STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Gardens Wellness & Rehabilitation	716 Mimosa Street Mineola, TX 75773

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 4 residents (Resident #3) reviewed for resident abuse. The facility failed to ensure CNA D did not handle Resident #3 roughly when he provided incontinent care. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: Record review of Resident #3's face sheet dated 04/14/2026, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included infectious gastroenteritis and colitis (inflammation of the stomach, intestines, and colon caused by an infection), essential primary hypertension (high blood pressure), and benign prostatic hyperplasia with lower urinary tract symptoms (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine). Record review of Resident #3's Comprehensive MDS assessment dated [DATE] indicated he was understood by others, and he understood others. Resident #3 had a BIMS score of 15, which indicated his cognition was intact. Resident #3 was dependent on staff for toileting, showering/bathing, dressing, and personal hygiene. Record review of Resident #3's care plan initiated 03/31/2026 did not address the level of assistance Resident #3 required for ADLs. During an interview on 04/14/2026 at 1:51 PM, Resident #3 said when he first came to the facility, he needed to be changed because he was dirty, and there was a male CNA that was very rough with him. Resident #3 was unable to provide a specific date. Resident #3 said even when the CNA was wiping him, he was being rough. Resident #3 said he should not have been treated that way because the staff were there to help him, and they were supposed to be gentle when providing care, turning, and wiping him. Resident #3 said he reported the CNA to the nurse when it happened, and to the Administrator the next day. Resident #3 said the Administrator told him she would investigate it, and she never came back to tell him anything. Resident #3 said the CNA had not provided care to him again. During an interview on 04/14/2026 at 4:29 PM, the ADON said on 04/09/2026 COTA C reported to her that Resident #3 said a staff member was rough with him. The ADON said Resident #3 told her a staff member was rough with him when he was changing him. The ADON said Resident #3 told her it was a man with glasses, beard. The ADON said Resident #3 also reported to her his right rib cage was hurting. The ADON said when she looked at the schedule, she identified the staff as CNA D. The ADON said she reported Resident #3's allegations to the Administrator as soon as she was able to on 04/09/2026 because it was an allegation of abuse. The ADON said she told the Administrator Resident #3 had made a complaint of abuse. The ADON said Resident #3's rib cage pain could have been from an assisted fall he had the day before, and they got an x-ray, and it was negative. The ADON said she completed a skin assessment on Resident #3, and he had no redness or bruising. The ADON said it was important for all allegations of abuse to be reported and investigated because allegations could be true and the residents could get hurt and so abuse allegations could be addressed in a timely manner. The ADON said the DON was not available for interview. During an interview on 04/14/2026 at 4:59 PM, COTA C said Resident #3 reported to her that in the middle of the morning/dark hours/early morning on 04/09/2026 a gentleman with glasses came in his room and (continued on next page)

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

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 4 residents (Resident #3) reviewed for abuse. The facility failed to implement their abuse policy when the Administrator failed to report to HHSC after the ADON reported to the Administrator an allegation of abuse made by Resident #3 on 04/09/2026. This failure could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life.Findings included: Record review of the facility's policy titled, Abuse Prevention and Prohibition Program revised 10/24/2022, indicated, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems. IX. Reporting/Response A. Facility Staff are Mandatory Reporters i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults. B. Administrator, or his/her designee, as Abuse Coordinator i. In order to facilitate reporting, ensure confidentiality, and promote order at the facility, the Administrator, or his/her designee, shall be the individual who reports known or suspected instances of abuse of residents at the facility to the proper authorities. C. All mandated reporters will report reasonable suspicion of a crime against a resident when it is objectively reasonable for a person to entertain a suspicion of conduct that appears to be financial abuse, physical abuse, neglect, abandonment, isolation, abduction or other treatment resulting in physical harm or pain or mental suffering, deprivation of goods or services that are necessary to avoid physical harm or mental suffering. The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime i. Immediately, but no later than 2 hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation). Record review of Resident #3's face sheet dated 04/14/2026, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included infectious gastroenteritis and colitis (inflammation of the stomach, intestines, and colon caused by an infection), essential primary hypertension (high blood pressure), and benign prostatic hyperplasia with lower urinary tract symptoms (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine). Record review of Resident #3's Comprehensive MDS assessment dated [DATE] indicated he was understood by others, and he understood others. Resident #3 had a BIMS score of 15, which indicated his cognition was intact. Resident #3 was dependent on staff for toileting, showering/bathing, dressing, and personal hygiene. Record review of Resident #3's care plan initiated 03/31/2026 did not address the level of assistance Resident #3 required for ADLs. During an interview on 04/14/2026 at 1:51 PM, Resident #3 said when he first came to the facility, he needed to be changed because he was dirty, and there was a male CNA that was very rough with him. Resident #3 was unable to provide a specific date. Resident #3 said even when the CNA was wiping him, he was being rough. Resident #3 said he should not have been treated that way because the staff were there to help him, and they were supposed to be gentle when providing care, turning, and wiping (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him. Resident #3 said he reported the CNA to the nurse when it happened, and to the Administrator the next day. Resident #3 said the Administrator told him she would investigate it, and she never came back to tell him anything. Resident #3 said the CNA had not provided care to him again. During an interview on 04/14/2026 at 4:29 PM, the ADON said on 04/09/2026 COTA C reported to her that Resident #3 said a staff member was rough with him. The ADON said Resident #3 told her a staff member was rough with him when he was changing him. The ADON said Resident #3 told her it was a man with glasses, beard. The ADON said Resident #3 also reported his right rib cage was hurting. The ADON said when she looked at the schedule, she identified the staff as CNA D. The ADON said she reported Resident #3's allegations to the Administrator as soon as she was able to on 04/09/2026 because it was an allegation of abuse. The ADON said she told the Administrator Resident #3 had made a complaint of abuse. The ADON said Resident #3's rib cage pain could have been from an assisted fall he had the day before, and they got an x-ray, and it was negative. The ADON said she completed a skin assessment on Resident #3, and he had no redness or bruising. The ADON said it was important for all allegations of abuse to be reported and investigated because allegations could be true and the residents could get hurt and so abuse allegations could be addressed in a timely manner. The ADON said the DON was not available for interview. During an interview on 04/14/2026 at 4:59 PM, COTA C said Resident #3 reported to her that in the middle of the morning/dark hours/early morning on 04/09/2026 a gentleman with glasses came in his room and moved him around roughly and hurt his rib. COTA C said Resident #3 was upset and said he wanted the person fired before he fired him. COTA C said she went to look for the Administrator to report Resident #3's allegation, but the Administrator was not in the building, so she reported it to the ADON. COTA C said it was important for all allegations of abuse to be reported because abuse could happen to other residents. During an interview on 04/14/2026 at 5:04 PM, the Administrator said the ADON notified her of Resident #3's allegation that CNA D was rough with him. The Administrator said she did not report the incident to HHSC because when she talked to Resident #3, she felt like it was more of a customer service issue. The Administrator said when she questioned Resident #3 about what he meant by CNA D being rough with him, Resident #3 said CNA D could have been gentler when moving him. The Administrator said if the staff were rough handling, abusive, or moving roughly it should be reported as abuse to HHSC. The Administrator said according to their policy on abuse if there was an allegation of abuse it should be reported within 2 hours to HHSC. The Administrator said it was important for allegations of abuse to be reported to ensure they had taken all the steps necessary, and all residents were safe, not just the resident making the allegation but all the ones around that may or may not be able to report abuse. During an interview on 04/14/2026 at 5:22 PM, CNA D said he was not allowed to go in Resident #3's room. CNA D said when Resident #3 first arrived at the facility, he provided incontinent care. CNA D said he turned Resident #3 on his side as far as he could because Resident #3 was not able to turn good at all. CNA D said he was not trying to be rough, but he had to push him a little when turning him on his side to get him cleaned up. CNA D said he had to use his body strength to push Resident #3 on his side because it was difficult to turn him over. CNA D said he should have gotten another person to help him change Resident #3 since he was having trouble turning him, but everybody else was busy. CNA D said the DON had talked to him regarding the incident with Resident #3 and he was provided an in-service on abuse and neglect.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, for 1 of 4 residents (Resident #3) reviewed for abuse and neglect reporting. The facility failed to ensure the Administrator reported to HHSC within 2 hours on 04/09/2026 when the ADON reported to her Resident #3 alleged CNA D was rough with him while providing incontinent care. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: Record review of Resident #3's face sheet dated 04/14/2026, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included infectious gastroenteritis and colitis (inflammation of the stomach, intestines, and colon caused by an infection), essential primary hypertension (high blood pressure), and benign prostatic hyperplasia with lower urinary tract symptoms (overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine). Record review of Resident #3's Comprehensive MDS assessment dated [DATE] indicated he was understood by others, and he understood others. Resident #3 had a BIMS score of 15, which indicated his cognition was intact. Resident #3 was dependent on staff for toileting, showering/bathing, dressing, and personal hygiene. Record review of Resident #3's care plan initiated 03/31/2026 did not address the level of assistance Resident #3 required for ADLs. During an interview on 04/14/2026 at 1:51 PM, Resident #3 said when he first came to the facility, he needed to be changed because he was dirty, and there was a male CNA that was very rough with him. Resident #3 was unable to provide a specific date. Resident #3 said even when the CNA was wiping him, he was being rough. Resident #3 said he should not have been treated that way because the staff were there to help him, and they were supposed to be gentle when providing care, turning, and wiping him. Resident #3 said he reported the CNA to the nurse when it happened, and to the Administrator the next day. Resident #3 said the Administrator told him she would investigate it, and she never came back to tell him anything. Resident #3 said the CNA had not provided care to him again. During an interview on 04/14/2026 at 4:29 PM, the ADON said on 04/09/2026 COTA C reported to her that Resident #3 said a staff member was rough with him. The ADON said Resident #3 told her a staff member was rough with him when he was changing him. The ADON said Resident #3 told her it was a man with glasses, beard. The ADON said Resident #3 also reported to her his right rib cage was hurting. The ADON said when she looked at the schedule, she identified the staff as CNA D. The ADON said she reported Resident #3's allegations to the Administrator as soon as she was able to on 04/09/2026 because it was an allegation of abuse. The ADON said she told the Administrator Resident #3 had made a complaint of abuse. The ADON said Resident #3's rib cage pain could have been from an assisted fall he had the day before, and they got an x-ray, and it was negative. The ADON said she completed a skin assessment on Resident #3, and he had no redness or bruising. The ADON said it was important for all allegations of abuse to be reported and investigated because allegations could be true and the residents could get hurt and so abuse allegations could be addressed in a timely manner. The ADON said the DON was not available for interview. During an interview on 04/14/2026 at 4:59 PM, COTA C said Resident #3 reported to her that in the middle of the morning/dark hours/early morning on 04/09/2026 a gentleman with glasses came in his room and moved him around roughly and hurt his rib. COTA C said Resident #3 was upset and said he wanted the person fired before he fired him. COTA C said she went to look for the Administrator to report Resident #3's allegation, but the Administrator was not in the building, so she reported it to the ADON. COTA C said it was important for all allegations of abuse to be reported because abuse could happen to other residents. During an interview on 04/14/2026 at 5:04 PM, the Administrator said the ADON (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 3 residents (Resident #2) reviewed for care plans. The facility failed to ensure a care plan was developed to address Resident #2's preference to not have males provide personal/hands on care. This failure could place residents at risk of not having their individual needs met and a decreased quality of life.Findings included: Record review of Resident #2's face sheet dated 04/14/2026, indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable movements), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities). Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she was able to make herself understood and usually understood others. The MDS assessment indicated Resident #2's BIMS score was 12, which indicated her cognition was moderately impaired. Resident #2 required partial/moderate assistance with showering/bathing self, and supervision or touching assistance with personal hygiene and dressing. Record review of Resident #2's care plan initiated 03/18/2026 did not indicate her preference to not have male staff assist her with hands on care. During an interview on 04/14/2026 at 2:15 PM, Resident #2 said she had told one of the nurses she did not want men cleaning her up or touching her. Resident #2 said she did not like it when the men touched her. Resident #2 said she kept having to tell the nurses she did not want men cleaning her up. During an interview on 04/14/2026 at 3:52 PM, LVN A said he was aware Resident #2 did not want males helping with her personal care. LVN A said one time he went in to try to help her, and she told him she wanted females only no males. LVN A said the preference for females only should be included in the care plan and the ADON and DON were the ones who put that in the care plan. LVN A said it was important to include this in the care plan so the residents felt respected, and because they could have a history of trauma. During an interview on 04/14/2026 at 4:29 PM, the ADON said she did not remember Resident #2 particularly saying she did not want a man to provide her personal care. The ADON said if a female resident did not want males providing care it was placed on the assignment sheets, and it should be a part of the resident's care plan. The ADON said the nurses should report to administration if a female resident does not want a male staff to provide care for the interdisciplinary team to discuss it and care plan it. The ADON said it was important for this to be included in the care plan because the residents could have trauma, and it was the residents' right to say they did not want males in the room. During an interview on 04/14/2026 at 5:04 PM, the Administrator said she was not aware Resident #2 did not want males providing her personal care. The Administrator said she expected this to be included in the residents' care plan, so all the staff were aware, and the residents' rights were respected. Record review of the facility's policy titled, Care Planning, revised 10/24/2022, indicated, To ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs.a culturally competent and trauma-informed comprehensive person-centered care plan will be developed for each resident. The care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs.changes may be made to the comprehensive care plan on an ongoing basis for the duration of the resident's stay.each resident's comprehensive care plan will describe the following: A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Gardens Wellness & Rehabilitation	716 Mimosa Street Mineola, TX 75773

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 3 residents (Resident #1) reviewed for ADLs. The facility failed to ensure Resident #1 received showers as scheduled. This failure could place residents at risk of not receiving needed services and care, decreased self-esteem, and a decreased quality of life.Findings included: Record review of Resident #1's face sheet dated 04/14/2026 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), bipolar disorder (a disorder associated with episodes of mood swings ranging from depression lows to manic highs), and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and usually understood others. Resident #1's MDS assessment indicated she had a BIMS score of 15, which indicated her cognition was intact. Resident #1 was independent for upper body dressing, required setup or clean-up assistance with eating and personal hygiene, and required substantial/maximal assistance with showering/bathing self and lower body dressing. Record review of Resident #1's care plan revised on 06/10/2025 indicated she had an ADL self-care performance deficit related to weakness of her dominant side and required extensive assistance by staff with showering and assistance by staff to dress and with personal hygiene. Record review of Resident #1's bathing task record dated 03/16/2026-04/14/2026 did not indicate she received a shower on 3/27/2026, 04/01/2026, and 04/13/2026. During an observation and interview on 04/14/2026 at 11:37 AM, Resident #1 said she was not receiving her showers as scheduled. Resident #1 said the last shower she had was Friday, 04/10/2026. Resident #1 said she was supposed to receive a shower yesterday, 04/13/2026. Resident #1 said the CNAs told her they were too busy and had 18-20 residents to take care of. Resident #1 had light brown stains on her white shirt. Resident #1 said because she had not received a shower she could not fix the back of her hair and it was messy from laying down on the pillow. During an interview on 04/14/2026 at 2:33 PM, CNA B said she provided care to Resident #1 and missed giving her some showers. CNA B said she missed giving baths and showers to the residents due to the construction and the water being too cold. CNA B said yesterday 04/13/2026, the showers were unavailable for use due to the construction. CNA B said Resident #1 was receiving showers Monday, Wednesday, and Friday, but on Friday 04/10/2026 there was a change to the shower schedules. Resident #1 was switched to Tuesday, Thursday, and Saturday for her showers. CNA B said it was important for the residents to get their showers to help them feel better. During an interview on 04/14/2026 at 4:29 PM, the ADON said the CNAs documented on the bathing task record and on shower sheets. The ADON said she was unable to provide shower sheets for Resident #1 because some things were missing due to the construction. The ADON said she was aware showers were missed yesterday (04/13/2026) because they were unaware the painters blocked off the showers. The ADON said some of the residents received bed baths. The ADON said she did not know how they ensured all the residents received their baths on 04/13/2026. The ADON said due to the remodeling, they had been making a lot of room changes, and she had not been able to monitor to ensure the residents were not missing their showers. The ADON said Resident #1's shower days were changed on Friday 04/10/2026 to Tuesday, Thursday, and Saturday. Due to this change, Resident #1 should have received a shower on Saturday 04/11/2026 so she would not go so many days without a shower. The ADON said the CNAs were supposed to be checking the shower schedule daily to ensure they did not miss any showers. The ADON said it was important for the residents to receive their showers for their dignity, quality of life, skin, and infection control. The ADON said the DON was not (continued on next page)

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	675981	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Gardens Wellness & Rehabilitation	716 Mimosa Street Mineola, TX 75773

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available for an interview. During an interview on 04/14/2026 at 5:04 PM, the Administrator said she was not aware of the residents not receiving showers as scheduled. The Administrator said it was not true that the construction was interfering with the CNAs giving showers. The Administrator said yesterday (04/13/2026), the painters painted both showers without notifying her, and they were unable to use either shower. The Administrator said this was the only time they were unable to use the showers. The Administrator said the CNAs were supposed to give bed baths to the residents scheduled for showers. The Administrator said it was important for the residents to receive showers because it was a basic need for quality of life and for them to be clean. Record review of the facility's undated policy titled, Showering a Resident, indicated, A shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Residents are offered a shower at a minimum of once weekly and given per resident request.

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	675981	A. Building B. Wing	04/14/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 3 medication carts (Hall 2 Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure LVN A secured the Hall 2 Medication Cart, when it was not in use and unattended on 04/14/2026. This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.Findings included: During an observation and interview starting on 04/14/2026 at 2:09 PM, the Hall 2 Medication Cart was unlocked and unattended stationed by the nurse's station. There were residents, staff, and multiple workers painting by the unlocked medication cart. The Regional Nurse observed the state surveyor standing by the Hall 2 Medication Cart and locked it. The Regional Nurse said the Hall 2 Medication Cart was LVN A's responsibility, and he should have locked it when he stepped away from it. The Regional Nurse said LVN A was outside on a smoke break. The Regional Nurse said the medication carts should not be unlocked when unattended for safety of the medications. During an interview on 04/14/2026 at 3:52 PM, LVN A said he was responsible for ensuring the medication cart was locked. LVN A said he thought he locked the Hall 2 Medication Cart before he went outside to smoke. LVN A said if the medication carts were left unlocked a patient or anybody could have gotten the medications. During an interview on 04/14/2026 at 4:29 PM, the ADON said the charge nurses were responsible for ensuring the medication carts were locked every time they stepped away from the medication cart. The ADON said it was important for the medication carts to be locked when unattended so the residents and no one could get into the medication cart except for the person who accepted responsibility for the cart. The ADON said the DON was not available for an interview. During an interview on 04/14/2026 at 5:16 PM, the Administrator said she expected the medications carts to be locked when the nurses walked away from them or when they were no longer facing the medication cart. The Administrator said all department heads were responsible for ensuring the medication carts were locked. If they saw an unlocked medication cart, they should lock it and notify her so she could take the proper steps and address it with the staff who left it unlocked. The Administrator said the medication carts should be locked because a resident who did not know any better could take the medications and harm themselves or the medications could be stolen, and the residents would not have what they needed. Record review of the facility's policy titled, Medication Storage, revised 01/2026, indicated, To establish standards that safeguard residents by preventing unauthorized access to medications and ensuring compliance with applicable federal and state pharmacy regulations. Medication carts must remain locked and always secured unless under direct and continuous supervision of authorized personnel during medication administration. These standards are required to ensure resident safety and regulatory compliance.This policy applies to all licensed nurses.medication rooms, carts, and cabinets must remain locked at all times. carts must be locked whenever they are not actively attended. The medication cart must be locked: when turning away from the cart, when more than arm's reach from the cart, during breaks, meals, or when leaving the unit.