STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675943	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Hope Manor	1623 W New Hope Dr Cedar Park, TX 78613

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the menu for 7 of 30 residents reviewed (Resident #11, Resident #12, Resident #26, Resident #29, Resident #54, Resident #66) for diet orders. The facility failed to ensure dietary staff served ground meat on 3/16/2026 for residents on a mechanical soft diet. This failure could place residents on mechanical soft diets at risk of choking and not receiving adequate nutrition.Findings included: Record review of Resident #11's face sheet dated 3/18/2026 reflected a [AGE] year-old female readmitted on [DATE]. Record review of Resident #11's MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated severely impaired cognition. Section I reflected that Resident #11 had diagnoses of non-traumatic brain dysfunction, hypertension (high blood pressure), cerebral vascular accident (stroke), and depression. Section K reflected that Resident #11 had no episodes of choking during meals in the 7-day lookback period. Section GG reflected that Resident #11 required setup or clean-up assistance with eating. Record review of Resident #11's physician order dated 11/10/2025 reflected a diet order for a MECH SOFT diet. Record review of Resident #11's care plan last revised on 1/08/2026 reflected that Resident #11 required mechanically altered foods and staff were to assess her for signs and symptoms of aspiration. Record review of Resident #12's face sheet dated 3/18/2026 reflected a [AGE] year-old female readmitted on [DATE]. Record review of Resident #12's MDS assessment dated [DATE] reflected a BIMS score of 9, which indicated moderately impaired cognition. Section I reflected that Resident #12 had diagnoses of heart failure, hypertension (high blood pressure), cerebral vascular accident (stroke), non-Alzheimer's dementia (neurocognitive disease), malnutrition, and depression. Section K reflected that Resident #12 had no episodes of choking during meals in the 7-day lookback period. Section GG reflected that Resident #12 required setup or clean-up assistance with eating. Record review of Resident #12's diet order dated 7/23/2025 reflected she needed a REG DIET MECH SOFT MEATS. Record review of Resident #12's care plan last revised on 1/06/2026 reflected that Resident #12 required mechanically altered foods and staff were to assess her for signs and symptoms of aspiration. Record review of Resident #26's face sheet dated 3/18/2026 reflected a [AGE] year-old female readmitted on [DATE]. Record review of Resident #26's MDS assessment dated [DATE] reflected a BIMS score of 1, which indicated severely impaired cognition. Section GG reflected that Resident #26 required setup or clean-up assistance with eating. Section I reflected that Resident #26 had diagnoses of non-Alzheimer's dementia (neurocognitive disease), anxiety disorder, depression, chronic kidney disease, muscle weakness, and lack of coordination. Section K reflected that Resident #26 had no episodes of choking during meals in the 7-day lookback period. Record review of Resident #26's diet order dated 2/26/2025 reflected she needed a MECH SOFT diet. Record review of Resident #26's care plan last revised on 3/16/2026 reflected that Resident #26 required mechanically altered foods and staff were to assess her for signs and symptoms of aspiration. Record review of Resident #29's face sheet dated 3/18/2026 reflected a [AGE] year-old female readmitted on [DATE]. Record review of Resident #29's MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated severely impaired cognition. Section GG (continued on next page)

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

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected that Resident #29 required supervision or touching assistance with eating. Section I reflected that Resident #29 had diagnoses of status post stroke, hypertension (high blood pressure), Alzheimer's disease (neurocognitive disease), malnutrition, depression, and anxiety disorder. Section K reflected that Resident #29 had no episodes of choking during meals in the 7-day lookback period. Record review of Resident #29's diet order dated 2/26/2025 reflected she needed a mechanical soft diet. Record review of Resident #29's care plan last revised on 3/05/2026 reflected Resident #29 required mechanically altered foods and staff were to assess her for signs and symptoms of aspiration. Record review of Resident #54's face sheet dated 3/18/2026 reflected a [AGE] year-old female admitted on [DATE]. Record review of Resident #54's MDS assessment dated [DATE] reflected a BIMS score of 8, which indicated moderately impaired cognition. Section GG reflected that Resident #54 required partial/moderate assistance with eating. Section I reflected that Resident #54 had diagnoses anemia, hypertension (high blood pressure), pneumonia, multidrug-resistant organism, hyperlipidemia (high cholesterol), arthritis, respiratory failure, and muscle weakness. Section K reflected that Resident #54 had one or more episodes of holding food in her mouth/cheeks or residual food in mouth after meals in the 7-day look-back period. Record review of Resident #54's diet order dated 2/19/2025 reflected she needed a MECH SOFT diet. Record review of Resident #54's care plan last revised on 3/02/2026 reflected t Resident #54 required mechanically altered foods and staff were to assess her for signs and symptoms of aspiration. Record review of Resident #66's face sheet dated 3/18/2026 reflected a [AGE] year-old female readmitted on [DATE]. Record review of Resident #66's MDS assessment dated [DATE] reflected a BIMS score of 5, which indicated severely impaired cognition. Section GG reflected that Resident #66 required setup or clean-up assistance with eating. Section I reflected that Resident #66 had diagnoses of status-post stroke, hypertension (high blood pressure), diabetes mellitus (uncontrolled blood sugar), hyperlipidemia (high cholesterol), seizure disorder, depression, malnutrition, and non-Alzheimer's dementia (neurocognitive disease), Section K reflected that Resident #66 no episodes of choking during meals in the 7-day look-back period. Record review of Resident #66's diet order dated 12/03/2023 reflected she needed a mechanical soft diet. Record review of Resident #66's care plan last revised on 2/20/2026 reflected that Resident #66 required mechanically altered foods and staff were to assess her for signs and symptoms of aspiration. During an observation of the kitchen on 3/16/2026 at 12:36 p.m. revealed that service line contained a turkey dish and there was no option with ground turkey-the pieces of meat were whole. During an observation and interview on 3/16/2026 at 2:39 p.m., Resident #12 was observed in bed, and she asked the surveyor what they thought about the length of her nails. During an observation on 3/16/2026 at 2:52 p.m., Resident #66 was sleeping in bed with her call light in reach. Resident #66 was unavailable for interview because she was sleeping. During an observation on 3/16/2026 at 3:24 p.m., Resident #29 was sleeping in bed with her call light in reach. Resident #29 was unavailable for interview because she was sleeping. During an observation and interview on 3/16/2026 at 3:47 p.m., Resident #11 was observed sitting in a geri chair in her room. Resident #11 said if her nails go much longer, she would need them trimmed. During an observation and interview on 3/17/2026 at 9:51 a.m., Resident #54 was observed in bed with her call light in reach. Resident #54 stated that she had concerns about her mattress being uncomfortable. During an observation and interview on 3/17/2026 at 10:08 a.m., Resident #26 was observed to be well groomed. Resident #26 said she just had her nails painted. During an interview on 3/17/2026 at 1:08 PM, Resident #54 stated that she did not have trouble eating her lunch the day prior on 3/16/2026. During an interview on 3/18/2026 at 10:36 a.m., the ST stated that she was familiar with Resident #11, Resident #12, Resident #26, Resident #29, Resident #54, and Resident #66. The ST stated that all of them had dysphagia except for Resident #29. The ST stated that Resident #54's dentures did not fit well, she liked to eat without them, and her dentition was the issue, not her swallowing. The ST stated that Resident #29 was on hospice, and a mechanical soft diet was recommended 2 years ago due to her cognition and for safety reasons. The ST stated that Resident #66 had dysphagia from a stroke, she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable living environment to help prevent the development of transmission communicable diseases and infections for four (Resident #14, Resident #36, Resident #40, and Resident #68) of seven residents reviewed for infection control. 1.The facility failed to ensure the SW used the proper PPE prior to entering Resident #14's room on 3/16/2026. 2. The facility failed to ensure CNA B did not use the same disposable wipe to cleanse Resident #36's urostomy tubing from the stoma site and out the first time and wiped the suprapubic catheter tubing a second time and then used a clean wipe for the third wipe.3. The facility failed to ensure CNA B performed hand hygiene and change gloves after providing suprapubic catheter care to Resident #36.This failure could place residents at risk for transmission of disease and infection.Record review of Resident #14's face sheet dated 3/18/2026 reflected a [AGE] year-old female readmitted on [DATE]. Record review of Resident #14's MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Record review of Resident #14's care plan last revised on 3/16/2026 reflected that she tested positive for ESBL in urine. Record review of Resident #14's Physician's Orders dated 3/16/2026 with an end date of 3/21/2026 reflected that she was on contact isolation for Diagnosis of VRE. Record review of Resident #36's undated face sheet revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate with urinary symptoms involved), chronic kidney disease Stage 3b (moderate to severe kidney function loss. Symptoms include fatigue, swelling, and nausea), congestive heart failure (when the heart is not pumping as well as it should, and the body may not get the oxygen it needs), cerebral atherosclerosis (hardening of the arteries in the brain), and vascular dementia (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain, as can happen with a stroke). Record review of Resident #36's Care Plan dated 03/18/2026 reflected: he had an indwelling suprapubic catheter. The goal reflected that the suprapubic catheter would remain in place without complications over the next 90 days. The approach reflected nursing to monitor for signs and symptoms of infection, bladder stones, septicemia (a serious bacterial infection that occurs when germs enter the bloodstream and spread throughout the body), hematuria (blood in the urine), skin breakdown, urine leakage around the catheter, and urinary tract infection, and to notify Medical Director of any abnormalities. Record review of Resident #36's Physician Orders reflected: Assure foley catheter in place with stat lock (StatLock was designed to minimize catheter movement). Enhanced barrier precautions for diagnosis of suprapubic catheter. Suprapubic catheter care every shift. Record review on 11/21/24 of Resident #36's Quarterly MDS assessment, dated 10/10/24 revealed a BIMS score of 14 indicating her cognition was intact. Further review of the MDS revealed Resident #36 was incontinent with bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #40's Face Sheet, dated 03/18/2026, reflected an [AGE] year-old female, admitted [DATE] with diagnoses that included wedge compression fracture of vertebra (a type of spinal fracture where the front part of a vertebra collapses, creating a wedge-shaped deformity., subsequent encounter for fracture with routine healing), rash and other nonspecific skin eruption (an area of irritated or swollen skin, and skin changes that do not have a clear or defined cause), anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), hypothyroidism (thyroid gland doesn't produce enough thyroid hormone leading to a slowdown in metabolism), malaise (a general feeling of discomfort, illness, or unease), vascular dementia (a type of dementia caused by reduced or blocked blood flow to the brain, leading to brain cell damage and cognitive decline), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #40's quarterly MDS dated [DATE], reflected a BIMS Score of 12, being moderately cognitively intact. Record review of Resident #40's Care Plan, dated 03/18/2026, reflected Resident #40 required assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #40 to maintain current level of function with assistance in his ADL care needs. Record review of Resident #68's Face Sheet, dated 03/18/2026, reflected an [AGE] year-old male, admitted [DATE] with diagnoses that included muscle wasting and atrophy lower left and right leg (loss of muscle mass and strength), muscle weakness (a condition where muscles cannot generate the expected amount of force, making movements more difficult than usual), difficulty in walking (hard to walk), lack of coordination (difficulty in controlling voluntary movements, resulting in clumsy, unsteady, or awkward motions), metabolic encephalopathy (a brain dysfunction that occurs due to systemic metabolic disturbances), atherosclerotic heart disease (the condition where plaque builds up in the coronary arteries, leading to reduced blood flow to the heart and increasing the risk of heart attacks and other cardiovascular issues), chronic kidney disease (a long-term condition in which the kidneys gradually lose their ability to filter waste and maintain essential bodily functions), and anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #68's quarterly MDS dated [DATE], reflected a BIMS Score of 7, which being cognitively impaired. Record review of Resident #68's Care Plan, dated 02/27/2026, reflected Resident #68 required assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #68 to maintain current level of function with assistance in his ADL care needs. During an observation and interview on 3/16/2026 at 11:20 a.m., Resident #14's room was observed to have PPE stocked in a drawer to the right of her room, but no signage was posted. CNA D stated that no PPE was required to enter Resident #14's room. Resident #14's door was open and Resident #14 said she had a bladder infection. During an observation on 3/16/2026 at 3:56 p.m., the SW was observed sitting on Resident #14's bed without any PPE. A sign was posted on the outer side of Resident #14's door to her room, which reflected that the resident was on contact precautions and a gown and gloves were required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/17/2026 at 2:56 p.m. peri-care and suprapubic catheter care was conducted for Resident #36 with CNA B, who removed the soiled dressing around Resident #36's urostomy tube, and placed it in the trash receptacle. She did not conduct handwashing/hand hygiene and a glove change and then began cleansing the suprapubic catheter from the stoma site and out approximately 5 inches with a disposable wipe. CNA B folded the same wipe in half and cleansed the suprapubic catheter from the stoma site and out approximately 5 inches. She again did not conduct handwashing/hand hygiene and a glove change. CNA B then provided Resident #36 with peri-care. CNA B removed the soiled gloves and conducted hand hygiene and then put on clean gloves and cleansed Resident #36's bottom. During an interview on 03/17/26 at 3:18 p.m. CNA B stated she had folded the disposable wipe she had used to cleanse the urostomy tubing from the stoma site and out the first time and wiped the suprapubic catheter tubing a second time and then used a clean wipe for the third wipe. CNA B also stated she had realized she should have performed hand hygiene and a glove change should have been done after providing suprapubic catheter care. CNA B stated she had worked in the facility for 1.5 years and she had received training on infection control, hand hygiene, and catheter care. She stated that not following infection control protocols when providing resident care could lead to the residents getting an infection. During an observation on 03/18/2026 at 11:14 a.m., it was revealed facility staff went into Resident #68 room to speak with the Resident and did not hand sanitize per EBP sign posted in front of Resident #68 room then proceeded to enter into Resident #40 room to speak with Resident and exited the Resident #40 room without hand sanitizing. During an interview on 03/18/2026 at 12:00 p.m. with Resident #68, he stated the following: he does not know if facility staff are hand sanitizing when coming into the room. During an observation on 03/18/2036 at 12:01 p.m. of Resident #68, he appeared to be clean, and groomed with no visual concerns. During an interview on 3/18/2026 at 12:25 p.m., the NP stated that Resident #14 was placed on contact precautions for vancomycin resistant enterococcus bacteria in the urine. The NP stated that the precautions started on Sunday 3/15/2026. The NP stated that Resident #14 needed to stay in her room because of the vulnerable population in the facility. The NP stated that's not appropriate in response to being asked about the SW being in Resident #14's room without PPE. During an interview on 03/18/2026 at 1:23 p.m. with Resident #40, she stated the following: she knows facility staff usually have gloves on coming into her room and she thinks facility staff are hand sanitizing when coming to and from her room. Resident #40 stated has not seen hand sanitizing taking place in front of her, but she believes facility staff are since the staff come in with gloves. During an observation on 03/18/2036 at 1:24 p.m. of Resident #40, she appeared to be clean and groomed with no forms of visual concerns. During an interview on 03/18/26 at 4:27 p.m. with the DON stated it should not be on one person to ensure staff are doing hand hygiene and following Infection Control measures. She stated QA staff, the DON and the ADON were responsible for ensuring staff are doing hand hygiene/following infection control measures when providing resident care, and it should not fall on one person. The QA staff, which include the DON, conduct competencies, check offs and training with staff members. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be utilized following current state and federal guidelines in conjunction with CDC guidance. The intent of this regulation is to ensure that the facility: Require staff to follow hand hygiene practices consistent with accepted standards of practice. Develop and implement an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and review and update the IPCP annually and as necessary. Establishes facility-wide systems for the prevention, identification, investigation, and control of infections of residents, staff, and visitors. It must include an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other people in the facility and procedures for reporting possible incidents of communicable disease or infections. Record review of facility in-service education for EBP documentation dated 01/07/2026 reflected to have been provided and not completed by nursing staff including CNA A, CNA B, CNA C, and LVN E. Record review of Handwashing and Hand Hygiene policy dated 08/2019 reflected This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following: Before and after direct contact with residents. Before and after entering isolation precaution settings. Review of the facility Policy and Procedure on Hand Hygiene, dated 08/2019, reflected, Statement – The facility considers hand hygiene the primary means to prevent the spread of infection.1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. 3. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or anti-microbial) and water for the following situations:a. Before and after direct contact with residents;b. Before and after handling an invasive device (e.g., urinary catheters, IV access sites);c. Before handling clean or soiled dressings, gauze pads, etc.;d. Before moving from a contaminated body site to a clean body site during resident care;e. After contact with a resident's skin;f. After handling used dressings, contaminated equipment, etc.;g. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident;h. After removing glovesi. Before and after entering isolation precaution settings4. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Record review of facility in-service education for Infection Control including hand hygiene documentation dated 12/22/2025 reflected to have been provided and completed by nursing staff including CNA A, and CNA B, but not completed by CNA C, or LVN E. Record review of the facility's policy titled Isolation – Categories of Transmission-Based Precautions revised in October of 2018 reflected the following: Policy Statement Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact Precautions-1. Contact Precautions may be implemented for residents known or suspected to be infected withmicroorganisms that can be transmitted by direct contact with the resident or indirect contact withenvironmental surfaces or resident-care items in the resident's environment.2. The decision on whether contact precautions are necessary will be evaluated on a case by case basis.3. The individual on contact precautions will be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675943	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Hope Manor	1623 W New Hope Dr Cedar Park, TX 78613

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed in a private room if possible. If a private room is notavailable, the Infection Preventionist will assess various risks associated with other resident placementoptions (e.g., cohorting, placing with a low risk roommate).4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room.a. While caring for a resident, staff will change gloves after having contact with infective material (forexample, fecal material and wound drainage).b. Gloves will be removed and hand hygiene performed before leaving the room.c. Staff will avoid touching potentially contaminated environmental surfaces or items in the resident'sroom after gloves are removed.5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the roomand avoid touching potentially contaminated surfaces with clothing after gown is removed. Facility Lesson, [NAME] (37435) - Infection Control No Notes

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 2 of 8 (Resident #84 and Resident #102) residents reviewed for nail care. The facility failed to ensure Resident #84's and Resident #102's fingernails were trimmed. This failure placed residents at risk for poor grooming, poor personal hygiene, and skin tears.Findings included: Record review of Resident #84's face sheet dated 3/18/2026 reflected a [AGE] year-old male admitted on [DATE]. Record review of Resident #84's MDS assessment dated [DATE] reflected a BIMS score of 10, which indicated moderately impaired cognition. Section I reflected that Resident #84 had diagnoses of hypertension (high blood pressure), renal insufficiency (kidney disease), non-Alzheimer's dementia (neurocognitive disorder), Parkinson's disease (neurological disorder), and malnutrition. Section GG reflected that Resident #84 required supervision or touching assistance with personal hygiene. Record review of Resident #84's care plan last revised on 2/12/2026 reflected he had ADL deficit related to cognitive and physical limitations and staff were to anticipate and ensure his needs were met. During an observation and interview on 3/17/2026 at 9:48 a.m. revealed Resident #84 was sitting in his wheelchair and his fingernails were observed to have about 4 mm of whites showing. Resident #84 stated that he needed something to scratch his head but that he preferred his nails to be a little shorter. Resident #84 stated that he had been in the facility for three or four months and no one had asked him if he wanted his nails trimmed. Resident #84 stated that his last shower was on Saturday (3/14/2026) or Sunday (3/15/2026). During an observation and interview on 3/18/2026 at 9:11 a.m., CMA F stated that nail care was usually done in the shower because they were soft and easier to cut. CMA F stated that nurses did diabetic's nails and CNAs could trim nails if residents were not diabetic. CMA F stated that CNAs checked residents' nails after residents ate to make sure there was no food stuck. CMA F stated that Resident #84 was diabetic and she did not know when Resident #84's last shower was. During an observation CMA F walked into Resident #84's room, looked at Resident #84's fingernails, and walked out. CMA F stated that Resident #84's nails looked clean but needed to be cut. Record review of Resident #102's face sheet dated 3/18/2026 reflected a [AGE] year-old male admitted on [DATE]. Record review of Resident #102's MDS assessment dated [DATE] reflected a BIMS score of 3, which indicated severely impaired cognition. Section I reflected that Resident #102 had diagnoses of anxiety disorder and depression. Section GG reflected that Resident #84 required supervision or touching assistance with personal hygiene. Record review of Resident #102's care plan last revised on 3/14/2026 reflected that he had ADL deficit related to cognitive and physical limitations and staff were to anticipate and ensure his needs were met. During an observation and interview on 3/16/2026 at 10:58 a.m., Resident #102 was observed in his room. Resident #102's fingernails had about 3 mm of whites showing and he said he had been meaning to ask about getting his fingernails and toenails done. Resident #102 stated, I usually don't wear them this long and pointed at his hand. Resident #102 stated that his toenails were worse. During an interview on 3/18/2026 at 9:16 a.m., LNV G stated that nail care varied for every person. LVN G stated that for diabetics, staff did not do the toenails at all at the facility-she said diabetic residents were referred out to the podiatrist. LVN stated nail care for non-diabetics was done once a week on Sundays by aids or nurses. LVN G stated the AD or anyone who volunteers, organized a nail clinic as an activity once a week. During an observation and interview on 3/18/2026 at 9:19 a.m., LVN G was observed walking into Resident #102's room. LVN G then walked out and stated that Resident #102's fingernails were clean, not jagged, but probably needed to be trimmed. LVN G stated she was not Resident #102's nurse so she did not know if he refused care. During an interview on 3/18/2026 at 9:23 a.m., RN H stated that Resident #102 did not refuse care with her, and she did not know when his last shower was, but she could check. During an interview on 3/18/2026 at 4:28 p.m., the DON (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that CNAs trimmed and cleaned nails as needed. The DON said nurses timed nails as well. The DON stated they had podiatry services if they needed something more advanced. The DON said she had not seen Resident #84's or Resident #102's nails that week (3/16/2026-3/18/2026). The DON stated staff were trained on nail care during orientation and if residents did not receive nail care, it could increase risk for self-inflicted skin tears. During an interview on 3/18/2026 at 4:50 p.m., the ADM stated aides were supposed to do nail care as needed and staff had been trained. The ADM stated if residents did not receive nail care, they could get something underneath their nails, and it could cause infection if they scratched themselves. Record review of the facility's policy titled Activities of Daily Living (ADL), Supporting revised March 2018 reflected the following: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care).