STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675975	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement written policies and procedures that identify, report, and protect from further abuse of residents, for 2 of 6 residents (Resident #14 and Resident #55) reviewed for abuse. * On 03/04/26, CNA B witnessed Resident #14 yell at Resident #55 that she was a [f-ing retard]. The incident was not reported to the abuse coordinator (AC) or HHSC. No preventative measures were put in place to prevent further abuse. * On 03/20/26, CNA B and MA C both witnessed Resident #14 shove Resident #55 into trash and dirty linen barrels in her wheelchair. CNA B and MA C did not consider this to be abuse and did not report the incident to the abuse coordinator. An Immediate Jeopardy (IJ) situation was identified on 03/25/26. While the IJ was removed on 03/26/26, the facility remained out of compliance at a severity of more than minimal harm that was not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of unidentified abuse, unreported abuse, not being protected from further abuse, and a decreased quality of life. Findings included: Record review of the facility's Abuse Prohibition Policy last revised 01/01/24 indicated: INTENT:This protocol was intended to assist in the prevention of abuse, neglect and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse.DEFINITIONS: Abuse means the willful infliction of injury, withholding or misappropriating property or money, unreasonable confinement, intimidation, or punishment with resulting physical hmm, pain or mental anguish. Physical abuse includes, hitting, slapping, kicking, shoving, pinching and controlling behavior through corporal punishment.Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or depravation. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). Verbal abuse is defined as the use of, oral, written or gestured language that willfully includes disparaging or derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal/mental abuse include, but are not limited to, cursing, yelling, saying things to frighten a resident, denying food or care, isolating a resident, etc.Abuse Prohibition Program:The facility's abuse prevention program includes the following components:-Screening-Training-Prevention-Identification-Investigation-Protection-Reporting/ Response Identification:1. Any allegation of abuse/neglect, made by residents/staff/visitors shall be reported to the Abuse Coordinator and investigated immediately.3. The facility supervisory staff will monitor behavior of staff members/ residents to identify potential for abuse, neglect, and misappropriation of resident funds. Protection:1. All residents will be immediately protected from harm.4. If another resident is the alleged perpetrator, they shall immediately be assessed for treatment options. The safety and protection of other residents is the facility's primary concern. Reporting/Response:1. Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination.2. The facility will (continued on next page)

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	report all allegations and substantiated occurrences of abuse,neglect or misappropriation of resident property to the state agency and to allother agencies as required by law and will take all necessary corrective actions depending on the results of the investigation. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment withserious bodily injury, exploitation with serious bodily injury, and injuries ofunknown source with serious bodily injury immediately or within two hours of the allegation. Resident to Resident Incidents: The following guidelines will be implemented when resident to resident incidences occur:1. The staff observing the incident will immediately separate the residents involved.2. The charge nurse will assess the victim to determine any injury.3. Physician and family of both victim and perpetrator will be notified of incident.4. An incident report will be completed for the perpetrator and the victim.5. The Abuse Coordinator will be immediately contacted.6. The interdisciplinary team will make the determination on what course of action needs to be taken with the perpetrator such as, but not limited to the following:* Immediate discharge from the facility due to potential for harm to other residents.* Can the behavior be controlled by location monitoring?* Need for referral to a psychologist/psychiatrist.7. If the perpetrator is placed on location monitoring, staff will be instructed onreason for monitoring and targeted behaviors being monitored.8. If the perpetrator is on a behavioral contract, facility staff will be in servicedaccordingly, and the resident and family will be notified of consequences.9. If the perpetrator continues to exhibit inappropriate behaviors/or violates thebehaviors identified on the behavioral contract, staff will immediately notify the Administrator /DON.10. The team will conduct an emergency review to determine further course of action such as immediate discharge.11. The victim will be seen by Social Services to determine further psychologicalsupport needed as well as follow up with physician/family.12. The Ombudsman will be notified of incident /allegations as appropriate. Record review of a face sheet dated 03/24/26 indicated Resident #14 was a [AGE] year-old male admitted on [DATE]. He was his own RP. His diagnoses included paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #14 had intact cognition with a BIMS score of 15 out of 15. He had adequate hearing and clear speech. He had no behaviors during the look back period. Record review of the care plan for Resident #14 indicated:-dated 01/27/21; he had been and had the potential to be verbally aggressive and accusatory behavior towards others - staff and residents.-dated 06/14/21; he had a history of and potential for behavior problem related to my age and facility accommodates my needs by allowing me to have autonomy to make my own decisions. -dated 10/30/25; he had requested to room with a female resident. He was able to make his own decisions and consented to the move.-dated 12/11/25; he exhibited episodes of verbal aggression/irritability toward staff when care for his girlfriend/roommate was not provided immediately. During an observation and interview on 03/23/26 at 01:30 p.m. Resident #14 was in his electric wheelchair sitting outside in the smoking area. He was sitting with Resident #55. Interactions between them were appropriate with no yelling. He said he told Resident #55 to shut up and go to the room to calm down. He said it was told that he cussed at her and called her a retard but that did not happen. He said he loved her and would not do that. Record review of a face sheet dated 03/24/26 indicated Resident #55 was a [AGE] year-old female admitted on [DATE]. She was her own RP. Her diagnoses included cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), vision loss (partial or complete loss of the ability to see), hypertension (a condition in which the force of the blood against the artery walls is too high), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #55 had intact cognition with a (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	BIMS score of 15 out of 15. She had adequate hearing and clear speech. She had severely impaired vision. She had no behaviors during the look back period. Record review of the care plan for Resident #55 indicated:-dated 10/30/25; she requested to room with a male resident. She was able to make her own decisions and consented to the move.-dated 09/17/25; she had impaired visual function related to total Blindness.-dated 09/25/25; she had a behavior problem. The resident had history of yelling at staff. During an observation and interview on 03/23/26 at 01:30 p.m. Resident #55 was sitting in her wheelchair outside in the smoking area. She was sitting with Resident #14. Interactions between them were appropriate with no yelling. She said someone said he cussed at her, but he did not. During an observation and interview on 03/25/26 at 12:20 p.m. Resident #55 was sitting in the dining room without Resident #14. She was calm. She said Resident #14 went to the emergency room to get checked out. She said she had no issues with Resident #14 yelling and cussing at her. She said she did not feel afraid of him. She said she loved him and he took care of her since she could not see. 1. Record review of Nurse Notes for Resident #55 indicated an entry dated 03/03/26 at 09:40 a.m. [Resident #55] was sitting outside in wheelchair with other residents and boyfriend [Resident #14]. Stated to boyfriend stomach was hurting. Boyfriend yell at her. [Resident #14] was crying stated boyfriend yelled at her and belittled her in front of everybody. Stated to nurse I want to move out of that room notified social worker. Signed by LVN A. Record review of Nurse Notes for Resident #14 indicated an entry dated 03/03/26 at 09:50 a.m. [Resident #14] was sitting outside in electric wheelchair with girlfriend [Resident #55] and other residents. Yelled at girlfriend, asked [Resident #14] why yelled at girlfriend stated she said her stomach hurt and all I said was she need to tell the nurse Social worker notified of behavior. Signed by LVN A. During an interview on 03/25/26 at 09:26 a.m. LVN A said Resident #55 came to her crying and upset about Resident #14 yelling at her and belittling her in front of other residents. She said she told the SW since Resident #55 said she wanted to move out of the room. During an interview on 03/25/26 at 09:42 a.m. the SW said LVN A reported to her Resident #55 wanted to move out of the room she shared with Resident #14 because he yelled at her and belittled her. She said she went to talk with Resident #55, and she recanted what was said and said she loved him. She said when she talked with Resident #14, he said Resident #55 said her stomach hurt and he told her to tell the nurse. She said the Administrator was made aware. During an interview on 03/25/26 at 10:10 a.m. the Administrator said she was aware of the incident on 03/03/26 where Resident #55 said Resident #14 yelled at her and belittled her in front of others, but when Resident #55 was asked about it she recanted her statement. Therefore she did not think it needed to be reported. 2. Record review of a witness statement dated 03/04/26 indicated CNA B put in her witness statement she witnessed Resident #14 yell at Resident #55 that she was a [f-ing retard]. The statement was turned into the abuse coordinator. The incident was not reported to the abuse coordinator or HHSC. During an interview on 03/24/26 at 01:55 p.m. CNA B verified her witness statement that she had witnessed on 03/04/26 Resident #14 yelled at Resident #55 she was a [f-ing retard]. CNA B said she wrote it in her witness statement and thought the AC would see it. During an interview on 03/25/26 at 10:10 a.m. the Administrator said she did not see where CNA B had put in her statement about Resident #14 calling Resident #55 a [f-ing retard]. She said it would be considered as verbal abuse and would be reportable to HHSC. 3. During an interview on 03/24/26 at 01:55 p.m. CNA B said she was making rounds on 03/20/26 she had her dirty linen barrel and trash barrel in the hallway. She said MA C was passing medications, so her cart was also on the hall. She said Resident #14 and Resident #55 came out of their room with him pushing her in her wheelchair. She said Resident #14 then shoved Resident #55 into the barrels. She said she was not sure if it was abuse and did not report it to the Administrator. During an interview on 03/24/26 at 02:15 p.m. MA C said she saw Resident #14 shove Resident #55 in her wheelchair. MA C said Resident #14 told her it was her fault that Resident #55 went into the barrels. She said she told him no it was not her fault it was he who shoved Resident #55 into the barrels. She said she did not think it was a type of abuse and did not report it to the Administrator. During an interview on 03/25/26 at 10:10 a.m. the (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator said she was not aware of the incident of Resident #14 shoving Resident #55 into the barrels until CNA B came to her and told her about 10 minutes ago. She said the incident could be considered as physical abuse and would be reportable to HHSC. The Administrator and DON were notified of the IJ on 03/25/26 at 02:07 p.m. due to the above failures. The administrator was provided with the IJ template on 03/25/26 at 02:09 p.m. The following Plan of Removal was submitted by the facility and accepted on 03/26/26 at 11:53 a.m.:[Facility Name]Plan of RemovalMarch 25, 2026 F607 Immediate Actions The facility attempted to separate the residents; however, both residents adamantly refused a room change. Due to adamant refusal to change room, 1:1 monitoring initiated for Resident #14. Monitoring done by staff until risk is fully mitigated and IDT determines supervision can be safely reduced. Care plans were reviewed and updated accordingly for Resident #55 and Resident #14 to reflect supervision needs and behavioral concerns for both residents on 3/25/2026 by MDS Coordinator. IDT provided education to both residents on 3/25/2026 regarding:Personal safety and boundaries Risks associated with unsupervised interactions Facility responsibility to intervene when safety concerns arise Outcome: Both residents verbalized understanding but continued to refuse room change; ongoing reinforcement planned A trauma-informed psychosocial assessment for Resident #55 was completed on 3/25/2026 by Social Services to evaluate for emotional distress, coercion, or unmet needsFindings: No immediate psychosocial harm identified; continued monitoring initiated Both residents were assessed for physical and psychosocial harm by nursing, with no additional injury identified on 3/25/2026 Life satisfaction rounds were completed on 3/25/2026 to ensure no other residents were negatively affected this was completed by Social Services. No negative findings with resident #14 and #55 Medical Director was notified by facility Administrator on March 25, 2026 regarding the facility alleged failure to follow abuse policies and procedures. Systemic Changes Administrator/DON were inserviced by CCS on abuse policy and reporting procedures to include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on Identifying abuse risk with residents in relationships Completed 3/25/2026. Competency validated via quiz. Administrator/DON inserviced staff on abuse policy and reporting procedures. To include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on Identifying abuse risk with residents in relationships Competency validated via quiz. Staff will not be allowed to work their next scheduled shift until inservice has been completed. Inservice complete 3/25/26 The above training material will be incorporated into the new hire orientation by Administrator effective March 25, 2026 and ongoing. An audit of incident reports for the last 3 months was completed by DON/Designee to ensure no other reportable incidents were identified on 3/25/2026. No negative findings identified An audit of grievances for the last 3 months was completed by Administrator to ensure no other reportable issues were identified on 3/25/2026. No negative findings identified If resident-to-resident abuse occurs and both residents refuse room change, the facility will implement immediate enhanced supervision (including 1:1 monitoring as indicated), revise care plans to reflect supervision needs, complete IDT review, assess capacity and risks, involve physician and responsible parties, and consider alternative interventions (behavioral, environmental, or schedule separation) to ensure resident safety. Ongoing reassessment will occur until risk is fully mitigated Monitoring and QA Administrator/DON will conduct daily review of all incidents, grievances and behavior notes x 14 days, then weekly x 4 weeks and monthly thereafter. The Administrator/DON will conduct random staff interviews (5 per week x 4 weeks) to validate understanding of abuse reporting. QAPI Committee will review weekly for 3 months for compliance, then monthly thereafter. Any identified issues will result in immediate re-education and disciplinary action if indicated. Actions for Resident Involved:The facility attempted to separate Resident #14 and #55; however, both residents adamantly refused to change rooms. Resident #14 was on 1:1 monitoring by facility staff until risk is fully mitigated and IDT determines supervision can be safely reduced. Resident #14's and #55's care plan has been updated to reflect supervision needs and behavioral concerns on 03/25/26 by MDS Coordinator. IDT provided education to both Resident #14 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and #55 regarding personal safety and boundaries, risks associated with unsupervised interactions, facility responsibilities to intervene when safety concerns arise with the outcome of both residents verbalized understanding but continued to refuse room change with ongoing reinforcement planned. Resident #55 received a trauma-informed psychosocial assessment by social services to evaluate emotional distress, coercion, or unmet needs. Findings of no immediate psychosocial harm identified; continued monitoring initiated. Residents #14 and #55 were assessed for physical and psychosocial harm by nursing staff, with no additional injury identified on 03/25/26. Life satisfaction rounds were completed on 03/25/26 to ensure no other residents were negatively affected this was completed by social services. No negative findings with Resident #14 and #55. Medical Director was notified by facility Administrator on 03/25/26 regarding the facility alleged failure to follow abuse policies and procedures. Administrator/DON was in serviced by CCS the abuse policies and reporting procedure to include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on identifying abuse risk with residents and relationships completed 03/25/2026 competency validated via quiz. Administrator/DON in service staff on abuse policies and reporting procedures to include the different types of abuse, reporting abuse, and what to do in the event of an allegation of abuse and additional focus on identifying abuse risk with residents and relationships. Competency validated via quiz. Staff will not be allowed to work their next scheduled shift until end service has been completed. Service completed 03/25/26. The above abuse training materials will be incorporated into the new hire orientation but Administrator effective March 25th, 2026, and ongoing. An audit of incident reports for the last three months was completed by DON/designee to ensure no other reportable incidents were identified on 03/25/26. No negative findings identified. An audit of grievances for the last three months was completed by administrator to ensure no other reportable issues were identified on 03/25/26. No negative findings identified. If resident to resident abuse occurs in both resident refuse room change the facility will implement immediate enhanced supervision (including 1 one monitoring as indicated, revised care plan to reflect supervision needed complete IDT review assess capacity and risk, involve physician and responsible parties, and consider alternative interventions (behavioral environmental or schedule separation) to ensure residents safety. Ongoing reassessments will occur until risk is fully mitigated. Review of the IJ monitoring for the facility's plan of removal reflected the following: During an observation and interview on 03/26/26 at 1:00 p.m. LVN T was sitting outside Resident #14's door she indicated she was providing 1:1 monitoring for Resident #14. LVN T indicated she was watching and listening for any abuse between Resident #14 and #55. LVN T said they were watching a movie and that she was to make sure that Resident #14 did not physically or verbally abuse Resident #55 or any other residents. LVN T said she was documenting on a flow sheet every 15 minutes and as needed. LVN T said if an incident occurred to intervene immediately, keep resident safe and notify the Administrator immediately thereafter. Record review of Resident #14's 1:1 monitoring tracking sheet indicated facility staff began 1:1 monitoring of Resident #14 on 03/25/26 at 6:00 p.m. and was continuing to monitor the residents. Resident #14's tracking sheets included every 15-minute documentation of location and identified activities with facility staff signatures. No new incident identified. Record review of signed statements provided by Resident #14 and #55 indicated they were educated on 03/25/26 regarding personal safety and boundary risks associated with unsupervised interactions and the facilities responsibilities of intervening when safety concerns arise. Their statements acknowledge they understood the information provided and refuse to change rooms with the understanding that current and ongoing reinforcement and monitoring are planned. Record review of Residents #14's care plan indicated it was updated on 03/25/26 to include he exhibited episodes of verbal aggression/irritability towards staff when care for his girlfriend/roommate is not provided immediately and revision of interventions to include one on one monitoring. Record review of Residents #55's care plan indicated it was updated on 03/26/26 to include she had requested to room with a male resident and she was her own responsible party and was cognitively able to make her (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	own decisions and revision of the interventions included she refused to move rooms, social worker to interview resident quarterly and as needed to discuss behaviors and potential room/roommate change, assess resident for injuries such as bruises/skin tears after any reportable incident, IDT meeting quarterly and as needed to discuss with resident any on-going concerns/issues identified, temporary separation when inappropriate interactions are identified and to have psych evaluate as needed. Record review of Resident #55's trauma-informed psychosocial assessment completed on 03/25/26 by SW indicated no immediate psychosocial harm identified related to incident. Resident #55's physical assessment dated [DATE] completed by LVN Y indicated no additional injuries identified. Record review of Resident #55's physical and psychosocial harm assessment dated [DATE] completed by LVN Y indicated no psychosocial harm or physical injury identified. Record review of Life satisfaction rounds completed on 03/25/26 by social services to ensure no other residents were negatively affected indicated no negative findings with Residents #14 and #55 Record review of a text message indicated the Medical Director was notified by the Administrator on 03/25/26 regarding the facility alleged failure to follow abuse policies and procedures. Record review of in-service dated 03/25/26 instructed by the CCS, indicated the Administrator and Director of Nursing was trained on abuse policy and reporting procedures to include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on Identifying abuse risk with residents in relationships. Record review of in-services dated 03/25/26 and 03/26/26 completed by the DON, indicated 70 of 72 facility staff and contract staff were trained on abuse policy and reporting procedures. To include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on Identifying abuse risk with residents in relationships. No staff will be allowed to work until this training was complete. During an interview on 03/26/26 at 6:30 p.m., the Administrator said she provided the abuse training for staff during the orientation process, and she would be utilizing the newly developed abuse policy guideline material during the orientation. She said during new orientation process staff would receive training on abuse policy and reporting procedures to include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on identifying abuse risk with residents in relationships. Record review of an audit of incident reports for the last 3 months completed by DON/Designee on 03/25/26 to ensure no other reportable incidents were identified for not following the abuse policy. No negative findings identified. Record review of an audit of grievances for the last 3 months was completed by Administrator on 03/25/26 to ensure no other reportable issues were identified for not following the abuse policy. No negative findings identified. During interviews conducted on 03/26/26 from 12:10 p.m. to 7:30 p.m. representing staff from various shifts (6 a.m.- 2 p.m., 2 p.m. - 10 p.m., 2 p.m.- 6 a.m.) and departments included LVN Q, VD R, MA G, ADON, CNA S, MA C, MA N, LVN T, CNA U, LVN H, LVN J, MDS RN, CNA V, SW, LVN A, LVN F, CNA M, LVN L, CNA W, AD, CNA X, LVN Y, CNA Z, CNA AA, CNA BB, CNA CC, CNA DD, CNA EE, MNT, CNA FF, CNA GG, CNA HH, CNA JJ, DDM, DM, DA KK, DA LL, DC MM, EM NN, HSK OO AND HSK PP. All staff were able to identify the different types of abuse, what to do if they witnessed resident to resident abuse, what signs to watch for in residents to prevent resident to resident abuse, and who to report any incidents of abuse. Staff were able to identify that they were to intervene immediately if abuse witnessed (both resident-to-resident even residents in relationships, and/or resident to staff). Staff were able to identify ways to prevent residents with high-risk behaviors and agitation from abuse and neglect. Example: To remove from reach of others, increase supervision. Staff knew they were to separate residents immediately, and ensure residents were safe. All staff were able to identify the responsibilities if assigned 1:1 monitoring. All staff were able to identify the responsibilities of caring for a resident with behavior and to intervene even if residents were in a relationship. All staff were able to identify the responsibilities for supervision and monitoring residents. All said they were in-serviced on 03/25/26 or prior to their shift on 03/26/26 regarding reporting alleged abuse immediately to the Administrator/AC and the allegation had to be reported to (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the State Agency within 2 hours of the incident. All were able to state that their abuse coordinator was the Administrator, if she were not available, they were to notify the DON. During an observation and interview on 03/26/26 at 2:00 p.m. Resident #14 and Resident #55 were in their room watching a movie and voiced no concerns. Resident #14 said staff are monitoring us closely and he would never harm his girlfriend (Resident #55). During an interview on 03/26/26 at 6:00 p.m. MA G said she was assigned to Resident #14 and indicated she was watching and listening for any abuse between Resident #14 and #55. MA G said they had been out for a smoke break and just returned to watch TV and that she was to make sure that Resident #14 did not physically or verbally abuse Resident #55 or any other residents. MA G said she was documenting on a flow sheet every 15 minutes and as needed. MA G said if an incident occurred to intervene immediately, keep residents safe and notify the Administrator immediately thereafter. During an interview on 03/26/26 at 6:10 p.m., the ADON said she received training 03/25/26 from the DON and the Administrator on Abuse policy, reporting abuse immediately, intervene and protect resident, interventions, and notify Administrator/AC immediately. If Administrator/AC not available or reachable notify DON. She said the Administrator had 2 hours from the time of the incident to report abuse allegations to the state agency. She said she trained staff on abuse, resident-to-resident altercations, intervening, separating resident, aggressors were watched while someone obtained help, and notified the administrator, staff to resident, protect resident and notify Administrator. She said the aggressor in an altercation was placed on one on one immediately protocol, psych notified, and they review and release. She said Resident #14 is on 1:1 monitoring for abuse or behaviors towards Resident #55 his girlfriend/roommate. She said Residents #14 and #55 care plan interventions were updated. She said that they were to follow the abuse policy even if the residents were in a relationship if abuse was suspected. During an interview on 03/26/2026 at 5:40 p.m., the DON said she received training 03/25/2026 from Regional Nurse/CCS on abuse policy and reporting procedures to include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on Identifying abuse risk with residents in relationships. She said she and the Administrator trained staff regarding the abuse policy and reporting procedure after she received her training from the Regional Nurse/CCS. She said Resident #14 was placed on 1:1 monitoring until risk is fully mitigated. She said both residents (14 and #55) have received updates on care plans, signed statements about refusing room changes and risk, psychosocial and physical assessments, and increased monitoring. She said social services completed life satisfaction rounds with no negative findings. She said she completed an audit of reportable incidents for the last 3 months regarding following the policy for reporting abuse and no negative findings identified during audit. During an interview on 03/26/2026 at 6:45 p.m., the Administrator said she received training on 03/25/2026 from Regional Nurse/CCS on abuse policy and reporting procedures to include the different types of abuse, reporting of abuse, and what to do in the event of an allegation of abuse and additional focus on Identifying abuse risk with residents in relationships. She said she and the DON trained staff regarding the abuse policy and reporting procedure after she received her training from the Regional Nurse/CCS. She said Resident #14 was placed on 1:1 monitoring until risk was fully mitigated. She said both Residents #14 and #55 had received updates on care plans, signed statements about refusing room changes and risk, psychosocial and physical assessments, and increased monitoring. She said social services completed life satisfaction rounds with no negative findings. She said she completed an audit of grievances for the last 3 months regarding following the policy for reporting abuse and no negative findings identified during audit. She said her ongoing monitoring would include conducting daily reviews of incidents, grievances and behavioral notes and conducting random staff interviews for abuse reporting. She said the abuse policy and reporting would be added to her QAPI review as well. The Administrator was informed that the Immediate Jeopardy was removed on 3/26/26 at 7:30 p.m. The facility remained out of compliance at a scope of pattern with the potential

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	675975	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure all nursing staff possess the competencies, and skill sets necessary to use, maintain and test the automated external defibrillator according to the manufacturer's guidelines for 1 of 1 facility automated external defibrillators and 4 of 4 licensed staff interviewed (LVN QQ, LVN L, LVN J and LVN H) and reviewed for nursing services.The facility failed to ensure nursing staff were competent to conduct testing of the facility's only AED according to the manufacture's guidelines.An Immediate Jeopardy (IJ) was identified on [DATE] at 4:45 p.m. While the IJ was removed on [DATE] at 5:45 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.This failure could place residents at risk for death.Findings included:During an observation on [DATE] at 2:30 p.m., the only available AED for the facility was sitting in a holder that was attached to the wall outside of the nurse's station. The AED had a black zipped case and was intermittently beeping, electrodes (a conductive materials used conductive materials used to transfer electricity to or from non-metallic components in a circuit) were not attached and the machine had a red x indicator light on.During an interview on [DATE] at 2:33 p.m., LVN QQ stated she worked the 2p-10p shift and was not responsible for checking to see if the AED was functioning properly. She said that was done on nights by LVN H and LVN J who worked opposite of each other. LVN QQ said she did not hear the AED beeping until surveyor brought it to her attention. LVN QQ looked at the AED and said the red x mark indicated the AED was off and when you turned it on it would go green. LVN QQ said the AED electrode pads were not attached to the machine and only needed to be attached if the machine was in use. LVN QQ said she had not been trained on this type of AED. LVN QQ said she had AED training [DATE], but the trainer had a different type of AED. LVN QQ said a delay in AED care for a resident could happen if the nurse was not familiar with the type of AED being used at the time during CPR. She stated not being trained to be able to understand and identify that the AED was not functioning properly, could delay CPR to the resident.During an interview on [DATE] at 2:35 p.m., LVN L stated she worked the 2p-10p shift and was not responsible for checking to see if the AED was functioning properly she said that was done on nights by LVN H and LVN J. LVN L said she had not heard the beeping noise from the AED. LVN L said she did not know why the AED had a red X mark, and the AED electrodes did not have to be attached until the AED was ready to use on a resident. LVN L said she had been trained in 2025 but couldn't remember exactly when and the trainer had used a different AED. LVN L said she was not familiar with the current AED machine, but that it would talk to her and tell her the steps to do. LVN L said not being trained in how to use and identify if the AED was ready to use could cause a delay of CPR care to the resident needing CPR emergency services.During an observation and interview on [DATE] at 2:43 p.m., the DON removed the AED from the case and said the AED was beeping. The DON verified and said the AED electrode to the pads were not attached to the machine and turned on the machine and the red X mark remained lit up the AED said change battery. The DON said that meant the battery was low, or the test went wrong and the pads did not need to be connected until it was ready to use. She said the night nurses (LVN H and LVN J) were responsible for conducting readiness checks on the AED and documenting those checks which included checking for expired AED pads and evidence of machine functioning properly like not beeping and a green check mark to indicate ready to use. The DON said her expectation was for all nurses to know how to use the AED and how to identify when it is not ready for use. The DON said she was not aware that the AED was not ready for use. The DON said CPR included the use of the AED. The DON said on September2025, the nurses were trained on the AED, but the trainer used a different AED from what the facility had on (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hand. She said if a resident experienced cardiac arrest during the time the AED was not functional, the facility would still be able to do CPR but not use the AED. The DON said the nurses were trained on the AED, but it was not the specific AED the facility used, and that nurses had CPR certification cards and the training included AED-use. The DON said she would create a form to include what the nurse is responsible for when checking on the AED.During an interview on [DATE] at 3:42 p.m., the Administrator said she had not noticed that the AED electrodes were not attached, machine beeping or that there was a red x mark. The Administrator said the nighttime nurses were responsible for checking the AED and documenting the results every night. When a policy was requested, the Administrator stated she believed there was a policy, but she was not sure. The Administrator said if the facility did not have a policy on the AED, they would use the manufacture's manual online to train the nurses. The Administrator said she was not aware that the nurses did not know what to check for on the AED to know it was not ready for use.During an interview on [DATE] at 3:30 p.m., LVN J said she worked the 10p-6a shift and she had not received instruction from the facility about how to check the current AED for readiness until yesterday from the DON. She said she would just check to make sure it was available part of the crash cart checklist. LVN J said she knew to check for a green check mark which meant it was fine and put a check mark on her checklist, but if the green check mark was not on and it was a red x mark, that usually meant the AED was not functional and would get with the Administrator. LVN J said she now had a form to document green check mark and AED electrodes were attached. She said not having a functioning AED or being trained on how to use the current type of facility AED, could maybe cause a delay in using the AED for CPR.During an interview on [DATE] at 4:52 p.m., LVN H stated she worked the 10p-6a shift, and she had not received instruction from the facility about how to check the current AED for readiness pads until yesterday from the DON. She said she was not aware of the AED not functioning because all she was looking for when checking the AED was if it was available. LVN H said she would just check the box on the form indicating it was available part of the crash cart checklist. She said not having a functioning AED could maybe cause a delay in using the AED for CPR, and not being trained on how to use the AED, the facility used could cause a delay in emergency AED treatment to the resident.During an interview on [DATE] at 12:40 p.m., the Medical Director said he expected the AED to be functioning, and all necessary items at all times. He said if the items were used, then it should be replaced immediately and the AED be placed back to be used again when needed. The Medical Director said if the nurses were not familiar with the current AED, then education was need because it could cause cardiac arrest or death if AED usage were delayed.Record Review of an undated resident list indicated 47 residents wished to be resuscitated in the event of cardiac arrest.Record review of the on-line owner's manual for the [AED brand name] Fully Automatic AED Plus Administrator's Guide, obtained on [DATE] at 3:30 p.m., at https://www.[NAME].com/-/media/Product-Materials/product-manuals/aed-plus-fully-automatic/01/9650-0311-(indicated: Safety Summary: Use the Fully Automatic AED Plus unit only as described in this manual. Improper use of the device can cause death or injury.DO NOT use or place the Fully Automatic AED Plus unit in service if the unit's status indicator window (located on the left side of the handle) displays a red X. DO NOT use or place the Fully Automatic AED Plus unit in service if the unit emits a beeping tone.Keep the electrode cable connected to the Fully Automatic AED Plus unit at all times.This device should only be used by properly trained individuals.If the device is stored outside the recommended environmental conditions, the electrode pads and/or batteries may be damaged or their useful life reduced.This device is intended for use by personnel who have been trained in its operation.Record review of the facility's policy titled Automatic External Defibrillator, dated [DATE] read in part: Policy: the facility has Automatic External Defibrillator (AED) equipment available for emergency use.5. Follow manufacturer guidelines and operating procedures, including pre-programmed voices prompts for use of the AED.Maintenance. The Director of Nursing or designee will test and document the operating status of the AED in accordance with manufacturer's guidelines.The Administrator and DON were notified on [DATE] at 4:45 p.m. that an Immediate (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Jeopardy was identified due to the above failures and the template was provided and POR requested via email at 4:56 p.m.The facility's plan of removal was accepted on [DATE] at 12:30 p.m., and included:Immediate Actions Taken to Remove JeopardyUpon identification of the deficient practice on [DATE], the facility immediately implemented the following corrective actions to remove the Immediate Jeopardy:The facility's AED was immediately assessed and removed from service due to malfunction (beeping alarm, red X indicator, pads not connected) on [DATE] by administrator.A fully functioning AED was obtained, inspected, and verified to be operational according to manufacturer guidelines, including:Pads properly connected No error indicators Battery verifiedThe AED function was placed in service on [DATE] at 4:45 PM. Staff Education and Competency Validation On [DATE], all licensed nurses and designated emergency response staff present in the facility were immediately re-educated by DON on [DATE] Proper use of the AED Manufacturer guidelines Identification of malfunction indicators (including red X and audible alarms} Requirement that pads remain connected at all times Staff completed return demonstration and/or verbal competency validation to ensure understanding. Any staff not present will be educated prior to next scheduled shift.All training material incorporated into new hire paperwork by Admin on [DATE]Identification of Affected ResidentsThe facility identified 47 residents with full-code status who had the potential to be affected by the deficient practice.All residents were assessed, and no adverse outcomes were identified related to this concern.Monitoring and System Changes to Prevent RecurrenceTo ensure ongoing compliance and prevent recurrence:A daily AED equipment check log was immediately implemented by DON and will be completed each shift by the Hall 100 charge nurse requiring: Visual inspection of device status Verification of pads connection. Confirmation of no alarms or error indicatorsDON/designee will be responsible for checking the completion of the log. AED checks are assigned to the licensed nurse on each shift.The DON or designee will audit compliance daily X 7 days, then weekly x 4 weeks, and monthly thereafter through QAPI.On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Verified the AED was operational according to manufacturer guidelines. Surveyor observed the AED alarm was not beeping, there was no red X indicator, but green check mark, electrodes were connected, and there was no battery error indicators. The survey team confirmed the POR by: staff interviews related to AED identification of malfunction indicators (including red X and audible alarms), electrodes remaining connected at all times, checking the AED, and documenting on new checklist form, observations of residents were conducted, review of in-services and skills check-off related to AED was completed.Review of new hire paperwork included training and checkoff for AED. Review of new checklist documentation indicated Review of 20 post-tests and 20 skills check-off sheets, dated [DATE] and [DATE], reflected licensed nurses demonstrated proper skills and demonstrated knowledge on performing AED identification of malfunction indicators, (including red X and audible alarms) and electrodes.During an interview on [DATE] at 4:30 PM, the ADM stated more than 90% of their staff had been in-serviced on safe usage of the AED and proper functioning of the AED.On [DATE] at 5:45 p.m, the administrator and DON were informed the IJ was removed. However, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	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 the appropriate care and services to prevent urinary tract infections to the extent possible for 1 of 2 residents (Resident #5) reviewed for indwelling catheters/ quality of care. (Resident #5) 1. Resident #5 had blood present inside his suprapubic catheter (a tube inserted into the bladder to drain urine) tubing and catheter drainage bag from 03/21/2026- 03/24/2026. 2.The facility staff failed to assess, document, and report findings to the physician and Resident #5 continued with signs of a possible UTI. 3.Resident #5 did not have a suprapubic strap in place to prevent dislodgement or trauma. This failure could place residents at risk of not receiving the required level of care, trauma, or possible sepsis. Findings included: Record review of a face sheet dated 03/25/2026 indicated Resident #5 was a [AGE] year-old male admitted on initially admitted on [DATE] and readmitted [DATE]. His diagnoses included chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot supply enough oxygen to the blood, often due to underlying lung or systemic diseases), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), quadriplegia (is a symptom of paralysis that affects all a person's limbs and body from the neck down), tracheostomy (a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), Colostomy (an operation that creates an opening for the large intestine through the abdomen), neuromuscular dysfunction of the bladder (occurs when nerve or spinal cord problems disrupt communication between the brain and bladder, leading to loss of bladder control and urinary complications), resistance to multiple antibiotics (known as multidrug resistance, poses a significant global health threat, making infections harder to treat and increasing the risk of severe illness and death.) bullous pemphigoid-(autoimmune response that causes blistering to skin and increases risk of kidney disease and blood-tinged urine), obstructive and reflux uropathy (blockages in the urinary track system that cause urine to remain in bladder or back flow into the kidneys causing kidney damage and blood-tinged urine), artificial opening to the urinary tract (surgical incision in the bladder for abdominal catheter placement), resistance to multiple antibiotics (known as multidrug resistance, poses a significant global health threat, making infections harder to treat and increasing the risk of severe illness and death.),Obstructive and reflex uropathy- (can cause blood-tinged urine due to back flow of urine into the kidneys or from bladder spasms.) Record review of the quarterly MDS assessment dated [DATE] indicated Resident #5 had a BIMS score of 0 out of 15 indicating his cognition was severely impaired, and he had an indwelling suprapubic catheter. Record review of a care plan revised on 09/25/2025 indicated Resident #5 had an indwelling suprapubic catheter and was at risk for frequent UTIs, dislodgement, or other complications. Goals included He will show no s/sx of Urinary infection through review date. The interventions included monitor and document intake and output as per facility policy, monitor for s/sx of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter and Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Record review of Nurse Notes from 03/02/2026-03/22/2026 for Resident #5 indicated there was no documentation related to blood being in his suprapubic catheter nor that he had pain in his groin region until the surveyor's intervention on 03/23/2026. Record review of Resident #5's order summary dated 12/20/2025 indicated there was an order that stated Check Supra Pubic leg strap for placement and change PRN every shift Record review of Resident #5's hospital after visit summary sheet dated 03/24/2026 at 6:12 a.m. indicated the reason for the visit was for Hematuria (blood in urine) and was diagnosed with urinary tract infection associated with indwelling catheter, initial encounter. He was (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	given ceftriaxone (antibiotic) injection prescribed cephalexin (Keflex)-an antibiotic to treat his UTI. Follow up instructions listed were to follow up with MD in 2 days (around 03/26/2026). During an observation on 03/23/2026 at 9:20 a.m., Resident #5 was resting in bed. He had a catheter bag on the right side of the bed. There was dark red blood that was settled at the base of the catheter tube and bright red blood at the top. There was blood noted in his drainage bag. During an observation on 03/23/2026 at 12:49 p.m., Resident #5 had bright red blood draining from his catheter tubing and into his drainage bag. The drainage bag appeared to have been emptied since the first observation. During an interview on 03/23/2026 at 1:02 p.m. with Resident #5's family member, the family member said his urine is usually medium yellow but for the past few days the family member had noticed blood in his urine. She said his urine color is usually yellow. An interview was attempted with Resident #5 on 03/23/2026 at 1:10 p.m., Resident # 5 did not reply to the surveyor's questions. During an observation and interview on 03/23/2026 1:54 p.m. with LVN L., a clot was noted inside the drainage bag approximately the size of a [NAME] half dollar. An increase of bright red blood was noted in the drainage bag. LVN L said Resident #5 had a history of having blood in his urine. She said he had not had labs ordered since 01/14/2026. She said she had noticed scant (small) amounts of blood in his urine that morning in his tubing and drainage bag. She said the assigned CNA M reported noticing light pink blood in his catheter that morning. She said she did not document nor notify the physician because she was used to seeing blood in his urine from the past. She said she did not assess his temperature or vital signs when she noticed the scant (small) amount of blood in his suprapubic catheter tubing and drainage bag. LVN L said she had not checked Resident #5's catheter since early that morning. LVN L looked at Resident #5's suprapubic catheter with surveyor confirmed the bleeding that gotten worse. She said she should have documented his change, notified the DON, and the physician that Resident #5's condition had worsened and was not at his baseline. She said she notified the physician and he ordered for the catheter to be flushed until clear. LVN L said she completed the flush as ordered by the physician. LVN L said she had been trained on assessing, documenting, and reporting. She said she could not recall how many days he had blood in his urine for the month of March and said she did not document her findings, notify the physician nor make the DON aware. She said the potential risk was Resident #5 becoming septic. During an interview and observation on 03/23/2026 at 2:05 p.m., with CNA M, she said she cared for Resident #5 on 03/21/2026 through 03/23/2026. She said on 03/21/2026 around 12:30 p.m. she and RN O were turning Resident #5 and noticed blood in his brief. CNA M said she asked Resident #5 if he was in any pain and he said yes. She said she asked him where the pain was and he replied everywhere but specified the pain was in his groin region. She said the next day, on 03/22/2026 around noon, she had noticed blood again in his brief and reported to RN O. During an observation on 03/23/2026 at 2:05 p.m. Both CNA M and the surveyor observed a clot was noted inside the drainage bag approximately the size of a [NAME] half dollar. She said the bleeding color was a lot brighter and worse than it was on Saturday and Sunday and there were no clots in his bag those days. During an interview on 03/23/2026 at 2:30 p.m., RN O said CNA M reported to her that Resident #5 had blood in his brief and a small amount in his catheter drainage bag around noon time. She said she did not recall Resident #5 saying he was in pain. She said she noticed dark blood in his catheter drainage bag approximately 300 milliliters. She said she did not call the physician because his urine is usually dark. RN O said she changed his catheter on 03/21/2026 when she noticed the bleeding. She said she could not recall the reason why she did not make a nurse's note regarding her findings and catheter change. She said it was her responsibility to document and notify the DON and physician of the blood in Resident #5's urine. During an interview on 03/23/2026 at 2:45 p.m., the DON said in the past Resident #5 had blood in his urine, but she was not made aware he had blood in his urine that started on 03/21/2026. She said she expected staff to assess, document, and notify herself and the Physician, when blood was noted in his suprapubic catheter tubing and drainage bag, to ensure Resident #5 did not have a UTI or sepsis. She said she had educated the nursing staff on documenting infections/ possible infections. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	She said in the past when Resident #5 would have blood in his urine he usually had a UTI or a blockage and that the physician would order treatment when he was made aware. She said Resident #5 was sent to the hospital on [DATE] around 2:00/3:00 a.m., as requested by the physician because he continued to have bright red blood in his urine. She said he returned to the facility 03/24/2026 with a diagnosis of a UTI and received an antibiotic. During an interview on 03/23/2026 at 3:00 p.m., with the Administrator, she said she expected staff to assess, monitor, document, and notify the DON and the physician when blood was noted in Resident #5's urine immediately to avoid a delay in care. She said staff had been educated on assessing, documenting, and notifying the DON and Physician. She said it was the nurse's responsibility to call the physician and make him aware of Resident #5's change in condition. During an interview on 03/26/2026 at 12:20 p.m., with Resident #5's Physician/ Medical Director He said he had not been made aware of blood in Resident #5's urine. He said if he had been notified by the nurses that Resident #5 had blood in his urine he would have ordered a UA, CBC, CMP to ensure Resident #5 did not have a UTI or had gone septic. He said he would expect to be notified within 2 hours of the nurse's assessment to ensure he did not have a UTI or was not septic. He said the associated potential risk for infection or sepsis.Record review of the facility's policy titled Condition & MD-Family Notification revision date: August 11, 2020, indicated- Purpose:To ensure that resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories:A significant change in the resident's physical, mental or psychosocial status. (See below for examples)A need to significantly alter treatment.Transfer of the resident from the facility.PROCEDUREWhen any of the above situations exists, the licensed nurse will contact the resident's family and their physician.Calls will be made to the family. A message may be left on an answering machine which does not give specifics but leaves a request for the facility to be called.The physician will be contacted immediately for any emergencies irrespective of the time of day.Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. Escalation of communication process: If the primary physician cannot immediately be reached in any emergency, the Medical Director [NAME] be called. If the MedicalDirector cannot be reached; the charge nurse will make arrangements for transportation to the emergency department for further evaluation and assessment.In a non-emergency situation, the primary physician will be called unless he/she has left an alternate name to call. If after two attempts, there is no response to the calls, the Medical Director will be contacted.Each attempt will be charted as to time the call was made, who was spoken to, and what information was given to the physician.Examples of Significant Changes:A sudden change in mental status including agitation, lethargy, sudden lack of responsiveness or manic behavior. Bleeding

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	675975	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was consulted regarding a need to alter treatment for 1 of 16 residents reviewed for notification of changes. (Resident #41). The facility failed to notify Resident #41's physician regarding the pattern of low blood pressure and of her low blood pressure medication being held for 14 out of 23 days for the month of March 2026. This failure could place residents at risk for complications due to delayed or failed physician intervention.Findings included:Record review of Resident #41's face sheet dated 03/25/2026 indicated she was a [AGE] year-old female admitted [DATE] with diagnoses of Alzheimer's disease with late onset (progressive disease that destroys memory and other important [NAME] l functions), dementia (loss of cognitive functioning), and hypertension (high blood pressure).Record review of Resident #41's quarterly MDS assessment dated [DATE] indicated a diagnosis of high blood pressure and a BIMS of 6. A BIMS score of 6 indicated she had severe cognitive impairment. Section GG0170. Mobility indicated she required substantial/ maximal assistance with activities of daily living. Record review of Resident #41's care plan dated 03/31/2026 indicated she had a diagnosis of hypertension (high blood pressure.) The goals listed were The resident will remain free of complications related to hypertension through review. Interventions listed were Avoid taking the blood pressure reading after physical activity or emotion distress. And Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. Record review of Resident #41's medication administration record dated March 2026 indicated Olmesartan Medoxomil Oral Tablet 40 MG (Olmesartan Medoxomil) Give 1 tablet by mouth one time a day for hypertension HOLD FOR SBP >110 (less than 110), DBP >60 (less than 60). On the following dates, the dose of the Olmesartan Medoxomil Oral Tablet 40 MG was held when Resident #41's B/P was outside the parameters ordered by the physician: -On 03/02/2026 -SBP: 103 and DBP: 54 by MA N,-On 03/03/2026- SBP: 96 and DBP: 62 by MA N,-On 03/06/2026- SBP: 104 and DBP: 72 by MA N,-On 03/08/2026-SBP: 100 and DBP: 64 by MA N,-On 03/10/2026- SBP: 105 and DBP: 74 by MA N,-On 03/12/2026- SBP: 103 and DBP: 77 by MA N,-On 03/13/2026-SBP: 102 and DBP: 50 by MA N,-On 03/14/2026-SBP: 100 and DBP: 65 by MA K,-On 03/15/2026-SBP:102 and DBP: 73 by MA N,-On 03/16/2026-SBP:105 and DBP: 58 by MA K,-On 03/17/2026- SBP:107 and DBP: 54 by MA N,-On 03/19/2026- SBP: 100 and DBP: 62 by MA N,-On 03/20/2026- SBP:101 and DBP: 54 by MA N, and-On 03/22/2026- SBP:103 and DBP:68 by MA N. During an interview on 03/24/2026 at 12:05 p.m., MA N said she did not notify her charge nurse every time she held Resident #41's blood pressure medication. She said she could not recall the reason she did not inform her charge nurse. She said she did not notify the physician regarding the blood pressure medication being held. She said she should have when she noticed the trend. MA N said she was responsible as the assigned charge nurse so she could notify the physician that Resident #5 had his blood pressure medication held. She said the potential risk to Resident #5 was her receiving a medication she no longer needed. She said she had been trained to notify her nurse when she holds any medications. During an interview on 03/24/2026 at 12:25 p.m., MA K said she did not notify her charge nurse that she held Resident #41's blood pressure medication. She said she had been taught by the DON to notify her charge nurse, and DON if a medication had been held for a consecutive amount of days. She said she was responsible for notifying the assigned charge nurse that she held Resident #41's medication. During an interview on 03/24/2026 at 12:30 p.m., LVN L said MA K and MA N did not make her aware that Resident #41's blood pressure medication was held 14 out of 23 times because her blood pressure was outside of ordered parameters. She said it was her expectation for all MAs to make their charge nurses aware of any medications that were held so they could notify the Physician. During an interview and record review on 03/24/2026 at 12:45 p.m., the DON reviewed Resident #41's March 2026 medication (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration record. The DON acknowledged that the Olmesartan Medoxomil was documented as held due to the prescribed parameters. She had been unaware of Resident #41's medications being held due to low results outside the parameters. She said best practice would be for nursing staff to notify the Physician when medications with parameters were held on consecutive occasions. The DON said the nursing staff should document in the resident's electronic record when notifying physician of medications being held and acknowledged Resident #41's electronic record gave no indication the physician had been notified of medications being held. Record review of the nurse's notes for Resident #41 dated from 03/02/2026 to 03/22/2026 indicated there was no documentation of the physician being notified that Resident #41's blood pressure medication was held. During an interview on 03/24/2026 at 2:00 p.m., the Administrator said her expectations were for the physician to be notified when a resident's medications were held, or at least every few times. The Administrator said she expected nursing staff to always follow physician orders, to notify of any changes in condition, and to document notifications.During an interview on 03/26/2026 at 12:20 p.m., Resident #41's Physician who is also the facilities Medical Director said he was not aware that Resident #41 had her blood pressure medication held 14 times as of 03/23/2026. He said he expected the MAs to report any medication they held to their charge nurse and for the charge nurse to make him aware after the 4th scheduled dose was held. He said if he had been made aware he would have reviewed her medications and discontinued the medication to prevent the potential of Resident #41 receiving a medication that was no longer needed.Record review of the facilities policy titled Condition & MD-Family Notification Revised date August 11, 2020, indicated Purpose: To ensure that resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories:A need to significantly alter treatment. PROCEDUREWhen any of the above situations exists, the licensed nurse will contact the resident's family and their physician.Calls will be made to the family. A message may be left on an answering machine which does not give specifics but leaves a request for the facility to be called.The physician will be contacted immediately for any emergencies irrespective of the time of day.Non-emergency notifications may be made the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. Escalation of communication process: If the primary physician cannot\immediately be reached in any emergency, the Medical Director [NAME] be called. If the MedicalDirector cannot be reached; the charge nurse will make arrangements for transportation to the emergency department for further evaluation and assessment.In a non-emergency situation, the primary physician will be called unless he/she has left an alternate name to call. If after two attempts, there is no response to the calls, the Medical Director will be contacted.Each attempt will be charted as to time the call was made, who was spoken to, and what information was given to the physician.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the services provided, as outlined by the comprehensive care plan, met professional standards of quality, for 2 of 6 residents (Residents #9 and #10) reviewed for services provided to meet professional standards. 1. LVN A administered gastrostomy tube (a surgical opening into the stomach from the abdominal wall for the introduction of food and medications) medications to Resident #9 without flushing the tube with water before and after medication administration or between medications on 03/24/26 during medication pass.2. LVN G mixed GlycoLax (laxative) in water then mixed crushed gastrostomy tube medications for Resident #10 with the mixture on 03/25/26 during the medication pass.3. LVN G flushed the gastrostomy tube with the GlycoLax mixture instead of water before medication administration and between medications on 03/25/26 during the medication pass. These failures could place residents at risk of inaccurate drug administration and not receiving the care and services to meet their individual needs. Findings included:1. Record review of a face sheet dated 03/24/26 indicated Resident #9 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body and is usually the result of brain damage) and hemiparesis (one-sided muscle weakness) left side, dysphagia (a condition that affects the ability to produce and understand spoken language), gastroparesis (a condition in which the muscles in the stomach don't move food as they should for it to be digested), and gastrostomy tube (a surgical opening into the stomach from the abdominal wall for the introduction of food and medications). Record review of the quarterly MDS dated [DATE] indicated Resident #9 was rarely understood by others and sometimes understood others. She had moderately impaired cognition with a BIMS of 10 out of 15. She had a gastrostomy tube, received 51% or more calories through feeding tube, and received 501cc or more per day of fluid intake through feeding tube. Record review of the care plan for Resident #9 reviewed on 03/23/26 indicated a care plan dated 10/07/24 she required tube feeding related to dysphagia. Interventions included flush gastrostomy tube with 70cc water before and after meds and 30ccbetween each medication initiated on 03/06/2026. Record review of physician orders for March 2026 indicated Resident #9 had:- an order dated 11/10/25 for NPO, diet not applicable; and- an order dated 01/22/26 flush gastrostomy tube with 70cc of water before and after medication administration and 30cc between each medication. During an observation and interview on 03/24/2026 at 8:43 a.m. LVN A administered medications via gastrostomy tube to Resident #9. LVN A did not flush the tube with water before administering the medications, did not flush the tube with water between each medication administered, and did not flush the tube with water after administering the medications. LVN A also administered Metoclopramide via gastrostomy tube. LVN A said she would not have done anything different. During an interview on 03/25/26 at 09:30 a.m. LVN A said the order for Metoclopramide should be clarified as to when to administer. She said she did not realize she did not flush the tube prior to and after the medication administration or between the medications. 2. Record review of a face sheet dated 03/24/26 indicated Resident #10 was a [AGE] year-old male admitted on [DATE]. His diagnoses included cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body and is usually the result of brain damage) and hemiparesis (one-sided muscle weakness) left side, dysphagia (a condition that affects the ability to produce and understand spoken language), and gastrostomy tube (a surgical opening into the stomach from the abdominal wall for the introduction of food and medications). Record review of the quarterly MDS dated [DATE] indicated Resident #10 usually understood by others and usually understood others. He had severely impaired cognition with a BIMS (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 04 out of 15. He had a gastrostomy tube, received 51% or more calories through feeding tube, and received 501cc or more per day of fluid intake through feeding tube. Record review of the care plan for Resident #10 reviewed on 02/02/26 indicated a care plan dated 06/19/23 he required tube feeding related to dysphagia. Interventions included flush gastrostomy tube with 30cc water before and after meds and 10ccbetween each medication initiated on 06/19/23. Record review of physician orders for March 2026 indicated Resident #10 had:- an order dated 03/04/25 for NPO, diet not applicable; and- an order dated 02/27/26 flush gastrostomy tube with 30cc of water before and after medication administration and 10cc between each medication. During an observation and interview on 03/25/26 at 08:15 a.m. LVN F administered medications via gastrostomy tube to Resident #10. LVN F:- mixed 1 capful of GlycoLax Oral Powder with 8 oz of water. - mixed 15cc of the GlycoLax mixture with each of his 5 crushed medications instead of water. - flushed the gastrostomy tube prior to administering medications with 30cc of the GlycoLax mixture instead of water. - administered 1 of the medications, mixed residual medication in the cup with the GlycoLax mixture instead of water, flushing with the GlycoLax mixture between instead of water. - administered 1 of the medications, mixed residual medication in the cup with the GlycoLax mixture instead of water, flushing with the GlycoLax mixture between instead of water.- administered 1 of the medications, mixed residual medication in the cup with the GlycoLax mixture instead of water, flushing with the GlycoLax mixture between instead of water- obtained water in a cup, administered the remaining medications with water flush between, and flushed the gastrostomy tube with 30cc of water after the medication administration. LVN F said she would not have done anything different. When surveyor asked if LVN F understood what drug cocktailing was, she said it was when medications were mixed and administered at one time. When asked if mixing the crushed medication with the GlycoLax/water mixture and flushing after each medication administration would be considered drug cocktailing, LVN F said yes it could be. During an interview on 03/25/26 at 02:18 p.m. the DON said gastrostomy tubes should be flushed with water before, after, and in between medications. She said they should not be flushed with medication in the water or mixed with water that had medication in it. She said medication should not be cocktailed because there could be a reaction of the medications mixed. She said the gastrostomy tube should always be flushed with water before medications, between medications, and after medications to ensure the tube was patent. During an interview on 03/25/26 at 02:40 p.m. the Administrator said she expected the staff giving medications to know how to do it correctly and to follow the policy. Record review of an Administering Medications through an Enteral Tube policy and procedure reviewed 03/03/2026 indicated: Purpose The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube.General Guidelines Follow the medication administration guidelines in the policy entitled Administering Medications.1. Request liquid forms of medications from the pharmacy, if possible.2. Do not add medication directly to the enteral feeding formula.3. Administer each medication separately and flush between medications.6. Use water for diluting medications and for flushing.Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure.5. Water for diluting medications;6. Water for flushing;.Steps in the Procedure.7. Stop feeding and flush tubing with at least 15 mL water (or prescribed amount).9. Dilute medication:a. Remove plunger from syringe. Add medication and appropriate amount of water to dilute.b. Dilute crushed (powdered) medication with at least 30 ml water (or prescribed amount).c. Dilute liquid medication with 30 mL or more (depending on viscosity) purified water.10. Administer each medication separately.13. If administering more than one medication, flush with 15 mL water (or prescribed amount) between medications.14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of water (or prescribed amount).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 5 errors out of 31 opportunities, resulting in a 16.13% percent medication error involving 3 of 6 residents reviewed for medication pass. (Residents #6, #9, and #10) * LVN A administered gastrostomy tube (a surgical opening into the stomach from the abdominal wall for the introduction of food and medications) medications to Resident #9 without flushing the tube with water before and after medication administration or between medications on 03/24/26 during medication pass. * LVN A administered Metoclopramide (gastrointestinal stimulant/anti nausea) to Resident #9 on continuous enteral feeding during the medication pass. * MA C administered docusate sodium (stool softener) 100mg 1 capsule to Resident #6 when the physician order was for 2 capsule during the medication pass. * LVN G mixed GlycoLax (laxative) in water then mixed crushed gastrostomy tube medications for Resident #10 with the mixture during the medication pass. * LVN G flushed the gastrostomy tube with the GlycoLax mixture before medication administration and between medications during the medication pass. These failures could place residents at risk for inaccurate drug administration and/or drug cocktailing resulting in decline in health and decreased quality of life. Findings included:1. During an observation and interview on 03/24/2026 at 8:43 a.m. LVN A administered acetaminophen (pain reliever), metroclopramide (gastrointestinal stimulant/anti nausea), amlodipine (calcium channel blocker), aspirin (non-steroidal anti-inflammatory), carvedilol (beta blocker), furosemide (diuretic), losartan (angiotensin II receptor blocker),lactobacillus acidophilus (probiotic), multivitamin, Vitamin D3, and polyethylene glycol (laxative) via gastrostomy tube to Resident #9. LVN A did not flush the tube with water before administering the medications, did not flush the tube with water between each medication administered, and did not flush the tube with water after administering the medications. LVN A also administered Metoclopramide via gastrostomy tube. LVN A said she would not have done anything different. Record review of physician orders for March 2026 indicated Resident #9 had:- an order dated 11/10/25 for NPO, diet not applicable;- an order dated 11/10/25 for metoclopramide 10 mg via gastrostomy tube before meals and at bedtime; and- an order dated 01/22/26 flush gastrostomy tube with 70cc of water before and after medication administration and 30cc between each medication. During an interview on 03/25/26 at 09:30 a.m. LVN A said the order for metoclopramide should be clarified as to when to administer. She said she did not realize she did not flush the tube prior to and after the medication administration or between the medications. 2. During an observation and interview on 03/24/2026 at 5:05 p.m. MA C administered oral medications to Resident #6. MA C was observed obtaining 1 capseal of Docusate Sodium 100 mg and administering to Resident #6. MA C said she would not have done anything different. Record review of physician order For March 2026 indicated Resident #6 had an order dated 02/21/26 for Docusate Sodium Oral Capsule 100 mg 2 capsule by mouth two times a day. During an interview on 03/25/26 at 04:01 p.m. MA C said Resident #6 should have received 2 cap seals of Colace and not just one. She said she misread it. 3. During an observation and interview on 03/25/26 at 08:15 a.m. LVN F administered medications via gastrostomy tube to Resident #10. LVN F:- mixed 1 capful of GlycoLax (laxative) Oral Powder with 8 oz of water. - mixed 15cc of the GlycoLax mixture with each of his Lorazepam (benzodiazepine), docusate sodium (stool softener), hydrocodone-acetaminophen (pain medication), metoclopramide (gastrointestinal stimulant/anti nausea), and Vitamin C crushed medications instead of water. - flushed the gastrostomy tube prior to administering medications with 30cc of the GlycoLax mixture instead of water. - administered 1 of the medications, mixed residual medication in the cup with the GlycoLax mixture instead of water, flushing with the GlycoLax mixture between instead of water. - administered 1 of the medications, mixed residual medication in the cup with the GlycoLax mixture instead of water, flushing with the GlycoLax mixture between instead of water.- administered 1 of the medications, mixed residual medication in the cup with the GlycoLax mixture instead of water, flushing with the GlycoLax mixture between instead of water- obtained (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water in a cup, administered the remaining medications with water flush between, and flushed the gastrostomy tube with 30cc of water after the medication administration. LVN F said she would not have done anything different. When surveyor asked if LVN F understood what drug cocktailing was, she said it was when medications were mixed and administered at one time. When asked if mixing the crushed medication with the GlycoLax/water mixture and flushing after each medication administration would be considered drug cocktailing, LVN F said yes it could be. Record review of physician orders for March 2026 indicated Resident #10 had:- an order dated 03/04/25 for NPO, diet not applicable; and- an order dated 02/27/26 flush gastrostomy tube with 30cc of water before and after medication administration and 10cc between each medication. Record review of an Administering Medications through an Enteral Tube policy and procedure reviewed 03/03/2026 indicated: Purpose The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube.General Guidelines Follow the medication administration guidelines in the policy entitled Administering Medications.1. Request liquid forms of medications from the pharmacy, if possible.2. Do not add medication directly to the enteral feeding formula.3. Administer each medication separately and flush between medications.6. Use water for diluting medications and for flushing.Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure.5. Water for diluting medications;6. Water for flushing;.Steps in the Procedure.7. Stop feeding and flush tubing with at least 15 mL water(or prescribed amount).9. Dilute medication:a. Remove plunger from syringe. Add medication and appropriate amount of water to dilute.b. Dilute crushed (powdered) medication with at least 30 ml water (or prescribed amount).c. Dilute liquid medication with 30 mL or more (depending on viscosity) purified water.10. Administer each medication separately.13. If administering more than one medication, flush with 15 mL water (or prescribed amount) between medications.14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of water (or prescribed amount). During an interview on 03/25/26 at 02:18 p.m. the DON said nurses should know how to administer medications through the gastrostomy tube correctly. She said gastrostomy tubes should be flushed with water before, after, and in between medications. She said they should not be flushed with medication in the water or mixed with water that had medication in it. She said medication should not be cocktailed because there could be a reaction of the medications mixed. She said the gastrostomy tube should always be flushed with water before medications, between medications, and after medications to ensure the tube was patent. She said MAs should administer the medications according to the physician orders. During an interview on 03/25/26 at 02:40 p.m. the Administrator said she expected the staff giving medications to know how to do it correctly and to follow the policy.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that residents were free of significant medication errors, for 3 of 8 residents (Residents #5, #4, and #10), reviewed for significant medication errors. * The facility did not ensure Residents #5, #4, and #10 did not receive Midodrine (medication used to raise the blood pressure) when there were parameters to hold the medication. This failure could place residents receiving medication to elevate the blood pressure at risk for stroke, hospitalization, and decreased quality of life.Findings included: 1. Record review of a face sheet dated 03/25/2026 indicated Resident #5 was a [AGE] year-old male admitted on initially admitted on [DATE] and readmitted [DATE]. His diagnoses included chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot supply enough oxygen to the blood, often due to underlying lung or systemic diseases), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), quadriplegia (is a symptom of paralysis that affects all a person's limbs and body from the neck down), tracheostomy (a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), Colostomy (an operation that creates an opening for the large intestine through the abdomen), neuromuscular dysfunction of the bladder (occurs when nerve or spinal cord problems disrupt communication between the brain and bladder, leading to loss of bladder control and urinary complications), resistance to multiple antibiotics (known as multidrug resistance, poses a significant global health threat, making infections harder to treat and increasing the risk of severe illness and death), atrial fibrillation (irregular heart rhythm). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #5 had Aa BIMS score of a 0 indicateding his cognition was severely impaired and had coronary artery disease (a common type of heart disease. It affects the main blood vessels that supply blood to the heart, called the coronary arteries. In coronary artery disease, there is reduced blood flow to the heart muscle. A buildup of fats, cholesterol and other substances in and on the artery walls, a condition called atherosclerosis, usually causes coronary artery disease. The buildup, called plaque, makes the arteries narrow.) Record review of Resident #5's care plan revision dated 09/25/2025 indicated Resident #5 had coronary artery disease (CAD) related to atrial fibrillation, hypercholesterolemia, HTN (hypertension). His interventions listed was administer all meds per MD orders. RX: Midodrine, give all cardiac meds as ordered by the physician. Monitor and document side effects. Report Adverse reactions to MD PRN, Monitor blood pressure. Notify physician of any abnormal readings Record review of physician orders dated 12/19/2025 thru 01/30/2026 indicated Resident #5 had an order for Midodrine 10mg three times a day related to atrial fibrillation (irregular heartbeat) hold for SBP > 110 (greater than). Record review of physician orders dated 01/30/2026 thru 02/24/2026 indicated Resident #5 had an order for Midodrine 10mg three times a day related to atrial fibrillation (irregular heartbeat) hold for SBP > 130 (greater than) and DBP >80 (greater than). Record review of physician orders dated 02/24/2026 thru current indicated Resident #5 had an order for Midodrine 10mg three times a day related to atrial fibrillation (irregular heartbeat) hold for SBP > 130 (greater than) and DBP >80 (greater than). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the January 2026 MAR for Resident #5 indicated Midodrine (blood pressure medication that increases the blood pressure.) was given when it should have been held on the following dates:. -on 01/01/2026- SBP: 112; the 8:00 p.m., dose given by LVN F, -on 01/05/2026- SBP: 114; the 8:00 p.m., dose given by LVN F, -on 01/06/2026- SBP: 112; the 8:00 p.m., dose given by LVN H, -on 01/07/2026- SBP: 118; the 8:00 p.m., dose given by LVN F, -on 01/08/2026- SBP: 126; the 8:00 p.m., dose given by LVN F, on 01/09/2026- SBP: 115; the 8:00 a.m., dose given by LVN L, -on 01/09/2026- SBP: 141; the 8:00 p.m., dose given by LVN F, -on 01/10/2026- SBP: 138; the 2:00 p.m., dose given by RN O, -on 01/10/2026- SBP: 129; the 8:00 p.m., dose given by RN O, -on 01/11/2026- SBP: 137; the 8:00 a.m., dose given by RN O, -on 01/11/2026- SBP: 122; the 2:00 p.m., dose given by RN O, -on 01/12/2026- SBP: 112; the 8:00 p.m., dose given by LVN F, -on 01/13/2026- SBP: 122; the 8:00 p.m., dose given by LVN F, -on 01/16/2026- SBP: 115; the 8:00 p.m., dose given by LVN F, -on 01/20/2026- SBP: 125; the 8:00 p.m., dose given by LVN F, -on 01/22/2026- SBP: 128; the 8:00 p.m., dose given by LVN F, -on 01/23/2026- SBP: 1117; the 8:00 a.m., dose given by LVN L, -on 01/24/2026- SBP: 132; the 2:00 p.m., dose given by RN O, -on 01/24/2026- SBP: 122; the 8:00 p.m., dose given by RN O, -on 01/25/2026- SBP: 129; the 8:00 a.m., dose given by RN O, -on 01/25/2026- SBP: 136; the 2:00 p.m., dose given by RN O, -on 01/25/2026- SBP: 122; the 8:00 p.m., dose given by RN O, -on 01/26/2026- SBP: 126; the 8:00 p.m., dose given by LVN F, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-on 01/27/2026- SBP: 132; the 8:00 p.m., dose given by LVN F, and -on 01/28/2026- SBP: 118; the 2:00 p.m., dose given by LVN H. Record review of the February 2026 MAR for Resident #5 indicated Midodrine was given when it should have been held. -on 02/08/2026- SBP: 133; the 8:00 p.m., dose given by RN O, -on 02/15/2026- SBP: 137; the 2:00 p.m., dose given by RN O, -on 02/17/2026- SBP: 119; the DBP: 86; the 8:00 p.m., dose given by LVN H, -on 02/25/2026- SBP: 129; the DBP:86; the 8:00 p.m., dose given by LVN J and -on 02/15/2026- SBP: 138; the 2:00 p.m., dose given by RN O. Record review of the March 2026 MAR for Resident #5 indicated Midodrine was given when it should have been held. -on 03/02/2026- SBP: 132; the 8:00 p.m., dose given by LVN P, -on 03/02/2026- SBP: 131; the 8:00 p.m., dose given by LVN P, -on 03/12/2026- SBP: 120; the DBP: 88; 8:00 p.m., dose given by LVN P, -on 03/18/2026- SBP: 130; the DBP: 82; 8:00 p.m., dose given by LVN P, -on 03/21/2026- SBP: 133; 8:00 p.m., dose given by RN O, and -on 03/21/2026- SBP: 131; 8:00 p.m., dose given by RN O. An interview was attempted 03/24/2026 at 11:15 a.m., with LVN J, a voicemail was left on her telephone. During an interview on 03/25/2026 at 11:49 a.m., with RN O, she said Midodrine is used to increase the blood pressure when it is low. She said she was aware that Midodrine had parameters and when a resident's blood pressure is outside of the ordered parameter then the blood pressure medication should be held. She said she should have held the Midodrine when Resident #5's blood pressure was out of the physician's ordered parameters. She said she was not aware that she had made the medication errors. She said the potential risk was a stroke. During an interview on 03/25/2026 at 12:45 a.m., with LVN P, she said she said she was not sure of what the medication Midodrine was used for. She said she assumed it helped with the blood pressure. She said Midodrine had a parameter for when to hold and when to give. She said she would hold the Midodrine if a resident's BP was 132/60. She said she should have held the Midodrine when his blood pressure was out of the parameters (hold for systolic blood pressure greater than 130 and hold for a (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diastolic blood pressure greater than 80). She stated I'll just be honest with you, I did not know what Midodrine was used for when I had administered, I thought it lowered the blood pressure she said she did not find out the use for Midodrine until two weeks ago from 03/25/2026 while working at the hospital. She stated, once I learned what the purpose of the medication Midodrine I realized I had been giving it when I should have held it. She said when she realized she had administered the Midodrine incorrectly she did not notify the DON. She said she did not report it earlier because she did not know she had made a medication error. She said once she became aware that she made a medication error, she did not report it to the DON or the physician. She said she did not know why she did not go back and report her error once she realized she made the error. She said she had read the parameters for Midodrine before she administered it. She stated I was confused on the medication and got the greater than and less signs backwards. She said she should have held the Midodrine when his bp was out of the parameter (hold for systolic blood pressure greater than 130 and hold for a diastolic blood pressure greater than 80.) She said she did not ask the DON or any other nurses for clarification on Midodrine. She said she did not know why she did not ask the DON or the other nurses for clarification on the medication. She said if the documentation reflects that she did not pay attention to the parameters for the Midodrine then that's what happened. During an interview on 03/25/2026 at 12:49 p.m., with LVN H, she said Midodrine is used to increase the blood pressure when it is low. She said she was aware that Midodrine had parameters and when a resident's blood pressure is outside of the ordered parameter then the blood pressure medication should be held. She said she should have held the Midodrine when Resident #5's blood pressure was out of the physician's ordered parameters. She said she was not aware that she had made the medication errors. She said she always reads the MAR's before administering medications. She said she could not recall the reason why she did not hold the Midodrine. She said the potential risk to Resident #5 was getting a medication he did not need. During an interview on 03/25/2026 at 1:00 p.m., with LVN F, she said Midodrine is used to increase the blood pressure when it is low. She said she was aware that Midodrine had parameters and when a residents blood pressure is outside of the ordered parameter then the blood pressure medication should be held. She said she was not aware that she had made the medication errors. She said the potential risk to Resident #5 would be his blood pressure staying elevated. During an interview on 03/25/2026 at 1:10 p.m., with LVN L, she said Midodrine is used to increase the blood pressure when it is low. She said she was aware that Midodrine had parameters and when a residents blood pressure is outside of the ordered parameter then the blood pressure medication should be held. She said she did not know why she did not hold the Midodrine. She said the potential risk to Resident #5 would be him potentially experiencing symptoms of high blood pressure. During an interview on 03/25/2026 at 1:16 p.m., with the DON, she said she did a medication audit for January 2026 and noticed the nurses had given Midodrine when it should have been held due to residents blood pressure being outside ordered parameters. She said she made the physician aware and received a new physician's order that increased the blood pressure parameters. She said she did not continue auditing monthly instead she audited every quarter. The DON said it is MA's and CNA's responsibility to ensure they administered medications according to the physician's order. She said she educated staff on ensuring they read and followed the physician's parameters. She said the associated potential risk was medication errors. During an interview on 03/25/2026 at 2:05 p.m., the Administrator said she expected staff to read and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abide by the blood pressure parameters listed on the MAR. She said the associated potential risk was resident's experiencing symptoms of hypertension and medication errors. During an interview on 03/26/2026 at 12:20 p.m., the Physician/ Medical Director said, it was very important for nursing staff that administer medications follow the MAR. He said he was not aware that Resident #5 was given Midodrine several times when it should have been held. He said he expected staff to ensure they were administering medications as ordered to avoid medication errors and the potential of residents experiencing a stroke. Record review of the facilities policy titled Medication Error Reporting Protocol Identifying and Managing Medication Errors and Adverse Consequences date reviewed 3/3/2026 Indicated: Policy: Staff and Practitioners shall try to prevent medication errors and adverse medication consequences and shall strive to identify and manage them appropriately when they occur. Protocol: 1. The staff and practitioner shall strive to minimize adverse consequence by: Following relevant clinical guidelines and manufacture's specifications for use, dose, administration, duration, and monitoring of the medications. Defining appropriate indications for use; and Deterring that the resident: 1. Has no known allergies to a medication Is not taking other medications, nutritional supplements, including herbal products, or foods that would be incompatible with the prescribed medication; and Has no condition, history, or sensitivity that would preclude use of that medication. The staff shall report clinically significant adverse medication consequences and medication errors with adverse clinical consequences to the DON/designee immediately. The staff shall complete the Medication Error report in its entirety, including appropriate notification of physician, etc. In the event of a clinically significant adverse medication consequence, nursing staff shall implement and follow any related physician orders, and shall monitor the resident as indicated. 5. The Medical Director, DON and Consultant Pharmacist shall review medication errors and adverse medication consequences as part of the facility QA process.? (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facilities policy titled Medication Administration Reviewed & Revised 3/5/2026 indicated: 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. The Director of Nursing or designee supervises and oversees all personnel involved in medication administration. Staffing schedules are arranged to promote safe medication administration without unnecessary interruption. Medications are administered according to prescriber orders and within the ordered time frames. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication; preventing potential medication or food interactions; and honoring resident choices and preferences, consistent with his or her care plan. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. 2. Record review of a face sheet dated 03/24/26 indicated Resident #4 was a [AGE] year-old male admitted on [DATE]. His diagnoses included hypotension (a condition in which the force of the blood against the artery walls is too low). Record review of the quarterly MDS dated [DATE] indicated Resident #4 was understood by others and understood others. He had intact cognition with a BIMS of 15 out of 15. He had an active (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosis of hypotension. Record review of the care plan for Resident #4 revised on 12/29/25 indicated a care plan dated 06/12/25 indicated he had hypotension with risk for changes in cognition and falls related to fluctuating blood pressures initiated on 06/19/23. Interventions included: - Give medications as ordered. Initiated 06/12/25; and - follow parameters set by MD for medication administration. Initiated 01/30/26 Record review of physician orders for March 2026 indicated Resident #4 had an order dated 03/25/26 for Midodrine 10mg every 8 hours related to hypotension hold for SBP greater than 130 or DBP greater than 80. Record review of the February 2026 MAR for Resident #4 indicated: - on 02/01-SBP was 136; the 09:00 a.m. dose was given; - on 02/02-SBP was 137; the 01:00 p.m. dose was given; - on 02/03-SBP was 135; the 01:00 p.m. dose was given; and - on 02/11-SBP was 142; the 01:00 p.m. dose was given. Record review of the March 2026 MAR for Resident #4 indicated: - on 03/02-SBP was 132; the 09:00 a.m. dose was given; - on 03/02-SBP was 135; the 09:00 p.m. dose was given; - on 03/05-SBP was 148; the 01:00 p.m. dose was given; - on 03/06-SBP was 132; the 09:00 a.m. dose was given; - on 03/09-SBP was 136; the 09:00 a.m. dose was given; - on 03/13-SBP was 133; the 01:00 p.m. dose was given; - on 03/16-SBP was 139; the 09:00 a.m. dose was given; - on 03/16-SBP was 138; the 01:00 p.m. dose was given; - on 03/19-SBP was 138; the 09:00 a.m. dose was given; - on 03/19-SBP was 140; the 01:00 p.m. dose was given; and - on 03/24-SBP was 140; the 09:00 a.m. dose was given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of a face sheet dated 03/24/26 indicated Resident #10 was a [AGE] year-old male admitted on [DATE]. His diagnoses included hypotension (a condition in which the force of the blood against the artery walls is too low). Record review of the quarterly MDS dated [DATE] indicated Resident #10 usually understood by others and usually understood others. He had severely impaired cognition with a BIMS of 04 out of 15. He had an active diagnosis of orthostatic hypotension. Record review of the care plan for Resident #10 reviewed on 02/02/26 indicated a care plan dated 06/19/23 indicated he had hypotension with risk for changes in cognition and falls related to fluctuating blood pressures initiated on 06/19/23. Interventions included: - Give medications as ordered. Initiated 06/19/23; - Monitor vital signs as needed. Notify MD of significant abnormalities. Initiated 06/19/23; and - follow parameters set by MD for medication administration. Initiated 01/30/26. Record review of physician orders for March 2026 indicated Resident #10 had an order dated 02/09/26 for Midodrine 10mg every 8 hours related to hypotension hold for SBP greater than 140 or DBP greater than 90. Record review of the February 2026 MAR for Resident #10 indicated: - on 02/21-DBP was 98; the 12:00 p.m. dose was given; - on 02/22-DBP was 92; the 12:00 p.m. dose was given; and - on 02/24-SBP was 145 and DBP was 91; the 07:00 p.m. dose was given. Record review of the March 2026 MAR for Resident #10 indicated: - on 03/10-SBP was 147; the 12:00 p.m. dose was given; - on 03/14-SBP was 147; the 12:00 p.m. dose was given; - on 03/16-SBP was 145; the 12:00 p.m. dose was given; - on 03/18-SBP was 151 and DBP was 104; the 12:00 p.m. dose was given; and - on 03/18-SBP was 154; the 07:00 p.m. dose was given.

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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. Based on observation, interview, and record review, the facility failed to ensure the planned menus were followed and prepared according to the weekly menu for 1 of 4 meals reviewed for food and nutrition services. (Lunch meal) The facility failed to ensure the menu was followed for the lunch meal on 03/23/2026. This failure placed the residents at risk of not receiving meals that are adequate to meet their nutritional needs and a decline in nutritional health status.The findings included:Review of the facility's weekly menu, for Week 4, dated 03/12/2026 indicated the following menu plan:03/23/2026 Monday Lunch: Smothered Chopped steak, black-eyed peas, spinach, garlic cheese biscuit, sherbert, tableside condiments, water and choice of beverage. Review of the Menu board posted outside of the dining room on 03/23/2026 at 11:28 a.m. indicated the following: lunch menu for the day: spaghetti, tossed salad, vegetable blend, garlic cheese biscuit, and sherbert. No substitute or Everyday Menu posted in the dining room. There was no weekly menu posted in the dining room.During a dining room observation on 03/23/2026 at 12:30 p.m., residents were served spaghetti noodles, with spaghetti sauce (with ground meat in the sauce), tossed salad (lettuce and tomatoes), vegetable blend (carrots, green beans), garlic biscuit, beverage (tea or lemonade) and condiments. During an interview on 3/23/2026 at 3:00 p.m., the DM indicated the lunch meal for 03/23/2026 calendar a week at a glance included Smothered Chopped steak, black-eyed peas, spinach, garlic cheese biscuit, sherbert, tableside condiments, water and choice of beverage. She stated this menu was not served because the new supplier they recently changed too had not delivered the order and the DDM told her to prepare and serve spaghetti, tossed salad, vegetable blend, garlic cheese biscuit, and sherbert. The DM stated the residents had a right to know in advance what they were receiving for meals so they could choose an alternative if they did not like what was being served. She said that the weekly menu was in a frame up on the wall in the dining room but had fallen and the glass shattered and signage not replaced. She said the new supplier does have a weekly menu at a glance, everyday menu and substitute meals. She stated the registered dietician came in on 03/23/2026 and reviewed the weekly menu and was aware of the lunch menu change for 03/23/2026 but did not update the menu provided to the surveyor. She said that she would make sure that the weekly menu, everyday menu and available substitutes are posted in the dining room and provided to residents that do not visit or eat in the dining room. She said some residents would get upset if they were not served what the menu called for because they were either looking forward to it or they would have wanted to consider their options or decrease in nutritional health.During an interview on 03/25/2026 at 4:10 p.m., with the DDM, he said that new vendor/supplier had provided a menu when they changed suppliers. He said that the new menu was scheduled to be served but the supply truck was not delivered as planned so the lunch menu for 03/23/2026 had to be changed. He said he directed the kitchen staff to prepare spaghetti noodles, spaghetti meat sauce, tossed salad, vegetable blend, and roll/biscuit instead. He said the facility started using the new supplier and menus in March of this year. He said that the facility had decided to make the supplier change due to grievances from the resident council meetings. He said the menu change was approved by the registered dietician, but the weekly menu provided to the survey team was not updated. He said the dietary team have an alternate substitute menu, and everyday available menu. He said he was not aware that the alternate substitute menu, everyday available menu and weekly menu were supposed to be posted in the dining room. He said that he provided the weekly menu to the staff to be delivered to the residents' rooms. He said residents should be offered what is on the printed weekly menu or a substitute of equal nutritional value and residents should be notified of any alterations of the daily menu. He said that he would verify that the weekly menu, everyday available menu and substitute menu was posted in the dining room and available for other residents that do not visit the dining room. During an interview on 03/25/2026 at 4:30 p.m., with the Administrator, she reported she had been working with dietary staff (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and got a new food/meal supplier as of March 2026 and the supply truck had been delayed this week. She said she was not aware that the dietary staff changed the lunch menu on 03/26/2026 from the scheduled menu. She reported she will ensure the menus and meal preparations are carried out following the scheduled menus and if a change is required that notifications are provided. She said that she was aware that the daily menus, everyday available menu and substitute menus were to be posted in the dining room and provided to applicable residents. She said she thought that the weekly scheduled menu was posted in the dining room but was unable to locate the signage during a tour but did locate a weekly scheduled menu at the nurses' station on the self near the resident sign out book. She said changing the menus without notifications could cause residents to not know the meal and unable to request substitute if desired which could lead to unmeet nutritional needs and a decline in nutritional health status. Record review of the facility policy, Menus dated May 2014, indicated Policy Statement It is in the center policy that menus are planned in advance to meet the nutritional needs of the resident patience in accordance with the recommended dietary allowance of the National Research council and National Academy of science menus will be developed to meet the criteria through the use of an approved menu planning guide. Action Steps. 6. The menus are served as written unless changed in response to preference unavailability of an item or a special meal. 8. Menus are posted in the nutritional service department dining room and resident patient care areas.

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	675975	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Rehabilitation and Nursing Center	705 N Main St Lumberton, TX 77657

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessment was electronically transmitted to the CMS System for 1 of 18 residents (Residents #56) records reviewed for resident assessments. The facility failed to ensure the discharge MDS assessment was completed and transmitted as required for Resident #56. This failure could place residents at risk of not receiving care and services as needed.Findings included: Record review of admission record for Resident #56, dated 03/26/2026, indicated Resident #56 was admitted on [DATE], was an [AGE] year-old female with diagnoses of ventricular premature depolarization (an early heartbeat originating from the heart's ventricles, causing a temporary disruption in the normal heart rhythm), dementia (loss of cognitive functioning), diabetes mellitus type 2 (a chronic condition that affects the way the body processes blood sugar), anxiety (persistent and excessive worry that interferes with daily activities), high blood pressure, and muscle weakness. The admission record included the date of discharge was 11/22/2025. Record review of CMS system indicated Resident #56 had a resident assessment/ MDS record over 120 days old. Record review of Resident #56's discharge MDS assessment, dated 11/25/2025, indicated she was discharged on 11/22/2025 with 11/25/2025 as the completion date (Z0500B) the RN Assessment Coordinator signed assessment however the MDS was not transmitted. Record review of the electronic record for Resident #56's list of MDS assessments, dated 10/12/2025 to 11/22/2025, indicated the discharge MDS was signed and completed, but not transmitted. During an interview on 03/25/2026 at 1:00 p.m., the MDS Nurse said Resident #56's discharge assessment was completed and signed on 11/22/2025 and was batched and sent to software for submission to CMS. She said she was unsure why Resident #56's discharge was not transmitted to CMS as required. She reviewed Resident #56's discharge assessment and identified that the assessment had been labeled as do not submit to CMS in the transmitting process. She identified the error, after surveyor's intervention, and corrected the error and submitted Resident #56's discharge MDS as a modification on 3/25/2026. She said that she was responsible for verifying that the MDS was completed and accurate, including identifying which MDS was to be transmitted to CMS and changing the status. She said that was an entry error and Resident #56's discharge MDS should have been transmitted to CMS within 14 days after completion. During an interview on 03/26/2026 at 2:50 p.m., the DON said the MDS nurse was responsible for the timely completion and transmitting each MDS assessment to CMS. She said the expectations were for all MDS assessments to be completed accurately, timely, and transmitted to CMS as the MDS reflected the resident and necessary care and services provided. During an interview on 03/26/2026 at 2:55 p.m., the Administrator, and CCS said the MDS nurse was responsible for the timely completion and transmitting each MDS assessment to CMS. CCS said that the regional MDS staff monitors the facility MDS for completion and transmissions and report to each facility outstanding MDS, not sure how Resident #56's discharge MDS got missed. They said the expectations were for all MDS assessments to be completed accurately, timely, and transmitted to CMS as the MDS reflected the resident care and services provided. Record review of the facility's policy titled, MDS 5.1 Transmitting MDS Data, dated October 2025, indicated, . Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. - Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 (care plan completion date) + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B (Date RN Assessment Coordinator signed assessment as complete) + 14 days).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: without adequate indication for its use) for 1 of 5 residents (Residents #9) reviewed for unnecessary medications. The facility failed to hold Resident #9's Carvedilol (used to lower blood pressure) medication (for 2 administration) when the blood pressure was outside the prescribed parameters. These failures could place residents at risk for at risk for adverse reactions and decline in health condition .Findings included:Record review of Resident #9's face sheet indicated a [AGE] year-old female admitted on [DATE] with diagnosis of stroke affecting her left non-dominant side with paralysis, high blood pressure, and difficulty swallowing with a feeding tube. Record review of Resident #9's quarterly MDS assessment, dated 02/15/2026, indicated a BIMS score of 10 indicating Resident #9 was moderately impaired cognitively. Hypertension was included as one of Resident #9's diagnoses. She had difficulty swallowing with a feeding tube in place for nutrition, hydration, and medication administration. Record review of Resident #9's care plan revision date of 09/18/2025 indicated a diagnosis of hypertension. Interventions included Give medications for hypertension, monitor vital signs and notify MD of significant abnormalities, and assess for any side effects. Record review of Resident #9's physician orders indicated the following:Carvedilol Tablet 12.5 mg give 1 tablet via PEG-Tube two times a day related to hypertension hold if SBP less than 110 or heartrate less than 60 started on 11/11/2025. Record review of Resident #9's January and March 2026 MAR indicated the following:Resident #9 received Carvedilol 12.5 mg when the vital signs were outside the prescribed parameters:- 01/04/2026 at 8:00 a.m., the BP was 109/65 administered by LVN E.- 03/14/2026 at 8:00 a.m., the BP was 106/54 administered by LVN D. During observation and interview on 03/24/2026 at 10:10 a.m., indicated Resident #9 was lying in hospital bed, she was alert and no signs of distress were noted. Resident #9 did not mention any concerns regarding her Carvedilol (B/P medication) when she was asked if she had any issues regarding her medications. During an interview on 03/26/2026 at 2:15 p.m., LVN D said on 3/14/2026 at 8:00 a.m. she said that Resident #9 had several blood pressure medications and ask if she held the other B/P medications on that morning, she said if the other B/P medications were held then she must have just clicked the administered box by error and she would not have given just the one B/P medication if the B/P was below the set parameters. She said she received in-services from the facility especially regarding medication administration, unnecessary medications, medication errors and that she received in-services, and the consulting pharmacist had observed her do a medication pass. She said a negative effect if a resident received a medication that was not accurate would be a medication error and the resident could have received a dose that was not needed and caused her B/P to drop low. Attempted to contact LVN E for an interview, was unsuccessful on 3/24/2026 at 2:45 p.m. and 3/26/2026 at 2:30 p.m., left message with no return call. During an interview on 03/26/2026 at 3:00 p.m., the DON, Administrator, and Regional Nurse said the expectations were for all medications to be administered per physician orders including according to parameters. They said the Medication Aide or Nurse administering medications on the cart are responsible for following the physician orders written on the medication administration record. They said an adverse effect a resident could experience receiving a medication incorrectly would depend on the medication, but this failure could result in resident's blood pressure becoming lower. A facility policy titled Administering Medications revised dated August 2022 indicated the following. 4. Medications are administered according to prescriber orders and within the ordered timeframe.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #9) observed for dressing changes. * LVN A did not change gloves, sanitize/wash hands between glove changes, and touched clean items with dirty gloves when providing dressing change to Resident #9. This failure could place residents at risk of exposure to communicable diseases and infections. Findings included: Record review of a face sheet dated 03/24/26 indicated Resident #9 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included gastrostomy tube (a surgical opening into the stomach from the abdominal wall for the introduction of food and medications). Record review of the quarterly MDS dated [DATE] indicated Resident #9 was rarely understood by others and sometimes understood others. She had moderately impaired cognition with a BIMS of 10 out of 15. She had a gastrostomy tube, received 51% or more calories through feeding tube, and received 501cc or more per day of fluid intake through feeding tube. Record review of the care plan for Resident #9 reviewed on 03/23/26 indicated a care plan dated 10/07/24 she required tube feeding related to dysphagia. Record review of physician orders for March 2026 indicated Resident #9 had an order dated 11/10/25 for every shift cleanse gastrostomy tube site with soap and water, pat dry, apply split gauze, and secure. During an observation and interview on 03/24/26 at 08:43 a.m. LVN A provided gastrostomy tube dressing change to Resident #9. After removing the dressing, she cleaned the area. She then without changing her gloves and performing hand hygiene obtained the clean dressing and applied it to the gastrostomy tube site. She said she would not have done anything different. During an interview on 03/25/26 at 09:30 a.m. LVN A said gloves were to be changed between dirty procedures and clean procedures. She said anytime gloves were changed hands were to be washed or use hand sanitizer prior to putting on clean gloves. She said clean items should not be touched with gloves used to clean a wound or gastrostomy tube site. She said she should have removed the gloves she used to clean Resident #9's gastrostomy tube site, sanitized her hands, and put on clean gloves before touching the dressing and applying it. She said using the same gloves could extend or worsen an infection if a resident had one. During an interview on 03/25/26 at 02:18 p.m. the DON said gloves should be changed between dirty and clean procedures. She said hand hygiene should be done between glove changes. She said clean dressings should not be touched with dirty gloves. During an interview on 03/25/26 at 02:40 p.m. the Administrator said she expected the staff providing dressing changes to know how to do it correctly and to follow the policy. Record review of a Handwashing/Hand Hygiene Residents policy dated 03/01/20 indicated: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Record review of CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 07/27/24 indicated: .When to change gloves and clean hands: * If gloves become damaged. * If gloves become soiled with blood or body fluids after a task. * If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs. * If moving from one patient to another patient. * If they look dirty or have blood or body fluids on them after completing a task. * Before exiting a patient room.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and test the automated external defibrillator according to the manufacturer's guidelines for 1 of 1 facility automated external defibrillators reviewed for physical environment. 1. The facility did not maintain a working automated external defibrillator (AED - used during sudden cardiac arrest) for use in the administration of CPR. On [DATE], the AED was beeping, electrodes were not attached, and the machine had a red x indicating the AED was not in safe operating condition.2. The facility had not tested the AED according to the manufacture's guidelines from [DATE] to [DATE] (total of 23 days).These failures could place residents who had a full code status at risk of not receiving necessary life-saving measures, decline in health, and death. Findings included:During an observation on [DATE] at 2:30 p.m., the only available AED for the facility was sitting in a holder that was attached to the wall outside of the nurse's station. The AED had a black zipped case and was intermittently beeping, electrodes were not attached and the machine had a red x indicator light on.During an observation and interview on [DATE] at 2:43 p.m., the DON removed the AED from the case and said the AED was beeping. The DON verified and said the AED electrode pads were not attached to the machine. She said the night nurses (LVN H and LVN J) were responsible for conducting readiness checks on the AED and documenting those checks which included checking for expired AED pads and evidence of machine functioning properly like not beeping and a green check mark to indicate ready to use. The DON said she was not aware that the AED was not ready for use. The DON said CPR included the use of the AED. The DON said 9/2025 the nurses were trained on the AED but the trainer used a different AED from what the facility had on had. She said if a resident experienced cardiac arrest during the time the AED was not functional, the facility would still be able to do CPR but not use the AED. The DON said the nurses were trained on AED but it was not the specific AED the facility uses and that nurses had CPR cards and training included AED. The DON stated she would get with the Administrator to either re-place the AED or figure out how to get it ready for use. DON said she would create a form to include what nurse is checking on the AED.During an interview on [DATE] at 3:42 p.m., the Administrator said she had not noticed that the AED electrodes were not attached, machine beeping or that there was a red x mark. The Administrator said the nighttime nurses were responsible for checking the AED and documenting the results every night. When a policy was requested, the Administrator stated she believed there was a policy, but she was not sure. The Administrator said if the facility did not have a policy on the AED they would use the manufacture's manual online. During an observation on [DATE] at 9:50 a.m., the AED was hanging on the wall outside of the nurse's station; the green check mark light, indicating operational readiness, was illuminated, the electrodes were attached, and the device was not beeping. During an interview on [DATE] at 3:30 p.m., LVN J said she worked the 10p-6a shift and she had not received instruction from the facility about how to check the current AED for readiness pads until yesterday from the DON. She said she would just check to make sure it was available part of the crash cart checklist. LVN J said she know to check for a green check mark which meant it was fine and put a check mark on her checklist, but if the green check mark was not on and it was a red x mark, that usually meant the AED was not functional and would get with the Administrator. LVN J said she now has a form to document green check mark and AED electrodes are attached. She said not having a functioning AED could maybe cause a delay in using the AED for CPR.During an interview on [DATE] at 4:52 p.m., LVN H she worked the 10p-6a shift and she had not received instruction from the facility about how to check the current AED for readiness pads until yesterday from the DON. She said she was not aware of the AED not functioning. LVN H said she would just check to make sure it was available part of the crash cart checklist. She said not having a functioning AED could maybe cause a delay in using the AED for CPR.Record Review of the facility form(old form) titled Crash Cart Checklist indicated a check mark in the box (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	labeled AED#1. There was no indication a red x or green check mark, electrodes attached or beeping alert. The revised form(new form) included areas of current daily date, green check visible, no red x, pads present, battery ok, no beeping, issues and staff initials.Record Review of an undated list indicated 47 residents wished to be resuscitated in the event of cardiac arrest.Record review of on-line owner's manual for the [NAME] Fully Automatic AED Plus Administrator's Guide, obtained on [DATE] at 3:30 p.m., at https://www.[NAME].com/-/media/Product-Materials/product-manuals/aed-plus-fully-automatic/01/9650-0311-(indicated: Safety Summary: Use the Fully Automatic AED Plus unit only as described in this manual. Improper use of the device can cause death or injury.DO NOT use or place the Fully Automatic AED Plus unit in service if the unit's status indicator window (located on the left side of the handle) displays a red X. DO NOT use or place the Fully Automatic AED Plus unit in service if the unit emits a beeping tone.Keep the electrode cable connected to the Fully Automatic AED Plus unit at all times.This device should only be used by properly trained individuals.If the device is stored outside the recommended environmental conditions, the electrode pads and/or batteries may be damaged or their useful life reduced.This device is intended for use by personnel who have been trained in its operation.Record review of the facility's policy titled Automatic External Defibrillator, dated [DATE] read in part: Policy the facility has Automatic External Defibrillator(AED) equipment available for emergency use.5. Follow manufacturer guidelines and operating procedures, including pre-programmed voices prompts for use of the AED.Maintenance. The Director of Nursing or designee will test and document the operating status of the AED in accordance with manufacturer's guidelines.