STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676017	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Health Care Center	460 W Main St Ranger, TX 76470

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 time frames to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and , for 4 of 16 residents (Resident #3, Resident #4, Resident #6, and Resident #43) reviewed for care plans. 1. The facility failed to ensure Resident #3's care plan objectives or goals were measurable. 2. The facility failed to ensure Resident #4's care plan objectives or goals were measurable. 3. The facility failed to ensure Resident #6's care plan objectives or goals were measurable. 4. The facility failed to ensure Resident #43's care plan objectives or goals were measurable. These failures could place residents at risk of not receiving individualized care and services to meet their needs.The findings include: 1. Record review of Resident #3's electronic face sheet, dated 05/20/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had medical diagnoses which included paranoid schizophrenia (a chronic mental disorder characterized by intense paranoia, delusions of persecution, and auditory hallucinations), schizoaffective disorder (a chronic mental health disorder that combines symptoms of schizophrenia with a mood disorder), high blood pressure, repeated falls, and pain. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. Record review of Resident #3's Comprehensive Care Plan, dated 12/27/2025, revealed Focus: Victim of emotional abuse by intimate partner. Goal: No known psychological abuse. 2. Record review of Resident #4's electronic face sheet, dated 05/20/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had medical diagnoses which included anxiety, heart failure, high blood pressure, and obesity. Record review of Resident #4's Quarterly MDS, dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 11 out of 15, which indicated moderate cognitive impairment. Record review of Resident #4's Comprehensive Care Plan, dated 05/09/2026, revealed Focus: Resident will maintain current weight and feel better about diet and meals provided. Goal: Residents health will be maintained. 3. Record review of Resident #6's electronic face sheet, dated 05/20/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had medical diagnoses which included anxiety, Alzheimer's disease, chronic pain, and high blood pressure. Record review of Resident #6's Quarterly MDS, dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 3 out of 15, which indicated severe cognitive impairment. Record review of Resident #6's Comprehensive Care Plan, dated 04/13/2026, revealed Focus: colace for constipation. Goal: Resident will have less constipation .Focus: Admit to Hospice. Goal: Resident will feel comfortable . with Hospice.Focus: Mechanical soft diet weight to be stable. Goal: Resident will be able to eat more food easier .Focus: Remeron for agitation. Goal: Medication will be administered for agitation and dementia outbreaks. 4. Record review of Resident #43's electronic face sheet, dated 05/20/2026, (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #43 had medical diagnoses which included anxiety, depression, and dementia. Record review of Resident #43's Medicare 5-day MDS, dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 3 out of 15, which indicated severe cognitive impairment. Record review of Resident #43's Comprehensive Care Plan, dated 03/22/2026, revealed Focus: Psychiatric evaluation for hollering out every 2-3min. Goal: Resident will have less hollering out throughout the review period. Interventions/Tasks: Resident will have less outbursts throughout the review period. Resident will push the call light instead of screaming or hollering. During an interview on 05/21/2026 at 12:43 PM, the DON stated goals should be measurable. She stated measuring the goals allowed the staff and other disciplines to see progress positively or negatively and evaluate the effectiveness of the interventions. The DON stated she had not received formal training on care plans. She explained she was told to read other care plans and learn from them. She stated care plans were reviewed frequently and revised if there was any change in the residents' care.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an indwelling catheter was not used unless there was valid medical justification for catheterization and that a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 3 of 16 residents (Resident #25, Resident #12, and Resident #49) reviewed for indwelling catheters. The facility failed to ensure that Resident #25 had a physician's order for an indwelling catheter and for monitoring and maintenance of an indwelling catheter. The facility failed to ensure that Resident #12 had a physician's order for an indwelling catheter and for monitoring and maintenance of an indwelling catheter. The facility failed to ensure that Resident #49 had a physician's order for an indwelling catheter and for monitoring and maintenance of an indwelling catheter. These failures could place residents with catheters at risk of not receiving continuity of catheter care and could place residents at risk of infection.Findings included: Resident #25 Record review of Resident #25's electronic face sheet, accessed on 05/20/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: upper respiratory infection, femur fracture, and neuromuscular dysfunction of bladder (nerves that control the bladder are not working). Record review of Resident #25's Significant Change MDS assessment, dated 05/13/2026, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Further review of MDS revealed the resident had an indwelling catheter. Record review of Resident #25's care plan, revised on 05/19/2026, revealed, Focus: The resident has a 16fr indwelling foley catheter.Interventions: Change 16fr catheter 1 x month. Monitor and document intake and output as per facility policy. Monitor/record/report to MD for signs and symptoms of urinary tract infection 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 Resident #25's electronic physicians orders revealed no evidence of an order for an indwelling catheter, monitor output, monitor for s/sx of UTI, or catheter care. Record review of Resident #25's electronic record revealed no evidence of foley catheter care or monitoring. Observation and interview on 05/19/2026 1:52 PM, revealed Resident #25 resting in bed with catheter bag hanging with no kinks in tubing. Urine clear yellow in color. Resident #25 stated she was recently in the hospital because she fell and broke her hip. She stated she has had the catheter since then. Resident #12 Record review of Resident #12's electronic face sheet, accessed on 05/20/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: neuromuscular dysfunction of bladder (nerves that control the bladder are not working) and prostatic hyperplasia (enlargement of prostate gland). Record review of Resident #12's Quarterly MDS assessment, dated 03/20/2026, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Further review revealed the resident had an indwelling catheter. Record review of Resident #12's care plan, last revised on 03/25/2026, revealed: Focus: Supra pubic catheter r/t neurogenic bladder .Interventions: Change monthly. Indwelling Foley Catheter to bedside drainage: 16- 20g 15-30 balloon silicone coated, Position catheter bag and tubing below the level of the bladder and away from entrance door. or place bag in a blue bag, Monitor and document intake and output as per facility policy, and Monitor/record/report to MD for signs and symptoms 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.[sic] Record review of Resident #12's electronic physician orders revealed no evidence of an order for an indwelling catheter, monitor output, monitor for s/sx of UTI, or catheter care. Record review of Resident #12's electronic record revealed no evidence of foley catheter care or monitoring. Observation and interview on 05/19/2026 2:10 PM, revealed Resident #5 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in electric wheelchair with catheter bag full of clear yellow urine with no privacy bag. He stated he used to have a privacy bag on his catheter bag but for some reason the night shift always removed it. He stated he had had a catheter for years. Resident #49 Record review of Resident #49's electronic face sheet, accessed on 05/20/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: retention of urine, Chronic Obstructive Pulmonary Disease (disease where lungs are damaged and inflamed), and neuromuscular dysfunction of bladder (nerves that control the bladder are not working). Record review of Resident #49's Significant Change MDS assessment, dated 03/25/2026, revealed a BIMS score of 09, which indicated moderate cognitive impairment. Further review revealed the resident had an indwelling catheter. Record review of Resident #49's care plan, revised on 03/26/2026, revealed: Focus: The resident has 16g indwelling Foley catheter attached to bedside drainage R/T urinary retention R/T neurogenic bladder due to neurogenic bladder .Interventions: The resident has a supra pubic catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. [sic] Record review of Resident #49's electronic physician's order revealed, Change catheter once a month, date 02/01/2026 and no evidence or order for foley catheter, monitoring for foley catheter, or care of foley catheter. Record review of Resident #49's electronic record revealed no evidence of foley catheter care or monitoring. Observation on 05/19/2026 at 3:00 PM revealed Resident #49 resting in bed call light in reach. Foley hanging with no kinks in tubing draining clear yellow urine. During an interview on 05/20/2026 at 8:45 AM, LVN B stated she was aware that Resident #25, Resident #12, and Resident #49 had catheters. She stated she assumed they had orders for them. She stated she did not monitor output and that foley care was performed by the aides. She stated a negative outcome for not performing care could have been infection. She stated not monitoring output could lead to missed decrease in urine or possible obstructions. During an interview on 05/21/2026 at 11:00 AM, the DON stated her expectation was that all catheters have a physician order with a proper diagnosis. She stated catheter care should be provided each shift and output should have been monitored. She stated she was not aware that these residents did not have the appropriate orders. She stated it was her responsibility as DON to monitor. During an interview on 05/21/2026 at 11:33 AM, the ADON stated all catheters should have an order for the catheter and for maintenance and monitoring. She stated Resident #25 had come back from the hospital with the catheter and the order was just missed. She stated Resident #12 and Resident #49 had a catheter for a long time and that there was no good reason as to why they did not have orders. Record review of the facility's policy titled, Urinary Catheter Care Procedure, not dated, revealed in part, Policy: The facility will provide catheter care using aseptic and infection control practices to reduce the risk of infection, trauma, and complications associated with urinary catheters. Catheter care shall be completed routinely. Indwelling urinary catheters shall only be used when medically necessary and with physicians' orders.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 (Resident #25, Resident #5, and Resident #49) of 16 residents reviewed for respiratory care. The facility failed to ensure Resident #25's nebulizer (used to receive medications by breathing in mist through the mouth) for breathing treatment was properly stored when not in use and failed to ensure an oxygen sign was in place. The facility failed to ensure Resident #5's nebulizer for breathing treatment was properly stored when not in use and changed out weekly per orders. The facility failed to ensure Resident #49's nebulizer for breathing treatment was properly stored when not in use. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Resident #25 Record review of Resident #25's electronic face sheet, accessed on 05/20/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: upper respiratory infection, and femur fracture. Record review of Resident #25's Significant Change MDS assessment, dated 05/13/2026, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Further review of MDS revealed the use of oxygen. Record review of Resident #25's care plan, revised on 05/19/2026, revealed no evidence of the use of oxygen or breathing treatments. Record review of Resident #25's physicians order dated 05/14/2026, revealed, Ipratropium bromide/Albuterol sulfate 3ML 1 inhalation orally four times a day. Further review revealed physicians order dated 08/04/2023, O2 at 2-4 LPM via NC as needed for shortness of breath. Observation and interview on 05/19/2026 1:52 PM, revealed Resident #25 resting in bed, oxygen on at 3LPM via nasal cannula with no date on tubing, nebulizer laying on nightstand with no date and not in a bag, and no oxygen sign outside of door. Resident #25 stated she has worn oxygen for years and that she usually just removed the nebulizer mask when the treatment finished and laid it on the table. Resident #5 Record review of Resident #5's electronic face sheet, accessed on 05/20/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: wheezing, upper respiratory infection, and shortness of breath. Record review of Resident #5's Quarterly MDS assessment, dated 03/06/2026, revealed a BIMS score of 05, which indicated severe cognitive impairment. Further review of MDS revealed no use of oxygen or respiratory treatments. Record review of Resident #5's care plan, revised on 03/05/2023, revealed: Focus: The resident has altered respiratory status/difficulty breathing . Interventions: O2 tubing to be changed weekly and prn if falls on the floor. All staff to help in monitoring when O2 or HHN not being used, it will be in a plastic bag. Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Remind him when O2 and/or nebulizer are not in use they must be in a bag to maintain cleanliness and assist as needed. Record review of Resident #5's physician's order dated 05/29/2025, revealed, Ipratropium-Albuterol inhalation solution 0.5-2.5MG/3ML- 3ml inhale orally every 4 hours as needed for wheezing. Further review revealed physician's order dated 02/08/2022, 02, H20, and HHN tubing checked and dated within 1 week, is off the floor and bagged if not using.[sic] Observation on 05/19/2026 at 2:00 PM revealed Resident #5's nebulizer laying on the bedside table, dated 04/24/2026, and not bagged. Resident #49 Record review of Resident #49's electronic face sheet, accessed on 05/20/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: retention of urine, Chronic Obstructive Pulmonary Disease (disease where lungs are damaged and inflamed), and neuromuscular dysfunction of bladder (nerves that control the bladder are not working). Record review of Resident #49's Significant Change MDS assessment, dated 03/25/2026, revealed a BIMS score of 09, which indicated moderate cognitive impairment. Further review revealed the use of oxygen. Record review of Resident #49's care plan, revised on 03/26/2026, revealed: Focus: The resident has shortness of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breath (SOB) r/t respiratory failure. Albuterol nebulizer treatment . Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects, Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring, and Use UNIVERSAL PRECAUTIONS as appropriate. Record review of Resident #49's electronic physicians ordered revealed, Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 1 vial inhale orally via nebulizer three times a day, dated 03/25/2026 and Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation)) 2 ml inhale orally two times a day, dated 11/10/2025. Observation on 05/19/2026 at 3:00 PM revealed Resident #49 resting in bed with call light in reach. Oxygen was in place with no date on the nasal cannula. Nebulizer mask lying on nightstand no date and not in a bag. During an interview on 05/20/2026 at 8:45 AM, LVN B stated nebulizers were to be changed out weekly and kept in a plastic bag when not in use. She stated a negative outcome for failing to keep the nebulizer and tubing clean, covered, and changed out would be infection. During an interview on 05/21/2026 at 11:00 AM, the DON stated her expectation was to keep nebulizers covered when not in use and to clean the nebulizer after each treatment. She stated she was unaware that the LVNs were not doing those things. She stated it was her responsibility as DON to monitor. During an interview on 05/21/2026 at 11:33 AM, the ADON stated all nebulizers should be cleaned after use and placed in a plastic bag. She stated nebulizers are to be changed out weekly and dated. She stated not bagging the nebulizers could lead to infection. She stated the staff just know that they are supposed to change them on night shift every week even if there is not an order in the chart. Record review of the facility's policy titled, Hand-Held Nebulizer Operating Instructions, not dated, revealed in part, .B. Equipment is cleaned after each treatment as follows.4.) Wash the nebulizer in warm water with mild soap and rinse thoroughly. %.) When completely dry, reassemble and place in a storage compartment. Record review of the facility's policy titled, Respiratory Care Services and Oxygen Safety Policy, not dated, revealed in part, Policy: Facility will provide respiratory care services to residents based upon physicians' orders, resident assessment, individual care plans, and applicable standards of care. Respiratory services shall include oxygen administration, monitoring, equipment maintenance, infection prevention practices, and emergency preparedness measures.4. Oxygen Safety Requirements.Oxygen in Use signage shall be posted.8. Infection Control. Respiratory equipment shall be cleaned and disinfected per manufacture recommendations and facility infection control policies.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents were free of a med error rate of 5% or greater for 2 (Resident #34, and Resident #43) of 4 residents reviewed for medication administration. The facility failed to ensure the medication rate (10.34 %) was less than 5%. This failure placed residents at risk of incorrect doses of medications and optimal therapeutic response. Findings included: Resident #34Record review Resident #34's face sheet dated 05/21/2026 revealed a [AGE] year-old female with an admission date of 09/12/2024. She had an active diagnosis of Asthma (a chronic respiratory condition that causes airways to swell, narrow, and fill with excess mucus and makes breathing difficult) and Chronic Obstructive Pulmonary Disease (a chronic obstructive lung disease that makes it difficult to breath and progressively gets worse over time). Record review of Resident #34's physician orders dated 05/21/2026 documented the following order: Brovana Inhalation Nebulization Solution 15 MCG/2ML (Arformoterol Tartrate) 1 inhalation inhale orally via nebulizer two times a day for the diagnosis of Chronic Obstructive Pulmonary Disease, and Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation) 1 inhalation inhale orally via nebulizer two times a day for Chronic Obstructive Pulmonary disease. Nebulizer treatment in room. During an observation and an interview on 05/19/2026 at 3:50 PM. Resident # 34 was observed in her room alone with her nebulizer treatment running. Resident #34 stated the nurses change her tubing on her nebulizer one time a week and they always left her medication for the nebulizer treatment in the room for her to finish and she turns the machine off when she was done. Stated she got 4-5 nebulizer treatments a day. During an observation on 05/20/2026 at 9:09 AM LVN B gave Resident #34 Brovana Inhalation Nebulization Solution 15 MCG/2ML vial (Arformoterol Tartrate) via nebulizer for the diagnosis of Chronic Obstructive Pulmonary Disease and Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation) 1 vial for inhalation inhale orally. LVN B left 1 vial of medication in the room with Resident #34 for the resident to administer to herself at a later time. LVN B did not stay in the room to see that Resident #34 took the medication. LVN B documented both medications as given and completed on Resident #34's electronic medication administration record. Resident #49Record review on 05/21/2026 of Resident # 49's face sheet dated 05/21/2026 revealed a [AGE] year-old female with an admission date of 08/03/2023. She had a diagnoses of Chronic Atrial Fibrillation, (a chronic abnormal rhythm of the heart causing the blood to pool in the heart and potentially cause blood clots) and Acute Upper Respiratory Infection. Record review of Resident #49's physician orders dated 05/20/26 revealed an order for Eliquis Oral Tablet 5 MG (Apixaban). Give 1 tablet by mouth one time a day related to CHRONIC ATRIAL FIBRILLATION, the medication was not in the medication cart. There was still an order on the MAR. LVN B stated that she thought the medication was discontinued while she was in the hospital and that was why is was not there in the cart. The medication was not given the physician was notified and the order was revised on 5/20/26 to restart the medication on 05/21/2026. During an observation on 5/20/25 at 8:00 a.m. LVN B was unable to find the Eliquis ordered for Resident #49 on the med cart and stated the medication was not available for administration. The med was not given as ordered. During the same observation on 5/20/26 8:00 AM, LVN B gave 1 vial of Ipratropium Bromide/Albuterol Sulfate 3 mL via nebulizer, returned to her medication cart and documented the Albuterol as completed and left the medication in the room with the resident without waiting to see that the medication was taken. In an interview on 05/20/26 at 9:30 AM with the LVN B, she said medication should be given as ordered and the nurses should remain with the resident until the medication was completed to ensure that the correct dose of the medication was given to the correct resident. She stated a negative outcome of leaving a medication in a resident's room for them to take unobserved would be that the correct dose might not be taken and the resident would not benefit from the intended therapeutic effect of the medicine. She stated medications should be ordered before the supply was exhausted and to be available for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration at the time it was due to be administered. She stated that an order should be written for any medication that was on hold or discontinued. In an interview on 05/20/26 at 2:00 PM with the DON, she said she expected medication to be given as ordered and for the nurses to remain with the resident until the medication was completed to ensure that the correct dose of the medication was given to the correct resident. She stated a negative outcome of leaving a medication in a resident's room for them to take unobserved would be that the correct dose might not be taken and the resident would not benefit from the intended therapeutic effect of the medicine. She stated she expected medications to be ordered before the supply was exhausted and to be available for administration at the time it was due to be administered. She stated she was not aware until now that the nurses were leaving the residents to administer their own nebulizer treatments. Record review of facility policy titled Administering Medications dated revised, April 2019, revealed the following in part: Medications are administered according to the physicians orders. If a drug is withheld or ungiven at times other than the scheduled time the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. The medication is initialed by the nurse after the medication is taken.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 3 (Resident #34, #37, and #49) of 6 residents reviewed for infection control. LVN A failed to sanitize the shared glucometer before and after use on Resident #37 LVN B failed to sanitize the shared blood pressure cuff between Residents #34 and #49 and perform hand hygiene after touching residents during medication administration. This failure could affect residents and place them at risk for cross contamination and infections. The findings included: Resident #34 Record review Resident #34's face sheet dated 05/21/2026 revealed a [AGE] year-old female with an admission date of 09/12/2024. She had an active diagnosis of Asthma (a chronic respiratory condition that causes airways to swell, narrow, and fill with excess mucus and makes breathing difficult) an Chronic Obstructive Pulmonary Disease (a chronic obstructive lung disease that makes it difficult to breath and progressively gets worse over time). Record review of Resident 34's Quarterly MDS dated [DATE], indicated the resident had a BIMS score of 10 which indicated moderate cognitive impairment. During an observation on 05/20/2026 at 9:09 AM, LVN B obtained a blood pressure reading with a wrist cuff and administered a nebulizer treatment to Resident #34 without sanitizing the blood pressure cuff prior to use and without performing hand hygiene before or after touching Resident #34. Resident # 37 Record review of Resident #37's face sheet dated 05/21/2026 revealed a [AGE] year-old female with an admission date of 02/19/2026. She had a diagnosis of Insulin Dependent Diabetes. Record review of Resident #37's Entry MDS dated [DATE] revealed the resident did not have a BIMS score completed but documented that she had no problems with memory recall. During an observation and an interview on 05/19/2026 LVN B performed a fingerstick blood sugar with a shared glucometer device. He used an alcohol wipe to clean the shared glucometer before and after use. He stated that he used alcohol wipes and another disinfectant wipe with a purple top, but he stated they were low on the disinfectant wipes right now and there were none on his cart, so he used the alcohol pad to clean the glucometer before and after obtaining a FSBS on Resident #37 . Her fingerstick blood sugar was 121. She did not require insulin according to her physician orders and her sliding scale. LVN B stated that failure to disinfect a glucometer with the proper disinfectant could have a negative impact on a resident by spreading germs. He stated that he did not know for sure if the alcohol swab that he used was effective in killing blood borne pathogens. Resident #49 Record review on 05/21/2026 of Resident #49's face sheet dated 05/21/2026 revealed a [AGE] (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old female with an admission date of 08/03/2023. She had a diagnoses of Chronic Atrial Fibrillation (a chronic abnormal rhythm of the heart causing the blood to pool in the heart and potentially cause blood clots) and Acute Upper Respiratory Infection. Record review of Resident #49's Entry MDS dated [DATE] revealed the resident did not have a BIMS completed but documented that she had no problems with memory recall. During an observation on 5/20/25 at 8:00 a.m. LVN B obtained a blood pressure reading with a wrist cuff and administered a nebulizer treatment to Resident #49 without sanitizing the blood pressure cuff prior to use and without performing hand hygiene before or after touching Resident #49. During an interview on 05/20/26 at 9:30 AM with the LVN B, she said she should have sanitized the blood pressure cuff before each use on the residents, and she should have performed hand hygiene with alcohol-based hand rub or soap and water after touching residents. She stated that failure to perform hand hygiene after resident contact could negatively affect a resident by spreading infection. In an interview on 05/21/2026 at 9:45 AM, the DON said it was her expectation for the staff to perform hand hygiene and to use the purple top disinfectant wipe provided by the facility. She stated ADON was in charge of ordering supplies and there were plenty of disinfecting wipes in the supply closet. She stated a negative outcome of not using proper

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Tag: F921/N4888 S/S=E Surveyor Name(s): Reisha Horn, RNImmediate Supervisor: [NAME], LBSWBased on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, comfortable, environment for residents, staff, and the public for 1 of 4 hallways reviewed, for physical environment. The facility failed to ensure the carpet was free of tears and stains in the back hallway on 05/20/2026. This failure place residents at risk of injury, and a diminished quality of life due to the lack of a well-kept and clean environment.Findings included: In an observation of the facility on 05/20/2026 at 11:00 AM, the carpet in the back hallway of the facility was ripped and soiled with visible stains. In an interview with the maintenance director on 05/20/2026, he stated he stated the tear had been in the carpet for a long time and that the carpet stains remained even after they were cleaned. In an interview with the DON on 05/20/2026 at 11:40 AM she stated it was her expectation for carpets to be intact and clean. She stated the torn carpet could be an accident hazard for the residents, staff and visitors. She stated she tripped on the torn carpet, and it caused her to fall last week. In an interview with the Administrator on 05/21/2026 at 9:15 AM, she said potential negative outcomes of the ripped carpet could be a fall hazard. She stated the carpet needed to be repaired or replaced. Record review of the facility policy provided titled Clean and Safe Environment Policy and Procedure, not dated, revealed the following [in part]: It is the policy of Ranger Care Center to provide and maintain a clean, sanitary, comfortable orderly, and safe environment for all residents, staff, visitors, and vendors. The facility will ensure that environmental conditions promote resident dignity, infection prevention, accident prevention, and compliance with all federal, state, and local regulations. Ranger Care Center is committed to maintaining a homelike environment free from hazards, unsafe conditions, offensive odors clutter, sanitation concerns, and environmental risks that could negatively impact resident health safety and quality of life. Hazards shall be identified and corrected immediately. The environment shall remain free from trip and fall hazards.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 8 residents (Resident #43) whose assessments were reviewed for assessments. The facility failed to ensure Resident #43's quarterly MDS assessment did not correctly document the resident as having an unhealed pressure ulcer. This failure could place residents at risk for inadequate care.The findings include: Record review of Resident #43's electronic face sheet, dated 05/20/2026, revealed a female who was admitted to the facility on [DATE]. Resident #43 had medical diagnoses which included a closed fracture of her left femur (upper thigh bone), dementia, anxiety, major depressive disorder, and rheumatoid arthritis (a disorder that causes the immune system to attack the lining of the joints). Record review of Resident #43's Medicare 5-day MDS, dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 4 out of 15, which indicated severe cognitive impairment. Section M - Skin Conditions, subsection M0210 Unhealed Pressure Ulcers/Injuries, Does this resident have one or more unhealed pressure ulcers/injuries? 1. Yes was entered. Subsection M0300 Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage, E. Unstageable (inability to determine a wounds depth due to dead tissue on the wound bed)- non-removable dressing/device: Know but not stageable due to non-removable dressing/device, 1 was entered which indicated the number of unstageable pressure ulcers/injuries due to non-removable dressing/device was selected. F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar, 1 was entered which indicated the number of unstageable pressure ulcers due to coverage of wound bed by slough (moist, sticky dead tissue) and/or eschar(a thick, dry, and leathery layer of dead tissue that forms over a deep wound or severe burn). Record review of Resident #43's physician orders, dated 03/12/2026, revealed Skin tears/abrasions, may cleanse with sterile NS (normal saline) pat dry with 4 X 4 may apply steri-strips (adhesive strips used to close minor skin openings) as indicated. No order for treatment of a pressure ulcer or diagnosis of a pressure ulcer was included in the physician's orders. Record review of Resident #43's skin assessment, dated 03/13/2026, revealed in the Notes section redness from sutures and pressure from lying on her side due to r hip sx. Resident #43's skin assessment, dated 03/16/2026, revealed in the Notes section skin issues only to bottom that is resolving from admission time. Resident #43's skin assessment, dated 03/31/2026, revealed in the Notes section resident had unwitnessed fall no new areas found. Record review of Resident #43's Comprehensive Care Plan, dated 03/13/2026, reviewed/revised 03/18/2026, revealed no current skin issues or risk for skin issues addressed. During an interview on 05/21/2026 at 12:38 PM, the ADON stated the DON was responsible for care plans. She stated wounds should be addressed on the care plan. The ADON stated she was not sure who was responsible for the accuracy of the MDS's or care plans. During an interview on 05/21/2026 at 12:43 PM, the DON stated the wound claimed on Resident #43's MDS was most likely selected in error. She stated the charge nurses were responsible for conducting and documenting skin assessments. She stated she was responsible for monitoring the completion of skin assessments. She stated failure to accurately assess and document could result in improper care and/or additional injury. The DON stated her expectations were for all MDS's and care plans to be accurate. During an interview on 05/21/2026 at 2:12 PM, the MDS Coordinator stated the DON was responsible for entering data in Section M - Skin Conditions on the MDS. She stated the DON was responsible for monitoring the accuracy of the MDS's. Record review of the facility's policy titled Comprehensive Assessment and the Care Delivery Process , revised December 2016, revealed Comprehensive assessments will be conducted to assist in developing person-centered care plans.6. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASARR) Level I Screening residents diagnosed with mental illness were provided with a PASARR Level II Screening for 1 of 1 residents (Resident #16) reviewed for PASARR Level 1 screenings. The facility failed to correctly identify Resident #16 as having a mental illness and did not complete a new PASARR Level One Screening. This failure could place residents at risk of not receiving needed services and care. The findings were: Record review of Resident #16's PASRR Level One Screening Forms, dated 02/19/2026, revealed she did not have a primary diagnosis of dementia. It revealed she was negative for mental illness, intellectual disability, or developmental disability. The form had not been updated. Record review of Resident #16's Care Plan, dated 03/12/2026, revealed the resident received antidepressant medication. Record review of Resident #16's face sheet, dated 05/21/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #11's had a diagnosis which included Schizoaffective Disorder Bipolar Type (a chronic mental condition combining schizophrenia symptoms [like delusions or hallucinations with severe mood swings of mania and depression. Treatment requires a lifelong mix of medication and therapy]). Record review of Resident #16's Physician Orders, dated 05/21/2026, revealed orders for Zoloft Oral Tablet 25 mg (Sertraline Give 75 mg by mouth one time a day related to Major Depressive Disorder single episode. In an interview on 05/21/2026 at approximately 9:45 AM, the DON revealed she was not familiar with the PASRR process. She stated the ADON had been doing the PASSR's in February 2026 when Resident # 16 was admitted from another facility. She stated the Administrator asked the former ADON to come back to the facility and assume responsibility for the PASRR's and assist with the Care plans and MDS until she was adequately trained. In an interview on 05/21/2026 at approximately 11:10 AM, the MDS Coordinator said that given the diagnosis (schizoaffective disorder) of Resident #16 a PL new 1 reflecting Mental Illness should have been completed. She stated she would be submitting the corrected forms at her earliest convenience. She stated she did not complete the form, she only submitted it and stated she did not know why the form was not completed incorrectly. Record review of the facility's, undated, policy titled PASSR Policy and Procedure stated in part: It is the policy of the facility to comply with all Federal and Texas Health and Human Services Commission requirements regarding the pre-admission screening and resident review process. The facility will ensure that all individuals admitted to the facility have appropriate PASSR documentation completed prior to admission, when required, and that all PASSR recommendations are implemented and maintained throughout the residents stay. The facility will not admit any residents requiring PASSR screening without the appropriate authorization and documentation and accordance with Medicaid, CMS and Health and Human Services regulations. Pre-admission screening requirements:Prior to admission, admission staff or a designee will obtain and review Level 1 screening, verify PASRR status, and confirm all required documentation is present and ensure Medicaid eligibility requirements are met. If an applicant is identified as PASRR positive, the facility must ensure a PASRR Level 2 evaluation is completed when required. admission authorization is obtained and specialized service recommendations accompany admission documentation The facility will not admit individuals lacking required PASSR clearance unless permitted under an exempted hospital discharge.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes needed t provide effective and person-centered care of the resident that meet professional standards of quality care and was developed within 48 hours of a resident's admission for 1 of 6 residents (Resident #13) reviewed for base line care plan completion. The facility failed to include Resident # 13's catheter in the baseline care plan within the required 48-hour time limit. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified. Findings include: Record review of Resident #13's electronic face sheet, dated 05/21/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #13 had diagnoses which included: Urinary Tract Infection, Neuromuscular dysfunction of the bladder (a condition where the brain, spinal cord, or nerve pathways cannot properly communicate with the bladder muscles and disrupts the normal process of holding and releasing urine) and Benign Prostatic Hypertrophy (an enlargement of the prostate gland that makes it difficult to pass urine). Record review of Resident #13's electronic medical record revealed there was no baseline care plan initiated within 48 hours of admission for his suprapubic catheter which was present at the time of his admission on [DATE]. The catheter was not added to his Care plan until 03/21/2026. During an interview on 05/21/2026 at 10:51 AM, the DON stated she was responsible for completing baseline care plans. The DON stated, she was not aware of the 48-hour requirement for a baseline care plan to be initiated on each resident. She stated she was aware of the requirement now, and her expectation was for the baseline care plan to be completed within 48 hours and address the basic needs to care for each resident until the MDS assessment and the comprehensive care plan was completed. The DON stated there was no negative outcome for Resident #13, a possible negative outcome would be a resident would not receive needed care. During an interview on 05/21/2026 at 11:29 AM, the administrator said the DON was responsible for completing base line care plans. The ADMN stated her expectation was that base care plans were completed within 48 hours of admission and included all of the residents' immediate care needs. Record review of the facility's, undated, policy titled; Baseline Care Plan revealed The facility will develop a person-centered baseline Care Plan for each resident with 48 hours of admission. The Baseline Care Plan will include instructions needed to provide effective and person-centered care that meets the resident's immediate needs and preferences. The facility will ensure the Baseline Care Plan is communicated to direct care staff and interdisciplinary team members responsible for the resident's care and services.Purpose: To ensure Immediate resident care needs are identified and addressed upon admission, staff have clear instructions for providing safe and effective care, residents preferences and goals are honored, risks are identified early to prevent adverse outcomes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments for 1 of 16 residents (Resident #43) reviewed for comprehensive care plans. The facility added an indwelling urinary catheter to Resident #43's care plan three days before receiving a verbal physician's order to place an indwelling urinary catheter. This failure could place residents at risk of not receiving individualized care and services to meet their needs. The findings include: Record review of Resident #43's electronic face sheet, dated 05/20/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #43 had medical diagnoses which included anxiety, Alzheimer's disease, high blood pressure, neurogenic dysfunction of bladder (a condition where nerve damage disrupts the communication between the brain and bladder, leading to a loss of bladder control), and chronic pain. Record review of Resident #43's Comprehensive Care Plan, dated 03/18/2026, revealed Focus: Risk for Impaired Urinary Elimination r/t cognitive inability to urinate. Placement of catheter. Goal: Resident Will Have Normal Urinary Elimination Pattern. Interventions/Tasks: Insert 16fr (a unit of measure indicating the diameter of the drainage tubing) foley (a fixed tube placed in the urinary bladder to drain urine) catheter per Dr. [name] orders and remain in place. Record review of Resident #43's Quarterly MDS, dated [DATE], revealed in Section C – Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 3 out of 15, which indicated severe cognitive impairment. Section H – Bladder and Bowel, subsection H0100. Appliances, Z. None of the Above was selected. Record review of Resident #43'a physician orders, dated 03/21/2026, revealed Orders to place 16fr foley catheter r/t abdominal distention. Order to collect urine and if it is more than 600ml leave the catheter in place. 1500ml drained. catheter to remain til Doctor states otherwise. During an interview on 05/21/2026 at 12:43 PM, the DON stated the care plan should be reviewed frequently and if there were any changes to the resident's status. She stated she revised the care plans when she did her assessments and completed the MDS's. She stated she did not know how long to leave the care plan focused on a prior problem. The DON explained every discipline involved in an individual's care provided input for the care plan. She stated PT, RT, OT, shift nurses, ADON, DON, and CNAs were all involved. The DON stated she had not had formal care plan training when she was hired. The DON explained she was told to look at other care plans and learn from them. [NAME], [NAME] (37) Horn, Reisha (41944) - Care Planning No Notes [NAME], [NAME] (37) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Horn, Reisha (41944) - RESIDENT NOTE No Notes

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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 observation, interview, and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs, to include adequate monitoring for 1 (Resident #25) of 16 residents reviewed for unnecessary medications. The facility failed to have an adequate diagnosis and indication for the use of the medication Clonazepam for Resident #25. The facility failed to have an adequate diagnosis and indication for the use of the medication Diazepam for Resident #25. The facility failed to monitor the side effects of Clonazepam and Diazepam medications for Resident #25. These failures could place residents at risk for adverse consequences and decline in health.Findings included: Record review of Resident #25's electronic face sheet, accessed on 05/20/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: upper respiratory infection, and femur fracture. Review revealed no evidence of a diagnosis related to anxiety. Record review of Resident #25's Significant Change MDS assessment, dated 05/13/2026, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Further review of MDS revealed the use of antianxiety medications. Record review of Resident #25's care plan, revised on 05/19/2026, revealed no evidence of anxiety or antianxiety medications. Record review of Resident #25's electronic physicians orders revealed, Diazepam (medication used to treat anxiety) 10mg/ml gel give 1ml Apply to inner wrist topically every 4 hours as needed for Prophylaxis with no diagnoses entered, dated 05/14/2026, entered by ADON, Clonazepam (medication used to treat anxiety) Oral Tablet Disintegrating 0.25 MG Give 1 tablet by mouth at bedtime for Prophylaxis related to COGNITIVE COMMUNICATION DEFICIT, dated 05/14/2026, entered by LVN D, and Clonazepam Oral Tablet Disintegrating 0.25 MG Give 1 tablet by mouth every 8 hours as needed for Prophylaxis with no diagnoses entered, dated 05/14/2026, entered by ADON. Further review revealed no evidence of orders to monitor for side-effects related to the use of Clonazepam and Diazepam. Record review of Resident #25's electronic MAR for May 2026, revealed Clonazepam had been administered at 8:00 pm on 05/14/26, 05/15/26, 05/17/26, 05/18/26, 05/19/26, 05/20/26, and 05/21/26 and administered at 9:26 am on 05/22/26. Further review of MAR revealed no doses of Diazepam had been administered. Observation and interview on 05/19/2026 1:52 PM, revealed Resident #25 resting in bed, oxygen on at 3LPM via nasal cannula. Resident #25 stated she was recently in the hospital because she fell and broke her hip. During an interview on 05/21/2026 at 11:00 AM, the DON stated her expectation was for all psychotropic medications to have proper diagnosis and indications. She stated she did not know why these orders were entered inappropriately. She stated side-effect monitoring orders should have been in place. She stated it was her responsibility as DON to monitor. During an interview on 05/21/2026 at 11:33 AM, the ADON stated the order had been entered by the floor nurse and that she had edited the orders to add a stop date but had not noticed that the diagnoses and indications were incorrect. She stated prophylaxis was not an appropriate diagnosis or indication for an antianxiety medication. Record review of the facility's policy titled, Psychotropic Medication Policy and Procedure not dated, revealed in part, Policy: The facility will ensure residents are free from unnecessary psychotropic medications and that each resident's drug regimen is free from unnecessary medications unless clinically indicated to treat a diagnosed condition with adequate monitoring and documentation.