STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675997	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carillon Inc	1717 A Norfolk Ave Lubbock, TX 79416

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to make information on how to file a grievance or complaint available to the residents for 10 of 10 confidential residents reviewed for grievances. The facility failed to ensure 10 of 10 residents were provided, through postings in prominent locations, the Grievance Procedure, were provided information who the facility grievance official was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place residents at risk of unresolved grievances and decreased quality of life. Findings include: In Interviews at an undisclosed date and time, 10 of 10 confidential residents stated they did not know they could file a Grievance anonymously; they did not recall the Grievance procedure being discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. The residents stated they did not know where to acquire a grievance form, who to turn the form into, and what happened once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Observations of prominent postings on 06/16/2026 at 4:25pm; the facility did not include instructions regarding the Grievance procedure with the prominent postings. Interview with the ADM on 06/17/2026 at 10:15am; the ADM stated he was the Grievance Officer for the facility. The ADM stated the Grievance form was available on a shelf on the wall by the downstairs elevator; he stated the forms can also be obtained by any staff member. The ADM stated he assigned grievances to the appropriate department, that department addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form, and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook for 3 plus years. The ADM stated he monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance and he discussed Grievances in daily IDT meetings. The ADM stated he would also meet with the complainant to ensure they were satisfied with the resolution, if needed. The ADM stated he and the management team were responsible for ensuring staff were trained on the Grievance process. The ADM stated he was not aware the Grievance procedure was not being discussed in Resident Council; the ADM agreed the availability of the Grievance forms, the Grievance procedure, and procedure for submitting a Grievance form anonymously should be explained to Residents at admission and continually discussed in monthly Resident Council meetings. The ADM stated the potential negative outcome for Residents not being educated on the Grievance process was unsatisfied Residents. Record Review of the Grievance Policy last updated in January 2024 reflected: Policy Statement:It is a policy to thoroughly investigate all residents and families' grievances/complaints. Resolution will be documented on the facility grievance/concern form. Policy Interpretation and Implementation: Federal and state law guarantee the right to submit a formal grievance to all residents of this facility. Grievance forms will be kept in the foyer on each floor of the facility.Any staff member may assist a family member or resident with completing the form.Completed forms will be given to the social services department. Appropriate staff member will complete the investigations.After the investigation is completed it will be documented on the grievance form; the completed form will be submitted to the ADM.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in facility 1 of 1 kitchen reviewed for food safety. 1) The facility failed to ensure food items in the refrigerator (x1), and freezer (x1), were labeled and stored in accordance with the professional standards for food service. 2) The facility failed to ensure the garbage can used for food waste was covered unless in use. 3) The DC failed to wear a hair restraint to cover his mustache. These failures could place residents at risk for food-borne illness and cross contamination.The findings included: During kitchen tour observations on 06/15/2026 that began at 9:32 a.m. and concluded at 10:33 a.m., revealed the following: -Garbage can, next to food prepping table, was uncovered and not in use. -The DC was not wearing hair restraint to cover his mustache area. Walk-in Freezer -What resembled scones, cookie doughs, apple scones, cinnamon rolls and white chocolate scones in different clear plastic bags, all with no label and no use by date. Walk-in Refrigerator -What resembled whipped topping in a clear plastic bag, with no use by date. During an interview on 06/17/2026 at 10:32 a.m., the EC stated, I am responsible for putting the labels and dating (use by date) on all food items, as well as all other kitchen staff, everyone is responsible for monitoring the labels and dating of all food items. He stated that kitchen staff were in a hurry, so they forgot to label the food items. The EC stated, yes, I came across the food and general kitchen sanitation policy(s) and have been trained on such task. He further stated they didn't think it needed to be covered when asked about the open garbage can next to the food prepping table. The EC stated that the DC was one of their new hires and that he must have removed the hair restraint and forgotten to put it back. He further stated, these failures, unlabeled food items, the food would have been dangerous for residents to eat and not covering the garbage can, not wearing the hair restraint could lead to food contamination. During an interview on 06/17/2026 at 11:04 a.m., the DC stated, I am responsible for putting the labels and dating (use by date) on all food items, as well as all other kitchen staff, all the kitchen staff were responsible for monitoring the labels and dating of all food items, residents could get very sick from such failure. He stated, I guess, some of us just forgot to label and date the food items and I have been trained on such task, equally seen both the food storage and kitchen sanitation policies. The DC stated he had just gotten out of the bathroom and had forgotten to use the hair restraint, a little stuff like that could have slipped off one's mind easily. He further stated, he did not know that the garbage can not in use were not covered, such failures could cause food contamination. During a telephone interview on 06/17/2026 at 11:21 a.m., the RD stated that the DM and kitchen staff were responsible for those tasks, labeling/dating of food items, while the DM should be the one monitoring such tasks. She stated, she thought they had been trained on such, because the kitchen experienced issues with food labeling and dating previously. The RD stated maybe the kitchen staff missed them, or not sure why food items were not labeled/dated and such failure could cause food borne illness and poor food quality. She further added that when not in use, the garbage can be covered, she did not know why the can was not covered and DC should wear hair restraint. She further added, the hair would have gotten into the food and the garbage can; that was a sanitation issue to her, and these could have led to food contamination. During an interview on 06/17/2026 at 11:31 a.m., the DM stated, I am responsible for putting the date (use by date) and labelling of all food items alongside with the rest of the kitchen staff, and I don't know why the kitchen staff forgot to do that. He stated he had been trained on such tasks and had come across food storage and kitchen policies, and all the kitchen staff were responsible for monitoring, dating and labelling of all the food items in the kitchen. He stated, the residents could get sick from such undated or unlabeled food items. He further stated that the garbage can next to the prepping table should have been covered when not in use, he did not know why it was not, such failure could lead to food contamination. He stated, the DC thought that he (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doesn't need to have hair restraint, but he should have had it on. He stated the negative outcome would still be food contamination. During an interview on 06/17/2026 at 12:01 p.m., the ADM stated, It should be the kitchen staff who opened that particular food item, that is responsible for dating and labelling that, while the DM will be monitoring such task. He stated they could be serving the residents expired food items which could lead to food borne illness. He stated, at this point, he couldn't say why, but the kitchen staff might have been in a rush; ultimately, the food items should have been labeled and dated. He further stated that, the kitchen staff have been trained and were continuously re-educated throughout the year and I have not seen the policy(s). When asked about the open garbage can, the ADM stated, if not in use, then it should be covered, I can't tell you why the can was not covered, that is something you should speak to with the DM and such would cause potential cross contamination. He further stated that all kitchen staff should have their hair restraint while prepping, and there was no reason why DC shouldn't have been wearing the hair restraint. Record review of the facility's policy and procedure titled, Food receiving and Storage, undated, reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: Refrigerated/Frozen StorageAll foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Record review of the facility policy and procedure titled, Garbage Can, undated, reflected the following: Purpose: Properly dispose of garbage and clean cans in order to comply with sanitation standards. Procedure: Place new garbage bags in can and replace lid. Place garbage cans in proper place. Record review of the facility policy and procedure titled, Employees - Personal Cleanliness, undated, reflected the following: Purpose: Personal cleanliness is extremely important and the responsibility of each Food & Beverage Department staff member. Bacteria can be present on hands, skin, breath, and hair; therefore, proper cleanliness practices are vital link in the prevention of food-borne illnesses. Procedure: Food employees in food preparation areas and during food preparation should wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 2 of 3 dumpsters (dumpsters #1 and #2), in that: -The doors for dumpsters #1 and #2 were left open.-Garbage was left outside of the dumpster. These failures could place residents at risk of exposure to germs and diseases carried by vermin and rodents.The findings included: Observation on 06/15/2026 at 10:01 a.m., revealed the facility's dumpster area, which was in the docking area behind the kitchen had commercial-size dumpsters (#1 and #2), with open doors. Further observations revealed improperly trashed iron bars (x5) and black trash bags (x2) on the ground behind both dumpsters (#1 and #2). During an interview on 06/17/2026 at 11:47 a.m., the MM stated that anyone who used the dumpster was responsible for making sure the trash was thrown into the dumpster properly and doors closed. He added that anyone who used the dumpsters was responsible for monitoring the identified failures, closing the dumpster doors, trashing the iron bars/black trash bags on the ground behind the dumpsters properly. He further stated, because people don't do their job properly, they should be held accountable. The MM stated he had not been trained on such task and have not seen any waste disposal policy. He stated that such failures could cause the spread of rodents and environmental pollution. During an interview on 06/17/2026 at 12:01 p.m., the ADM stated, typically, I would have that carried out by the MM, it is an IDT (Inter disciplinary team) approach to make sure that the dumpster doors were closed after trashing and garbage trashed properly. He stated, at this time, they do not have anyone assigned to monitor the mentioned or identified failures. He further stated, he cannot speak to why the iron bars/black trash bags on the ground behind the dumpster were not properly trashed and dumpster doors not closed, that is due to lack of coordination. The ADM added that the staff have not been trained on such task at this time and have not come across the waste disposal policy. He further stated, staff need to have proper hand hygiene after disposing the trash before returning to resident care areas, that would be a potential infection risk. Record review of the facility policy and procedure titled, Dumpster Use and Waste Disposal Policy, undated, reflected the following: Policy Statement: All waste shall be disposed of in designated dumpsters. Dumpster areas must remain clean and free of debris, pests, and safety hazards. Dumpster lids and exterior doors leading to dumpster areas shall remain closed and secured when not in use. Procedures: 1. Waste Disposal1. Place all trash directly into designated dumpsters.2. Do not leave waste on the ground or beside dumpsters.3. Secure trash bags before disposal.5. Dispose of regulated or hazardous waste according to facility policy and applicable regulations.2. Dumpster and Door Requirements1. Dumpster lids and access doors must remain closed when not in use.2. Exterior doors to dumpster areas shall not be propped open.3. Dumpster Area Cleanliness1. Keep the dumpster area clean and free of trash, spills, odors, pests, and safety hazards.2. Clean the surrounding area as needed to maintain sanitary conditions.Monitoring and Compliance1. Facility staff shall routinely inspect dumpster areas.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 3 of 3 residents (Residents #3, #66 and #85) and 2 of 2 (RN A and RN B) staff reviewed for infection control. The facility failed to use EBP during wound care for 3 Residents (Residents #3, #66 and #85). This failure could place residents at risk for spread of infection and cross contamination. Findings include: Resident #3 Record review of Resident #3's clinical record revealed a face sheet, dated 06/17/2026, which indicated the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident #3's diagnoses included Alzheimer's disease (cognitive loss), prostate cancer, depression (mental health condition), hypertension (high blood pressure) and peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs). Review of Resident #3's comprehensive MDS assessment, dated 04/15/2026, revealed his BIMS score of 05 which indicated his cognition was severely impaired. MDS section M - Skin Condition revealed resident #3 had one stage 3 pressure ulcer. Record review of Resident #3's care plan dated 04/22/2026 revealed a focus area for wound management - stage 3 pressure injury to the right glute with intervention to provide wound care per treatment orders. Record review of Resident #3's physician orders dated 06/17/2026 revealed an order Wound Care - cleanse right glute with NS, pat dry and apply Polymem DOT MWF every day shift every Mon, Wed, Fri for wound care, dated 06/03/2026. During an observation on 06/16/2026 at 10:14 a.m. RN B provided wound care for Resident #3. RN B entered Resident #3 room with no PPE on. No visible PPE outside of Resident #3's room. There was no visible signage on or around Resident 3's room to indicate transmittable based precautions were in place for Resident #3. Resident #66 Record review of Resident #66's clinical record revealed a face sheet, dated 06/17/2026, which indicated the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #66's diagnoses included left femur fracture, muscle weakness, and hypertension (high blood pressure). Review of Resident #66's comprehensive MDS assessment, dated 05/19/2026, revealed his BIMS score of 12 which indicated her cognition was moderately impaired. MDS section M - Skin Condition revealed Resident #66 had one unstageable -deep tissue injury. Record review of Resident #66's care plan dated 05/15/2026 revealed a focus area for wound management - unstageable to left heel with intervention to provide calcium alginate to left heel and cover with silicone every day. Record review of Resident #66's physician orders dated 06/17/2026 revealed an order Wound Care - cleanse left heel with wound cleanser and pat dry. Apply calcium alginate and cover with silicone dressing every day shift for wound care, dated 06/10/2026. During an observation on 06/16/2026 at 01:40 p.m. RN A provided wound care for Resident #66. RN A entered Resident #66 room with no PPE on. No visible PPE outside of Resident #66's room. There was no visible signage on or around Resident 66's room to indicate transmittable based precautions were in place for Resident #66. Resident #85 Record review of Resident #85's clinical record revealed a face sheet, dated 06/17/2026, which indicated the resident was an [AGE] year-old male admitted to the facility on [DATE]. Resident #85's diagnoses included Alzheimer's disease (cognitive loss), edema (swelling), diabetes (high blood sugar), and hypertension (high blood pressure). Review of Resident #85's quarterly MDS assessment, dated 05/11/2026, revealed his BIMS score of 09 which indicated his cognition was moderately impaired. MDS section M - Skin Condition revealed resident #85 was at risk for pressure ulcers. Record review of Resident #85's care plan dated 05/28/2026 revealed a focus area for wound management - venous ulcer to bilateral legs intervention to provide calcium alginate and cover with silicone dressing every day. Record review of Resident #85's physician orders dated 06/17/2026 revealed an order Wound Care - cleanse 2 right lower legs wounds and 1 left lower leg with NS, pat dry and apply calcium alginate and cover with silicone dressing every day shift for wound care, dated 06/15/2026. During an observation on 06/16/2026 at 02:10 p.m. RN A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided wound care for Resident #85. RN A entered Resident #85 room with no PPE on. No visible PPE outside of Resident #85's room. There was no visible signage on or around Resident 85's room to indicate transmittable based precautions were in place for Resident #85. During an interview on 06/16/2026 at 03:30 p.m., RN A stated Residents #66 and #85 were not on EBP. She stated the wounds were not infection. She stated Resident #66 wound to left heel was open and had some drainage. She stated Resident #85 wounds to lower bilateral legs were open and weeping from edema. She stated she had been trained in EBP. She stated the ADON and DON make rounds to monitor for compliance with EBP. She stated the potential negative outcome of not following EBP could be introducing infection to the wounds. During an interview on 06/16/2026 at 03:41 p.m., RN B stated EBP was needed for Resident #3 because his wound was not infected. She EBP was only needed with complex wounds that require multi layered dressings. She stated she had been trained in EBP. She stated Resident #3 wound was open with a little drainage. She stated the potential negative outcome of not following EBP could be transferring infection to the residents or staff. She stated if the resident was on EBP they would have a sign at their door and PPE outside their room the door. During an interview on 06/17/2026 at 10:30 a.m., the DON stated she was not sure what type of wounds Residents #3, #66 or #85 had. She stated ADON would be better to answer that question. She stated Residents #3, #66 and #85 were not on EBP because they did not have infection or a complex wound dressing. She stated Residents #3, #66 and #85 had simple dressing. She stated a simple dressing was one layer dressing and a complex dressing was two or more layers. She stated residents placed on EBP had indwelling tubes (foley, central lines, picc lines), complex wound dressing, wound vacs or anyone with infections. She stated the purpose of EBP was to protect the residents from infections from other residents. She stated IP was responsible for making sure EBP was in place for residents who needed EBP. She stated all staff were trained in EBP. She stated the potential negative outcome of not following EBP could be transmitting infectious disease to another resident. During an interview on 06/17/2026 at 10:45 a.m., the ADON stated Resident #3 had a stage 3 pressure ulcer on right glute that was open. He stated Resident #66 had an unstageable pressure ulcer on her left heel that was now open. He stated Resident #85 had venous statis ulcer on bilateral legs and wounds were open. He stated Residents #3, #66 and #85 all had simple dressings and EBP was not needed. He stated residents who needed EBP were residents with complex wound dressings that have 2 or more layers and infection. He stated the clinical team wrote the facility enhanced barrier protection policy. He stated the purpose of EBP was to prevent transmitting MDROs from resident to resident. He stated the IP and any nursing staff were responsible for making sure EBP was put in place. He stated all staff have been trained. He stated the potential negative outcome could be spreading infection to residents. During an interview on 06/17/2026 at 11:16 a.m., the ADM stated he refers all wounds and EBP to clinical staff. He stated the purpose of EBP was to prevent the spread of infectious body fluids and disease to residents or staff. He stated he was not aware EBP was not used for Residents #3, #66 and #85. He stated all staff have been trained in EBP. He stated the clinical team was responsible for making sure EBP was put in place. He stated the potential negative outcome could be other residents exposed to infectious disease due to nurse spreading infection to other residents and staff. During an interview on 06/17/2026 at 12:18 p.m., the IP stated she was not sure what type of wound Residents #3, #66 and #85 had. She stated, The purpose of EBP was to keep the residents protected from what could be on our clothes and what germs we have on us. She stated she reviews the weekly wound log provided by ADON to determine who needs EBP. She stated she accesses the residents' wounds and if no complex wound dressing, only needs simple wound dressing, no infection or MDROs the resident would not need EBP. She stated she does not consider wound classification as needed for EBP. She stated she looks at the characteristics of the wound and if the wound was stable, covered and drainage was controlled she doesn't consider EBP. She stated all staff had been trained in EBP. She stated she was responsible for making sure residents who need EBP have the signs and PPE supplies. She stated, I am not sure how the federal regulation read but if a resident has (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a colonized infection in wound at the moment, do you keep them on EBP for life or was it at the discretion of the facility policy. She stated the facility policy for EBP was reviewed annually. Record review facility policy titled Enhanced Barrier Precautions revised dated November 11, 2025, revealed the following:Policy Statement - Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.Policy Interpretation and Implementation .1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.a. gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).b. Personal protective equipment (PPE) is changed before caring for another resident .3. EBPs are indicated for residents with:a. Foley cathetersb. Complex/infected woundsc. PICC/CVL linesd. Drains (JP, pleurex, etc.) .8. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.9. PPE is available near or outside the resident rooms. Record review facility sign titled Enhanced Barrier Precautions, undated revealed the following: .Providers and staff must also:Wear gloves and gown for the following High-Contact Resident Care Activities.Wound Care: any skin opening requiring a dressing.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 2 of 6 residents (Residents #10 and #26) reviewed for advanced directives. The facility failed to ensure Residents #10 and #26 who were listed as DNR (Do Not Resuscitate), had Do Not Resuscitate forms that did not have missed required information. These failures could place residents at risk of not having their end-of-life wishes honored and incomplete records. Findings include: Resident #10 Record review of Resident #10's, undated, face sheet revealed a [AGE] year-old-male who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included chronic kidney disease (rapid loss of kidney function) and Acute Cystitis with Hematuria (inflammation of the bladder). The face sheet indicated under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #10's physician order summary, dated 06/17/26, reflected the following order: DNR-Do Not Resuscitate dated 05/01/26. Record review of the comprehensive MDS assessment dated [DATE] revealed Resident #10 was usually understood (difficulty communicating some words or finishing thoughts but was able if prompted or given time). The MDS revealed Resident #10 had a BIMS score of 06 which indicated the resident's cognition was severely impaired. Record review of Resident #10's care plan, dated 04/30/26, reflected a care plan for DNR. Record review of Resident #10's DNR form dated 8/06/24 reflected the resident's signature was absent from the DNR form, the doctor signed on the signature line intended for the resident's signature. Resident #26 Record review of Resident #26's, undated, face sheet revealed an [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included Alzheimer's Disease (brain disorder, most common form of dementia) and chronic kidney disease (rapid loss of kidney function). The face sheet indicated under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #26's physician order summary, dated 06/17/26, reflected the following order: DNR-Do Not Resuscitate dated 01/28/26. Record review of the comprehensive MDS assessment dated [DATE] revealed Resident #26 was usually understood (difficulty communicating some words or finishing thoughts but was able if prompted or given time). The MDS revealed Resident #26 had a BIMS score of 3 which indicated the resident's cognition was severely impaired. Record review of Resident #26's care plan, dated 05/05/26, reflected a care plan for DNR. Record review of Resident #26's DNR form dated 09/25/25 reflected Resident #26 signed on the signature line for a legal guardian, agent, or proxy. The physician's signature, date, printed name, and license number was missing. During an interview on 06/17/26 at 11:35am with the SW, she stated the DNR was not valid if it's not filled out correctly. She stated the social services department was responsible for ensuring DNRs were completed correctly. She verified missing information on DNR for Residents #10 and #26. She stated DNRs were monitored for accuracy during every care plan meeting. She stated the reason the DNR's were not complete was human error. She stated she was trained on DNRs. The SW stated the potential negative outcome for residents if a DNR was not completed correctly was catastrophic, very bad. During an interview on 06/17/26 at 11:55am with the ADM, he stated the DNR was not valid if not filled out correctly. He stated the IDT team was responsible for making sure the DNR was completed accurately. He stated DNRs were audited for accuracy when obtained and upon admission. He verified missing information on the DNR for Residents #10 and #26. He stated he did not know why the information was missing or incorrect. He stated the potential negative outcome was the residents' wishes were not followed. He stated he was trained in how to complete DNRs and his expectations were for them to be filled out completely and be correct. Record review of the Advanced Directives Policies and Procedures (Revised 2001) reflected the following: The resident has the right to formulate an advance directive, including the right to accept or refuse (continued on next page)

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	675997	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carillon Inc	1717 A Norfolk Ave Lubbock, TX 79416

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.

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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 transmit a completed discharge assessment that accurately reflected the residents' status for 1 of 27 sampled residents (Resident #40) whose records were reviewed, in that: Resident #40's Discharge MDS was not transmitted within 14 days of the completed date. This failure could place residents at risk by not receiving the appropriate assessments.Record review of Resident #40's admission Record dated 06/17/2026 revealed an [AGE] year-old female originally admitted to the facility on [DATE] and discharged from the facility on 01/30/2026. Resident #40 had the following diagnoses: chronic obstructive pulmonary disease (a progressive lung disease causing breathing and airflow problems), atrial fibrillation (a type of heart arrythmia), congestive heart failure (a progressive condition where the heart does not pump blood efficiently), Type II Diabetes Mellitus (a metabolic condition where the body does not process sugar effectively), and hypertension (high blood pressure). Record review of Resident #40's electronic medical record MDS tab revealed a Discharge Return Not Anticipated MDS dated [DATE] with a status of complete. The assessment history revealed the Discharge MDS had not been submitted (no batch created). Record review of Resident #40's Discharge MDS dated [DATE] revealed the following: Section A0310 Type of assessment: .F. Code 10 - Discharge assessment - return not anticipated .Section A2000 discharge date : [DATE] .Section A2300 Assessment Reference Date:Observation end date - 01/30/2026Response locked and Signed by: [Name]-former MDS Coordinator on Wed [DATE] at 03:16:39 PM During an interview on 06/17/2026 at 1:29 PM, the Clinical Reimbursement Coordinator stated the MDS Coordinator who completed Resident #40's Discharge MDS was no longer employed by the facility. She stated Resident #40 was not traditional Medicare; she was managed care and certain MDS assessments were not transmitted to CMS when a resident was on managed care. She stated Resident #40's Discharge MDS should have been submitted to CMS. The Clinical Reimbursement Coordinator stated all Discharge MDS' should be transmitted to CMS within 14 days of the completed MDS. She stated there was a box they must uncheck once the MDS was completed or it would not be transmitted to CMS. She stated the box was checked and the Discharge MDS for Resident #40 had not been transmitted to CMS. The Clinical Reimbursement Coordinator stated she would correct the Discharge MDS for Resident #40 and it would be transmitted today (06/17/2026). She stated she and another staff member were responsible for completing and transmitting MDS' and they had each been trained in completing the MDS within proper timeframes through their MDS certification and ongoing MDS training. During an interview on 06/17/2026 at 1:52 PM, the ADM stated he was not aware Resident #40's Discharge MDS had not been transmitted until today. He stated the timeframe to submit a Discharge MDS to CMS once it had been completed was (14) fourteen days. He stated the purpose of the Discharge MDS was to ensure all proper coding and financial reimbursement was correct. The ADM stated the MDS Coordinator who was responsible for completing and submitting Resident #40's Discharge MDS was no longer employed by the facility. He stated the facility hired another MDS Coordinator and she and the Clinical Reimbursement Coordinator were responsible for ensuring all MDS assessments were completed and submitted timely. The ADM stated those staff were each trained on the MDS process through formal MDS certification and annual recertification, as well as corporate training. He stated the potential negative outcome for failure to submit MDS assessments within the proper timeframe was billing errors and financial penalties. Record review of the facility policy titled, MDS Completion and Submission Timeframes (Revised July 2017) revealed: Policy StatementOur facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.Policy Interpretation and Implementation1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Submission and Processing (ASAP) system in accordance with current federal and state guidelines.2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . Review of the RAI manual dated October 2025 revealed:. 09. Discharge assessment - Return not anticipated (A0310F=10) .Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days) .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 8 percent based on 2 errors out of 25 opportunities, which involved 1 (Resident #81) of 3 residents reviewed for medication administration. RN A failed to give Resident #81's medications according to physician's orders when she administered the medications Amlodipine (for blood pressure) and Losartan Potassium (for blood pressure) outside the ordered vital sign parameters. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and a decline in health.Record review of Resident #81's admission Record dated 06/17/2026 revealed an [AGE] year-old female with an admission date of 03/06/2026. Resident #81 had diagnoses which included: hypotension (low blood pressure), candidiasis (fungal infection), essential primary hypertension (high blood pressure without an identifiable medical cause), Parkinsonism (a syndrome effecting motor function), and cognitive communication deficit (communication problem caused by disruption of brain function). Record review of Resident #81's Quarterly MDS assessment, dated 06/09/2026, revealed a BIMS score of 08, indicating the resident had moderate cognitive impairment. Record review of Resident #81's current physicians orders revealed an order with a start date of 03/07/2026 for Amlodipine 5 mg tablet give 1 tablet by mouth one time a day related to essential primary hypertension - hold if pulse is less than 60. Record review of Resident #81's current physicians orders revealed an order with a start date of 03/06/2026 for Losartan Potassium 50 mg tablet give 1 tablet by mouth two times a day related to essential primary hypertension - hold if pulse is less than 60. Record review of Resident #81's MAR for June 2026 revealed Amlodipine 5 mg and Losartan Potassium 50 mg were administered to Resident #81 by RN A on 06/16/2026. During a medication administration observation on 06/16/2026 at 9:14 AM for Resident #81, RN A dispensed one Amlodipine 5 mg tablet and one Losartan Potassium 50 mg tablet into a dispensing cup and entered the room of Resident #81. RN A placed a wrist blood pressure cuff to the right wrist of Resident #81 and assessed the following vital signs: blood pressure = 129/65, pulse = 57. RN A then administered the medications to Resident #81 and left the room. RN A then recorded Resident #81's blood pressure and pulse on the MAR and clicked yes to indicate the medication administration was complete. During an observation and interview on 06/16/2026 at 3:20 PM, RN A opened the MAR for Resident #81 and verified the vital signs assessed prior to the observed medication administration were as follows: blood pressure = 129/65, pulse = 57. RN A stated Resident #81 should not have been administered the Amlodipine 5 mg tablet or the Losartan Potassium 50 mg tablet, due to the resident's pulse being below the ordered parameter of 60 beats per minute. RN A stated she should have held the Amlodipine and Losartan Potassium medications, according to the physicians order. She stated she made an error and did not realize Resident #81's pulse was below the set parameters at the time of administration. RN A stated she had been trained on accurate medication administration during her nurse training. She stated the ADON made random rounds during medication pass and checked for accuracy and competency of medication administration. She stated the procedure when a medication error was made was to first check the resident and reassess vital signs, if necessary, then notify the provider and get any new orders, then notify nursing administration and pass the information on to the oncoming nurse at shift change. RN A stated she would also make an entry in Resident #81's progress notes regarding the medication error. RN A stated a potential negative outcome for administering a medication that does not follow ordered parameters was a resident could have vital signs that were outside of the ideal rate, which could cause harm to the resident. During an interview on 06/17/2026 at 8:55 AM, the DON stated she was not aware until after the observed medication pass that physicians orders had not been accurately followed. She stated all staff had been trained on accurate medication administration. The DON stated the facility utilized rounds and competency checks for monitoring and training of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurate medication administration. She stated random rounds during medication administration were conducted by nursing administration. She stated the pharmacy consultant conducted monthly competency checks for medication administration and the nurse consultant conducted quarterly competency checks during onsite visits. The DON stated her expectation of staff for accurate medication administration was 100% compliance with physicians orders and to exercise the 5 Rights of medication administration at all times. The DON stated a progress note was entered in the electronic health record once Resident #81's provider was notified of the medication error. She stated no new orders were received from the provider for Resident #81. She stated a potential negative outcome for failure to follow physicians orders during medication administration was a resident could be hospitalized or, in extreme cases, it could result in resident death. During an interview on 06/17/2026 at 11:33 AM, the ADM stated he was not aware that physicians orders for medications had not been accurately followed until after the medication observation was conducted. He stated nursing administration was responsible to assure staff were administering medications accurately and according to physicians orders. He stated the system to monitor accuracy of medication administration was by audits conducted by nursing administration, pharmacy consultants, and the nurse consultant. The ADM stated all nursing staff had been trained on accurate medication administration and received continuing education at the facility level. The ADM stated a potential negative outcome for failure to follow physicians orders during medication administration was hospitalization or other serious injuries or reactions from medications. Record review of the facility policy titled Administering Medications (Revised April 2019) revealed: Policy headingMedications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation.4. Medications are administered in accordance with prescriber orders . 11. the following information is checked/verified for each resident prior to administering medications:.b. Vital signs, if necessary.