/03/26 at 4:29 PM The DON said CNAs should not apply any chemical grade medications/prescription medications. The DON said the failure created a risk for the CNA not correctly applying the medication and causing adverse effects. The DON said she (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was responsible for ensuring CNAs did not give medications.During an interview on 04/03/26 at 5:16 PM the Administrator said anything that is a medication should be given by a nurse or someone certified to give medications. The Administrator said the failure placed a risk for not being applied correctly because medications were not authorized for CNAs to administer. The Administrator said the DON was responsible for ensuring the CNAs knew what their scope of practice was. Record review of the facility policy, revised on 03/05/26, indicated: Medication Administration Purpose: To ensure medications are prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice. General Standards: 1. Only individuals licensed or legally authorized in this state may prepare, administer, and document medications. 2. The Director of Nursing or designee supervises and oversees all personnel involved in medication administration.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish based on the comprehensive assessment and consistent with the resident's needs and choices for 2 of 2 residents (Residents #48 and #46) reviewed for activities of daily living. The facility failed to provide communication assistance to effectively communicate with staff for Residents #48 and #46. These failures could place residents at risk for declining and diminishing quality of life.Findings included: 1.Record review of Resident #48's face sheet, dated 04/03/26, reflected Resident #48 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included the progressive loss of cognitive function and brain tissue associated with aging. Record review of Resident #48's quarterly MDS assessment, dated 01/10/26, reflected Resident #48's preferred language was English and did not need/want an interpreter to communicate with a doctor or health care staff. Resident #48 made herself understood and understood others. Resident #48 had a BIMS score of 4, which reflected her cognition was severely impaired. Resident #48 could repeat 3 words after first attempt. Record review of Resident #48's comprehensive care plan, reflected Resident #48 had a communication problem related to Language barrier-Spanish speaking and did not speak English well and got embarrassed in group settings. The care plan interventions included: anticipate/meet needs and discuss with resident/family concerns or feelings regarding communication difficulty. Record review of the facility's undated/untitled form reflected Resident #48 spoke in a non-dominant language. During an interview and observation on 03/31/26 at 12:53 p.m., Resident #48 was sitting on the side of the bed eating her lunch. The surveyor began talking to Resident #48 in English and asked if her needs were being met. Resident #48 stated she spoke with little English. There was no communication device observed in her room. During a telephone interview on 04/01/26 at 9:26 a.m., Resident #48's family member stated one of her concerns was language barrier between Resident #48 and staff. Resident #48's family member stated Resident #48 was able to speak a few words here and there in English but her preferred language was Spanish and her communication should be Spanish. Resident #48's family member stated when Resident #48 was first admitted the prior Administrator was bilingual and was able to translate for Resident #48. Resident #48's family member stated she felt no one was able to advocate for her. During an interview on 04/01/26 at 12:13 p.m., LVN F stated Resident #48 spoke Spanish most of the time. LVN F stated she communicated with Resident #48 by hand gestures and sometime writing it on a piece of paper. LVN F stated there were times she had used google to help translate. LVN F stated she did not know about an app on a tablet to help communicate with Resident #48. LVN F stated it was important to ensure effective communication to understand exactly what Resident #48 said and make sure her needs were met. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/02/26 at 1:55 p.m., CNA B stated Resident #48 spoke and understood very little English. CNA B stated her primary language was Spanish. CNA B stated prior to 04/01/26 he communicated with Resident #48 using hand gestures while speaking. CNA B stated Resident #48 did not understand full sentences just short phrases like food and shower. CNA B stated the Administrator sent out a text on 04/01/26 to staff about an app to use to translate for residents who could not understand English. CNA B stated it was important to ensure effective communication because if the communication was not fluent you could not fulfill the needs of the residents. During an interview on 04/02/26 at 2:25 p.m., CNA C stated Resident #48 spoke very little English but would speak back in Spanish and broken English. CNA C stated she communicated with Resident #48 by hand gestures and if she did not understand what the resident was trying to say she would ask her to point at it. CNA C stated the MDS Coordinator had told her last Saturday (03/28/26) to use an app on a tablet to help translate English to Spanish, but she did not use the tablet because the tablet was not always available. CNA C stated it was important to ensure effective communication to ensure their needs were being met. During an interview on 04/02/26 at 3:27 p.m., LVN A stated Resident #48's primary language was Spanish. LVN A stated Resident #48 understood simple words in English. LVN A stated a communication board or translator would be effective for staff that only spoke English to meet Resident #48's needs. LVN A stated he was not aware of an app on a tablet to be used to translate for Resident #48. LVN A stated it was important to effectively communicate with Resident #48 to ensure her wants/needs were met and if there was a problem she could communicate with staff. During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected Resident #48's quarterly MDS assessment to state her primary language was Spanish. The DON stated she had never had a full conversation with Resident #48. The DON stated in passing Resident #48 would say hello in Spanish. The DON stated the facility had an app on a tablet that could be used to translate, and she expected staff to use the app to communicate with Resident #48. The DON stated she was responsible for monitoring and ensuring residents had equipment that was needed to communicate by random rounds. The DON stated it was important to effectively communicate with Resident #48 to ensure her needs were being met. 2. Record review of Resident #46's face sheet, dated 04/03/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included blindness, stroke, and high blood pressure. Record review of Resident #46's quarterly MDS assessment, dated 03/05/26, indicated Resident #46 understood and was understood by others. Resident #46's BIMS score was 15, which meant she was cognitively intact. The MDS indicated Resident #46 required help total assist with toileting, bed mobility, dressing, transfers, personal hygiene, and eating. The MDS indicated her primary language was Spanish. Record review of Resident #46's care plan dated 01/13/26, indicated Resident #46 was at risk for perceived or actual physical harm during care interactions related to blindness, language barrier, and difficulty interpreting staff actions during meal assistance. The intervention was for staff to utilize certified interpreter services or facility-approved language assistance to support understanding during meals and care. Record review of the facility's undated/untitled form reflected Resident #46 spoke in a non-dominant (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	language. During an interview and observation on 03/31/26 at 12:53 p.m., Resident #46 was in her bed. The surveyor began talking to Resident #46 in English and she started talking in Spanish. There was no communication device observed in her room. During an interview on 03/31/26 at 12:05 p.m., CNA L said Resident #46 spoke and understand very little English. CNA L said Resident #46 was blind. CNA L said her primary language was Spanish. CNA L said Resident #46 did not understand full sentences, just short phrases like food and water. CNA L said she did not speak Spanish but used her phone to communicate with Resident #46. She said at times she still had some communication issues. CNA L said communication was important to ensure the resident needs were being met. During an interview on 03/31/26 at 2:30 p.m., CNA H said Resident #46 spoke very little English. CNA H stated she communicated with Resident #46 by using an app on her phone. She said the facility had not provided any type of communication board or tool for Resident #46 that she was aware of. CNA H said it was important to ensure effective communication to ensure their needs were being met. During an interview on 04/02/26 at 3:27 p.m., LVN G said Resident #46's primary language was Spanish. LVN G said he was not aware of any communication board or translator for Resident #46. He said he used his phone to translate and felt he communicated well with Resident #46. He said it would be better if they had some type of translator for staff to use because a communication board may not be effective for Resident #46 because she was blind. He said it was important to be able to communicate with Resident #46 and for her to be able to communicate with staff. During an interview on 04/03/26 at 3:36 p.m., the DON said when she started at the facility last year, she learnt about an application on a tablet device during her orientation. She said she was not sure why staff was not aware of the application on the tablet device the facility provided. She said she had heard unknown staff saying they used the google application on their phones, but she did not know why or ask why. She said Human Resource was supposed to go over the tablet application during orientation. She said it was important to communicate with all residents to be able to ensure their needs were being met. She said without effective communication care could be missed. During an interview on 04/03/26 at 3:46 p.m., Human Resources said he does the general orientation. He said each department was responsible for reviewing any equipment staff needed to know to perform their job duties. He said he did not go over any computer/tablet applications staff were to use for any Spanish speaking residents. During an interview on 04/03/26 at 4:49 p.m., The Administrator stated he had not had a full conversation with Resident #48. The Administrator stated he had spoken to staff, and they stated Resident #48 spoke English and Spanish. The Administrator stated he had sent out a text message to all staff that anyone that has a language barrier should be using the app on the tablet or the detailed communication board that was located at the nursing station to communicate with residents. The Administrator stated the text was not specifically related to Resident #48. The Administrator stated he expected the translator to be used if that was what Resident #48 was comfortable with. The Administrator stated the DON was responsible for monitoring. The Administrator stated it was important to effectively communicate with Resident #48 to understand her wishes and needs clearly and so there was no communication barrier between her and staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated and untitled policy indicated, Policy Statement: We provide support for those in need of assistance with communication, whether it is for language services or access to technology. Policy Interpretation and Implementation:9. It is understood that providing meaningful access to services provided by this facility requires that the residents' needs and questions be accurately communicated to the staff. Oral interpretation services include interpretation from the resident's primary language back to English.10. It is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the individual.

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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 observations, interviews, and record review, the facility failed to provide residents with limited range of motion appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion for 1 of 10 residents (Resident #14) reviewed for range of motion. The facility did not ensure Resident #14 wore a left wrist roll (a device to prevent further decline in an extremity contracture) on 03/31/26, 04/01/26 and 04/02/26. This failure could place residents who had contractures at risk of not attaining/or maintaining their highest level of physical, mental, and psychosocial well-being.Findings include:Record review of Resident #14's face sheet, dated 04/03/26, reflected Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a group of disorders that affects a person's ability to move and maintain balance and posture), traumatic brain of injury (damage to the brain from a hit, fall, or object) and contracture of muscle (permanent or long-term shortening, stiffening, and tightening of muscles, tendons, or skin caused reduced joint mobility, painful ad fixed deformities. Record review of Resident #14's quarterly MDS assessment, dated 01/11/26, reflected Resident #14 rarely/never understood others, and rarely/never made himself understood. The assessment did not address Resident #14's BIMS score but reflected she had long-term and short-term memory problems. Resident #14 had functional limitation in range of motion on both sides, on the upper and lower extremities.Record review of Resident #14's comprehensive care plan, revised 02/13/25, reflected Resident #14 had limited physical mobility related shaken infant syndrome and contractures. The care plan interventions included: resident to wear left wrist roll daily, or as tolerated for contracture prevention/management. Record review of Resident #14's physician order summary report dated 04/03/26, reflected an active physician's order for Resident #14 to wear left roll daily or as tolerated for contracture prevention/management with a start date 12/23/25. During an observation and interview on 03/31/26 at 12:43 p.m., an attempted interview with Resident #14, reflected he was non-interviewable due to cognitive loss. Resident #14 was sitting up in a Broda chair (a wheelchair with ergonomic tilt and recline functions, designed to reduce pressure points, enhance comfort, and improve posture). Resident #14 did not have a wrist roll to his left wrist. Resident #14's wrist roll device was lying on his dresser. During an observation on 04/01/26 at 10:10 a.m., Resident #14 was sitting up in a Broda chair. Resident #14 did not have a wrist roll device to his left wrist. The wrist roll device continued to be on the Resident #14's dresser. During an observation on 04/01/26 at 4:41 p.m., Resident #14 was sitting up in a Broda chair being pushed by the Activity Director on the sidewalk outside of the facility. Resident #14 did not have a wrist roll to his left wrist. During an observation on 04/02/26 at 8:00 a.m., Resident #14 was lying in bed asleep. Resident #14 did not have a wrist roll to his left wrist. Resident #14's wrist roll continued to be on his dresser. During an interview on 04/02/26 at 2:25 p.m., CNA C stated the CNAs and LVNs were responsible for applying the hand roll to Resident #14's hand. CNA C stated she had seen the wrist roll on his dresser but was never told what hand it should go in, and she never asked the charge nurse either. CNA C stated she could not recall the last time she seen the hand roll in his hand. CNA C stated a hand roll was important for a resident with limited range of motion or contracture to prevent further contractures. During an interview on 04/02/26 at 3:27 p.m., LVN A stated Resident #14 should have a wrist roll in his left hand. LVN A stated Resident #14 did not refuse the wrist roll. LVN A stated the CNAs and nurses were responsible for ensuring the wrist roll was being applied. LVN A stated he had placed the wrist roll on his hand either Tuesday (04/31/26) or Wednesday (04/01/26) but could not recall the date. LVN A stated it was important for wrist roll to be placed in Resident #14's left hand to prevent the nails from going into his skin. During an interview on 04/02/26 at 4:22 p.m., the DOR stated Resident #14 should have the hand roll in his left hand during his daily functional task while sitting or lying. The (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DOR stated the CNAs and nurses were responsible for ensuring the wrist roll was applied to his left hand daily. The DOR stated the hand roll was not always in hands at times when therapy came to perform their treatment sections. The DOR stated she had not spoken to the DON about consistently with the left-wrist roll when she seen him two times a week. The DOR stated the wrist roll prevented contractures and maintained tone (limit a fix position). During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected the CNAs and nurses to place the wrist roll in Resident #14's left hand if they noticed it was not in there. The DON stated she was responsible for monitoring contracture prevention/management by daily random rounds. The DON stated during her random rounds she had noticed in the past the wrist roll was not applied. The DON stated she immediately in serviced staff on replacing the roll. The DON stated it was important for the wrist roll to be applied in the left hand to prevent further contractures and skin integrity. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he knew Resident #14 had contractures but did not know he was supposed to have a left wrist roll in his daily. The Administrator stated the person that implemented the interventions was the charge nurse. The Administrator stated the DON was responsible for oversight of the contracture prevention/management. The Administrator stated it was important to ensure the left wrist roll was applied to prevent contractures and skin digging in his hand. Record review of the facility's policy titled, Contracture Management Program, revised 03/04/26, reflected. To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of range of motion. 5) Interventions care planned by MDS or designee to ensure they are carried out.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 3 residents (Resident #70 and Resident #47) reviewed for respiratory care.1.The facility failed to ensure Resident #70, and Resident #47 had a physician order for the use of oxygen.2.The facility failed to ensure Resident #47's oxygen concentrator filter was clean. 3.The facility failed to ensure Resident #47 had the use of oxygen included on her care plan. These failures could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory disease.Findings included: 1.Record review of Resident #70's face sheet, dated 04/03/26 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, Chronic obstructive pulmonary disease also known as COPD (lung and airway diseases that restrict your breathing), diabetes (a condition that happens when your blood sugar (glucose) is too high), and high blood pressure. Record review of Resident #70's medical records did not indicate a MDS assessment had been completed because it was not yet due. Record review of Resident #70's baseline care plan dated 03/27/26, indicated she used oxygen. No interventions. Record review of Resident #70's physician's orders dated 03/27/26, did not indicate an order for oxygen. During an observation and interview on 03/31/26 at 1:17 p.m., Resident #70 was in bed, alert. She had oxygen set at 5 liter per nasal cannula. She said she wore oxygen because it helped her breathe better. She said she thought it should be set to 3 liter per nasal cannula. During an interview and record review on 04/02/26 at 2:20 p.m., RN G said he was Resident #70's nurse. He said Resident #70 had a diagnosis of COPD and required oxygen. He said her oxygen should be set at 4 liters per nasal cannula. He looked at Resident #70's orders and did not see an order for oxygen. He said the order for oxygen was missing when he input Resident #70's orders. He said it was important to have orders so that other staff would know what Resident #70's oxygen should be set at. He said not enough or too much oxygen could cause respiratory distress. During an interview on 04/03/26 at 3:36 p.m., the DON said the nurses were responsible for writing physician orders when received. She said residents who wore oxygen should have orders written with the oxygen rate, diagnosis, and a sign place on their door. She said she did random rounds to check oxygen rates, dates on tubing and for signs on the door. She said it was important for nurses to know what the rate of oxygen to prevent respiratory distress. 2.Record review of Resident #47's face sheet dated 04/01/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure (disease in which the lungs cannot adequately provide oxygen to the blood), diabetes mellitus (chronic metabolic disorder characterized by high blood sugar due to the body's (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inability to produce insulin), high blood pressure, dementia (decline in mental ability severe enough to interfere with daily life caused by physical brain changes), and congestive heart failure (chronic progressive condition in which the heart cannot pump blood efficiently). Record review of Resident #47's quarterly MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 13 which meant she was cognitively intact. The MDS also indicated she required total assistance from staff for all her activities of daily life. The MDS did not indicate Resident #47 required oxygen. Record review of Resident #47's comprehensive care plan last revised 12/21/2025 did not indicate the use of oxygen. Record review of Resident #47's order summary report dated 04/01/26 did not indicate an order for oxygen use. During an observation on 03/31/2026 11:37 AM, Resident #47 was lying in bed and had her oxygen on set at 2 liters per minute with the oxygen concentrator filter in place covered in gray matter. During an observation on 04/01/26 at 9:02 AM, Resident #47's oxygen filter continued to be covered in gray matter. During an observation on 04/02/26 at 11:27 AM, Resident #47's oxygen concentrator filter continued to be covered in gray matter. During an observation and interview on 04/03/26 at 3:03 PM, the ADON was at the nurse's station and said she thought that there should have been a schedule for the oxygen concentrators filters to be cleaned and nasal cannulas to be changed out. The ADON then walked in Resident #47's room and said resident was sent to the hospital but the oxygen concentrator filter appeared dirty and should have been cleaned and changed out the tubing weekly on Sundays by the 2-10 nurses. The ADON said the failure placed a risk for infection. During an interview on 04/03/26 at 4:30 PM, the DON said her expectation was for the nasal canula to be changed on a weekly basis and oxygen concentrator filter should be cleaned as well. The DON said Resident #47 should have had an order for oxygen use and it should have been placed on her care plan. The DON said the failure placed a risk for infection. The failure of not having the order placed Resident #47 at risk for receiving oxygen that she should not have been given. During an interview on 04/03/26 at 5:20 PM, the Administrator said the nurses should been changing and cleaning the oxygen concentrator filters and monitoring the cleanliness every Sunday. The Administrator said Resident #70 and Resident #47 should have an order for oxygen. He said Resident #47 should have had an order to clean the oxygen concentrator filter and change out the tubing. The Administrator said the failure of the oxygen concentrator filter being dirty placed a risk for Resident #47 breathing unclean oxygen and causing infection and increased breathing issues. The Administrator said the failure of not having order for oxygen in placed a risk for staff not knowing what settings to put the oxygen on and that could cause Resident #47 to get too much or not enough oxygen. Record review of the facility policy, reviewed 03/03/26, Oxygen Administration and Oxygen Safety indicated: Purpose The purpose of this procedure is to provide guidelines for safe oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration and oxygen safety guidelines. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess any special needs of the resident.8.Regulator; and Tools used for oxygen equipment shall be kept free of grease, oil, etc.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 residents (Resident #9) reviewed for trauma-informed care. The facility failed to ensure Resident #9 had physician's orders for monitoring post-traumatic stress disorder behaviors The facility did not ensure Resident #9's care plan reflected a diagnosis of post-traumatic disorder and included interventions for post-traumatic stress disorder behaviors This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. Findings Included:Record review of Resident #9's face sheet dated 4/3/26, reflected Resident #9 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included chronic kidney disease, stage 5 (Kidneys function at less than 15% capacity, causing severe buildup of waste, fluid, and toxins, which necessitates treatment like dialysis or a kidney transplant to sustain life), major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), hallucinations (sensory experiences-seeing, hearing, smelling, tasting, or feeling things-that appear real but are created by the mind in the absence of external stimuli). and post-traumatic stress disorder (a mental health condition that's triggered by a terrifying event, either experiencing it or witnessing it). Record review of Resident #9's admission MDS assessment dated [DATE], reflected Resident #9 made himself understood and understood others. Resident #9's BIMS score was 15 which indicated the resident's cognition was fully intact. The MDS assessment reflected Resident #9 had an active diagnosis of post-traumatic stress disorder. Record review of Resident #9's Pre-admission Screening and Resident Review screening dated 1/23/26, indicated no diagnosis or history of post-traumatic stress disorder or any other mental illness. Record review of Resident #9's Social History Form- Trauma Informed Care dated 1/29/26 indicated the resident had a previously documented diagnosis of mental disorder and history of trauma. The form indicated the resident did have a diagnosis of post-traumatic stress disorder. The form indicated Resident #9 had experienced a serious accident and physical assault and had been in a situation that was extremely frightening as well as witnessed an extremely frightening situation. The Trauma Informed Care form indicated Resident #9 had triggers of loud noises, specific smells, restraints, and large crowds. The form indicated removing stimuli and medications prescribed for the trauma related diagnosis helped to alleviate the triggers. Record review Resident #9's base line care plan dated 1/31/26 revealed the resident had no mental health needs, no behavioral concerns, and no interventions for post-traumatic stress disorder. Record review of Resident #9's orders dated 4/3/26 indicated no monitoring for traumatic stress behaviors or triggers. In an interview on 4/3/26 at 4:40 pm, the DON stated the Social Worker was responsible for ensuring the diagnosis of post-traumatic stress disorder triggers trauma informed care on the resident's chart. The DON stated it is important to be aware if a resident requires trauma informed care to be able to provide the best possible care by avoiding triggers. In an interview on 4/3/26 at 5:55 pm, the Administrator stated he expects all residents with a diagnosis of post-traumatic stress disorder to have trauma informed care. The Administrator stated he expects all admission screenings to be done in the appropriate amount of time and all services available be offered. The Administrator stated the Social Worker was responsible for the trauma assessment, but the ADON and DON were also responsible for knowing of the diagnosis and proceeding accordingly. The Administrator stated it is important to care for residents with a post-traumatic stress disorder diagnosis appropriately for the safety of the residents and the staff. In an interview on 4/3/26 at 6:15 pm the Social Worker stated the trauma assessment was part of the initial admission assessment. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Worker stated she was responsible for that assessment. The Social Worker stated that Resident #9 did trigger for trauma informed care, but Resident #9 did not have issues. The Social Worker stated it was important to ensure a resident with post-traumatic stress disorder have trauma informed care so that the resident can get needs met and be most comfortable at the facility. Record review of the facility policy titled Trauma-Informed and Culturally competent Care, dated 10/22 and last reviewed 3/3/26, stated the facility will perform a universal screening of residents and use the screening to identify the need for further assessment and care. The facility will perform an assessment involving an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. The facility will utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments. The facility will develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. The facility will identify and decrease exposure to triggers that may re-traumatize the resident. The facility will recognize the relationship between past trauma and current health concerns.

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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. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, dispensing, administering and reconciliation to determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled of all drugs and biologicals) for 1 of 1 storage area, and 1 of 2 medication rooms (hall 100) reviewed for pharmacy services.1.The facility failed to keep a record of receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. 2.The facility failed to ensure staff counted narcotic medication in the refrigerator on hall 100 medication room which contained Lorazepam (antianxiety medication) and Morphine (pain medication).These failures could place residents at risk of drug diversion, or misappropriation of medication.Findings included:1.During an observation and interview on 04/02/26 at 02:44 PM, the following medications were observed in the controlled medication storage cabinet awaiting to be disposed:*Tramadol 50mg- 20 tablets,*Lorazepam 0.5mg- 27 tablets,*Tramadol 50mg- 7 tablets, and*Morphine 20mg/ml- 27.5 milliliters. The DON said the controlled medications waiting to be disposed were kept in the locked cabinet that had 2 locks in place. The DON said she was responsible for the discontinued medications, and she was the only one with the key to the locks on the cabinet. The DON said when she reconciled medications that need to be disposed of the medications were brought to her, she checked the narcotic medication count and verified the count with the nurse and she then logged the medication on the destruction log that was kept in the cabinet, and then placed the medication in the locked cabinet. The DON said she would usually log them as she received the medications but guessed someone stopped her in between because she could see where she started to log one of the medications that were not logged. The DON said the risk of her not logging the medications would be not knowing which medications were not accounted for and placed a risk for medication errors and drug diversions. Record review of the facility's medication destruction binder on 04/02/26, indicated the last medication destruction was completed on 02/20/26.During an interview on 04/03/26 at 5:44 PM, the Administrator said he expected the discontinued controlled medications to be logged when the DON received the medications and prior to the medication being placed in the destruction box. The Administrator said the failure placed a risk for the miscounting of medication or not knowing if any of the medications were missing. 2.During an observation on 04/02/26 at 2:39 p.m., revealed 1 open bottle of Lorazepam and Morphine and 2 unopened bottles of Morphine Sulfate in the hall 100 medication room refrigerator door.During an interview on 04/02/26 at 3:20 p.m., LVN K said she was the charge nurse on hall 100 this morning (04/02/26) for the 6am-2pm shift. She said she did not count the medication in the refrigerator. She said she did not know that those medications were in the refrigerator. She said failure to count all narcotics could lead to missing medication or a risk for drug diversion.During an interview on 04/02/26 at 4:20 p.m., LVN A said he was the charge nurse on hall 100 for the 2pm-10pm shift on 03/31/26 and 04/01/26. He said he did not count Resident #54's or #39's medication in the refrigerator for either day. He said he was aware they were inside the refrigerator sitting on the shelf inside the door. He said he knew they should have been placed in the lock box but did not place them in the box. He said the risk could be missing medication.During an attempted call on 04/02/26 at 5:00 p.m., LVN Q did not answer but a message was left (related to counting narcotics).During a phone interview on 04/02/26 at 5:01 p.m., LVN O said she was the charge nurse for hall 100 on Tuesday (03/31/26) for the 6am-2pm shift and does not recall counting any medications in the refrigerator. She said she started a week ago and had not counted any medications in the refrigerator. She said the oncoming and off going nurses were supposed to count all narcotics each shift. She said it was important to count to ensure all medication was accounted for and to prevent missing medications. During an interview on 04/03/26 at 3:39 p.m., the DON said the narcotic medications should be always stored under double lock including (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications in the refrigerator. She said the nurses should be counting the narcotics each shift. She said if they were not counting medication, it could cause missing medication or have a drug diversion. She said she was doing random checks and saw no omits in the narcotic sign out sheets but would change the process of checking narcotics.During an interview on 04/03/26 at 5:32 p.m., the Administrator said the nurses should be counting narcotics every shift. He said if the nurses were not counting the medications there could be a discrepancy, or missing medications. The Administrator said the DON was responsible for monitoring and overseeing nurses by rounding. Record review of the undated facility policy, Controlled Substances, indicated, Policy Statement The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Dispensing and Reconciling Controlled Substances 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.7. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs 2 of 24 residents (Residents #14 and #18) reviewed for laboratory services. 1. The facility did not obtain a physician's ordered Tegretol level (to measure the medication's level in the blood to ensure it is within a safe, therapeutic range) for Resident #14. 2. The facility did not obtain a physician's ordered Vitamin D level (to measure the level of vitamin D in the blood, identifying deficiencies that can cause bone weakness, soft bones (osteomalacia), or fractures) for Resident #18. These failures could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level. Findings included: 1. Record review of Resident #14's face sheet, dated 04/03/26, reflected Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included unspecified convulsion (muscle contract and relax quickly and cause uncontrolled shaking of the body). Record review of Resident #14's quarterly MDS assessment, dated 01/11/26, reflected Resident #14 rarely/never understood others, and rarely/never made himself understood. The assessment did not address Resident #14's BIMS score but reflected she had long-term and short-term memory problems. Record review of Resident #14's comprehensive care plan, revised 08/18/25, reflected Resident #14 had a seizure disorder related to shaken infant syndrome. The care plan interventions included: give medications as ordered, monitor lab, and report any sub therapeutic or toxic results to MD. Record review of Resident #14's physician order summary report dated 04/03/26, reflected an active physician's order for .Tegretol level every four-month starting on the last day of month with a start date 10/31/23. Record review of Resident #14's electronic medical record reflected his last Tegretol level was drawn on 10/31/25. 2. Record review of Resident #18's face sheet, dated 04/03/26, reflected Resident #18 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Vitamin D deficiency (inadequate levels of Vitamin D). Record review of Resident #18's quarterly MDS assessment, dated 03/20/26, reflected Resident #18 understood others, and made herself understood. Resident #18's BIMS score was 15, which indicated her cognition was intact.Record review of Resident #18's comprehensive care plan, revised 07/07/25, reflected had a nutritional problem or potential nutritional problem and was at risk for malnutrition related to malnutrition, vitamin deficiency, and cachexia (condition that caused significant weight loss and muscle loss). The care plan interventions included: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Record review of Resident #18's physician order summary report dated 04/03/26, reflected an active physician's order for .vitamin D with a start date 02/25/26. Record review of Resident #18's electronic health record did not reflect a vitamin D level that was drawn as ordered on 02/25/26. During an interview on 04/03/26 at 1:23 p.m., the ADON stated she was responsible for monitoring and reviewing labs by going into PCC every morning and clicking on the startup tab which was a summary of what happened in a 24-hr period such as lab orders that needed to be drawn. The ADON stated she had seen where the physician had put in a lab order for Residents #14's Tegretol level and Resident #18's vitamin D level to be drawn but when she reviewed the orders in the startup section, she clicked the box which reflected as completed. The ADON stated she should have contacted the lab to come out and complete the order and placed the lab requisition sheet in the lab book at the nursing station. The ADON stated she thought the labs had already been drawn so she marked it as completed, but it was for the labs to be drawn that day. The ADON stated she had not been trained on how to properly review the unreviewed lab results until yesterday (04/02/26) by the regional corporate nurse. The ADON stated when she first was hired, she received 3-day training by the regional corporate nurse, but she did not go over how to ensure the labs were drawn at the appropriate time. The ADON stated it was important to ensure labs were drawn per the physician order to ensure their levels were therapeutic and prevent deficiency in their health. During a telephone (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 04/03/26 at 1:56 p.m., the Medical Director stated he expected labs to be drawn as ordered. The Medical Director stated he could not recall if the facility notified him about the missed labs. The Medical Director stated it was important to ensure labs were drawn per the physician order to keep the level of medication therapeutic.During an interview on 04/03/26 at 4:04 p.m., the DON stated once the order was received, a lab requisition should be filled out and placed in the lab book to be drawn at the nursing station. The DON stated the lab company comes in daily to draw labs. The DON stated the ADON was responsible for monitoring and overseeing labs. The DON stated it was important to ensure labs were drawn per the physician order to prevent toxicity and to ensure levels are therapeutic. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected labs to be drawn per physician order. The Administrator stated the nursing department heads were responsible for monitoring and overseeing. The Administrator stated it was important to ensure labs were drawn as scheduled for their overall health. Record review of the facility's policy titled Laboratory Services reviewed 03/03/26 reflected. It is the policy of this facility to ensure that laboratory services meet the needs of residents and that the results are reported promptly to the ordering provider to address potential concerns and for disease prevention, provide for resident assessment, diagnosis, treatment, and that the facility has established policies and procedures. 1. The facility will provide or obtain laboratory services to meet the needs of its residents and will be responsible for the quality and timeliness of the services.3. The facility will provide or obtain laboratory services only when ordered by a physician, physician assistance or nurse practioner.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident receives and the facility provides food that accommodates residents' food preferences for 1 of 24 residents (Resident #18) reviewed for food preferences and the accommodation of resident's meal choices. The facility did not honor Resident #18's preference for double vegetables. This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of Resident #18's face sheet, dated 04/03/26, reflected Resident #18 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Vitamin D deficiency (inadequate levels of Vitamin D) and unspecified severe protein-calorie malnutrition. Record review of Resident #18's quarterly MDS assessment, dated 03/20/26, reflected Resident #18 understood others, and made herself understood. Resident #18's BIMS score was 15, which indicated her cognition was intact. Record review of Resident #18's comprehensive care plan, revised 07/07/25, reflected Resident #18 had a nutritional problem or potential nutritional problem and was at risk for malnutrition related to malnutrition, vitamin deficiency, and cachexia (condition that caused significant weight loss and muscle loss). The care plan interventions included: provide and serve diet as ordered. Record review of Resident #18's physician order summary report dated 04/03/26, reflected an active physician's order to add double veggies to meals per patient request with a start date 6/20/25. Record review of the lunch meal ticket dated 04/01/26 for Resident #18 reflected extra vegetables. During an observation and interview 04/01/26 at 12:37 p.m., Resident #18 received one serving of cauliflower with cheese sauce. After reviewing the lunch meal ticket with CNA C and the Executive Director they both agreed Resident #18 did not receive double vegetables. During an interview on 04/03/26 at 9:07 a.m., LVN P stated she was responsible for ensuring Resident #18 received double vegetables with her lunch meal on 04/01/26. LVN P stated she was unaware she needed double vegetables. LVN P stated she should have read the complete ticket all the way to the bottom. LVN P stated it was important for Resident #18's food preference to be followed to prevent the potential of weight loss. During an interview on 04/03/26 at 11:41 a.m., [NAME] N stated she was aware Resident #18 should have received double vegetables with her meal, but she overlooked the ticket by mistake. [NAME] N stated she should have looked at the ticket as she prepared the tray to ensure she received the correct portions. [NAME] N stated it was important for their food preferences to be followed because it was their right. During an interview on 04/03/26 at 2:58 p.m., the Dietary Manager stated he was aware that Resident #18 wanted double vegetables with her lunch and dinner. The Dietary Manager stated he assumed Resident #18 wanted double vegetables related to her health. The Dietary Manager stated [NAME] N was responsible for ensuring Resident #18 received double vegetables. The Dietary Manager stated he monitored by pulling a random breakfast and lunch tray to ensure the ticket matched the tray. The Dietary Manager stated it was important for their food preferences to be followed because it was their right. During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected Resident #18's food preferences to be followed. The DON stated the nurse should be checking the trays prior to serving the residents. The DON stated she monitored by randomly observing meal service. The DON stated if she noticed the tray did not match the ticket, she would take it back to dietary for correction. The DON stated it was important for their food preferences to be followed because Resident #18 may not eat which could lead to nutritional issues such as weight loss and poor wound healing. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected food preferences to be followed. The Administrator stated the cooks were the first line of defense and the nurses were the second line of defense of being responsible to ensure the residents received the correct dietary preferences. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing meal service. The (continued on next page)

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	675879	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrell Healthcare Center	204 W Nash Terrell, TX 75160

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated it was important to follow dietary preferences and guidelines because it was the resident right. Record review of the facility's policy titled Food and Nutrition Service Menus revised 06/23/25 reflected. Each resident is provided with a nourishing, palatable, well-balanced diet that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. 7 (a) if an incorrect meal is provided to a resident, or a meal. nursing staff will report it to the Food Service Manager so that a new food tray can be issued.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs and as prescribed by the physician for 1 of 24 residents (Resident #18) reviewed for therapeutic diets. The facility did not ensure Resident #18 was given double protein portion as ordered by the physician. This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity.Findings Included: Record review of Resident #18's face sheet, dated 04/03/26, reflected Resident #18 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Vitamin D deficiency (inadequate levels of Vitamin D) and unspecified severe protein-calorie malnutrition. Record review of Resident #18's quarterly MDS assessment, dated 03/20/26, reflected Resident #18 understood others, and made herself understood. Resident #18's BIMS score was 15, which indicated her cognition was intact. Recor review of Resident #18's comprehensive care plan, revised 07/07/25, reflected had a nutritional problem or potential nutritional problem and was at risk for malnutrition related to malnutrition, vitamin deficiency, and cachexia (condition that caused significant weight loss and muscle loss). The care plan interventions included: provide and serve diet as ordered. Record review of Resident #18's physician order summary report dated 04/03/26, reflected an active physician's order for double protein with a start date 06/22/25. Record review of the lunch meal ticket dated 04/01/26 for Resident #18 reflected double protein portion. During an observation and interview 04/01/26 at 12:37 p.m., Resident #18 received a single serving of the entree which was a pork chop. After reviewing the lunch meal ticket with CNA C and the Executive Director they both agreed Resident #18 did not receive two serving of pork chops. During an interview on 04/03/26 at 9:07 a.m., LVN P stated she was responsible for ensuring Resident #18 received double protein with her lunch meal on 04/01/26. LVN P stated she was unaware she needed two servings of the entree. LVN P stated she should have read the complete ticket all the way to the bottom. LVN P stated it was important to ensure residents received the correct diet order to prevent further weight loss. During an interview on 04/03/26 at 11:41 a.m., [NAME] N stated she was aware Resident #18 should have received two servings of pork chops with her meal, but she overlooked the ticket by mistake. [NAME] N stated she should have looked at the ticket as she prepared the tray to ensure she received the correct portions. [NAME] N stated it was important to ensure Resident #18 received the correct diet order to prevent weight loss. During an interview on 04/03/26 at 2:58 p.m., the Dietary Manager stated [NAME] N was responsible for ensuring Resident #18 received two pork chops with her meal on 04/01/26. The Dietary Manager stated he monitored by pulling a random breakfast and lunch tray to ensure the ticket matched the tray. The Dietary Manager stated it was important to ensure Resident #18 received the correct diet order to prevent further weight loss. During an interview on 04/03/26 at 4:04 p.m., the DON stated she expected Resident #18 to have double protein with each lunch and dinner. The DON stated the nurse should be checking the trays prior to serving the residents. The DON stated she monitored by randomly observing meal service. The DON stated if she noticed the tray did not match the ticket, she would take it back to dietary for correction. The DON stated it was important Resident #18 received double protein portions to prevent weight loss and poor wound healing. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected double protein to be given, and order followed for Resident #18. The Administrator stated the cooks were the first line of defense and the nurses were the second line of defense of being responsible to ensure the residents received the correct dietary preferences. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing meal service. The Administrator stated it was important Resident #18 received double protein portions to prevent weight loss. Record review of the facility's policy titled Food and Nutrition Service Menus revised 06/23/26 reflected. Each resident is provided with a (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nourishing, palatable, well-balanced diet that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. 7 (a) if an incorrect meal is provided to a resident, or a meal. nursing staff will report it to the Food Service Manager so that a new food tray can be issued.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to collaborate with hospice representatives and coordinating long term care facility staff participation in the hospice care planning process for those residents receiving hospice services, and communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family for 1 of 2 resident (Resident #9) reviewed for hospice services. The facility failed to obtain and ensure Resident #9's most current Hospice Plan of Care/ Interdisciplinary Group Reports, Medication Report, and Physician Orders were part of the current clinical record. The facility failed to ensure Resident #9's hospice medication regimen paired with the facility's medication regimen. These deficient practices could place residents at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings Included:Record review of Resident #9's face sheet dated 4/3/26, reflected Resident #9 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, stage 5 (Kidneys function at less than 15% capacity, causing severe buildup of waste, fluid, and toxins, which necessitates treatment like dialysis or a kidney transplant to sustain life), and heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #9's admission MDS assessment dated [DATE], reflected Resident #9 made himself understood and understood others. Resident #9 BIMS score 15 which indicated the resident's cognition was fully intact. The MDS assessment reflected Resident #9 was admitted to hospice as a resident and within the last 14 days. Record review of the order summary report dated 4/3/26, reflected Resident #9 was evaluated and admitted to hospice on 1/30/26. Record review of Resident #9's hospice binder on 4/3/26 at 3:49 pm, indicated Plan of care/ Interdisciplinary Group Reports, dated 3/4/26- 3/18/26 Medication Report, dated 3/4/26- 3/18/26 Physician Orders, dated 3/4/26- 3/18/26 Record review of Resident #9 hospice binder reviewed on 4/3/26 at 3:49 pm, reflected the hospice medication list and the facility's physician orders did not match. The following orders were noted on the hospice medication record: Acetaminophen 650 mg rectal suppository every four hours as needed for pain/fever; Bisacodyl 10 mg rectal suppository daily as needed for constipation/ bowel obstruction. The facility order summary report reflected: Acetaminophen Oral Packet 500 mg by mouth every six hours as needed for pain; no order for Bisacodyl. During a telephone interview on 4/3/26 at 10:54 am, the Hospice Patient Care Manager stated Interdisciplinary Group meetings were held every 14 days. Patient Care Manager stated the marketer and RN case managers were responsible for ensuring the hospice binders were updated with the current notes and orders. The Patient Care Manager stated she expected the hospice case manager to communicate any changes or updates that occurred between meeting dates to the facility and write orders at the facility accordingly. The Patient Care Manager stated she expects the resident's case manager to review the facility's medication list monthly to ensure the medication list was correct and updated. The Patient Care Manager stated it was important to ensure the binders were updated and the medication lists were correct so the resident can get what he or she needs when he or she needs it. The Patient Care Manager said it was important for continuity of care. In an interview on 4/3/26 at 4:30 pm, the DON stated she did not know who was responsible for ensuring the hospice binders were up to date. She stated it was probably her and the ADON's responsibility. The DON stated there was no one currently monitoring the on-going orders. The DON stated there should be regular communication with the hospice case managers. The DON stated it was important to maintain current hospice binders for the continuity of care. In an interview on 4/3/26 at 5:25 pm, the Administrator stated the ADON and DON are responsible for monitoring the hospice binders and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensuring they stayed current. The Administrator stated it was important so the residents could get the care they needed at the end of life. Record review of the facility's policy titled Coordination of Hospice Services dated 4/21/21 indicated the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. The policy stated the facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.

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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 to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #18) reviewed for infection control.The facility did not ensure LVN O discarded dirty linen properly while providing wound care to Resident #18.This failure could place residents at risk for cross contamination and the spread of infection.Findings included: Record review of Resident #18's face sheet, dated 04/03/26, reflected Resident #18 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included non-pressure chronic ulcer (a slow healing, open sore caused by poor circulation) of unspecified part of unspecified lower leg with unspecified severity, non-pressure chronic ulcer of other part of right lower leg with fat layer exposed, and peripheral vascular disease (circulation disorder involving damage to or narrowing of blood vessels outside the heart and brain, commonly caused by plaque (fat substance) buildup). Record review of Resident #18's quarterly MDS assessment, dated 03/20/26, reflected Resident #18 understood others, and made herself understood. Resident #18's BIMS score was 15, which indicated her cognition was intact. Resident #18 had two venous and arterial ulcers present. Record review of Resident #18's comprehensive care plan, revised 03/27/26, reflected she had a venous ulcer of RLE related to PVD. The care plan interventions included: evaluate wound for size, and monitor/document/report PRN for s/sx of infection. Record review of Resident #18's physician order summary report dated 04/03/26, reflected an active physician's order to soak legs with warm towel for about thirty minutes, wash legs with soap and water, pat dry and apply clobetasol cream (ointment), xerofoam (wound dressing) and wrap with kerlix (wound dressing) three times per week for wound care with start date 03/28/26. During an observation on 03/31/26 at 12:45 p.m., LVN O performed hand hygiene and applied a set of gloves. LVN O removed the wet towels from Resident #18's leg and placed them on her dresser. There was skin shedding observed on both towels. LVN O completed the wound care. During an interview on 04/02/26 at 4:50 p.m., LVN O stated she should have gotten a plastic bag to place the dirty linen prior to starting wound care. LVN O stated she normally kept a plastic bag in her pocket, but she realized after she started the wound care, she did not have one. LVN O stated she could not put the towels on the floor, so she placed them on Resident #18's dresser. LVN O stated it was important to ensure infection control practices were followed to prevent the spread of infection. During an interview on 04/03/26 at 9:42 a.m., the ADON stated she was the Infection Control Preventionist for the facility. The ADON stated she expected LVN O to bring a plastic bag with the wound care materials and place the dirty wet towels in the bag not on Resident #18's dresser. The ADON stated she random observations of wound care were done to ensure compliance. The ADON stated she had not assessed LVN O performing wound care. The ADON stated it was important to ensure infection control practices were followed to prevent the spread of infection. During an interview on 04/03/26 at 4:04 p.m., the DON stated LVN O should have ensured she had all her wound care supplies before she started performing wound care. The DON stated she expected her to place the wet towels in a plastic bag instead of on Resident #18's dresser. The DON stated she did random observations of wound care, but she had not watched LVN O performed wound care. The DON stated it was important to ensure infection control practices were followed to prevent the spread of infection. During an interview on 04/03/26 at 4:49 p.m., the Administrator stated he expected wet towels to be placed in a plastic bag to be disposed of. The Administrator stated the ADON was responsible for monitoring and overseeing infection control. The Administrator stated it was important to ensure infection control practices were followed to prevent the spread of infection. Record review of the facility's policy titled, Infection Prevention and Control Program, revised 03/03/26 reflected. An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment and to help prevent the development and transmission of communicable diseases and infections. The policy did not address how to discard linen during wound care. Record review of the skill checklist competency checkoff reflected LVN O had been checked off for non-sterile dressing change on 09/01/25.