STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676019	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lampstand Nursing and Rehabilitation	2001 E 29th St Bryan, TX 77802

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food in accordance with professional standards for 1 of 1 kitchen observed for food service safety.1. The facility failed to properly store, label and date all food items located in the walk-in refrigerator on 04/08/2026 and 04/10/2026.2. The facility failed to ensure the dry food pantry was clean and free of accumulated black residue on the wall and shelves.These failures could have placed residents at risk for food contamination and foodborne illness.Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food in accordance with professional standards for 1 of 1 kitchen observed for food service safety.1. The facility failed to properly store, label and date all food items located in the walk-in refrigerator on 04/08/2026 and 04/10/2026.2. The facility failed to ensure the dry food pantry was clean and free of accumulated black residue on the wall and shelves.These failures could have placed residents at risk for food contamination and foodborne illness.Findings included:Observation during the initial tour of the kitchen on 4/08/2026 beginning at 9:07 AM, the following was observed in the walk-in refrigerator: 1 storage bag filled with slices of bread, crackers, cookies, pudding, and one other item unlabeled; the storage bag was labeled lunch bag with 4/5 date, no use by/discard date. Storage bag with several disposable cups of tartar sauce with a prep date of 3/27, no use by/discard date. 1 container with 3 prepared hamburger patties with melted cheese on top with prep date of 4/7 with use by date of 4/17(10 days later) 1 container of leftover gravy with a prep date of 5/6 and use by date of 5/11/2026 in the month of April.During a follow-up tour of kitchen of the dry food pantry area on 04/09/2026 beginning at 9:58AM, revealed a large area behind the food storage racks on the wall contained a black substance that resembled mold. The substance was also observed on the bottom shelf of the storage rack, and on the floor in dry food storage area.During tour of kitchen on 04/10/2026 beginning at 10:40 AM revealed a plastic storage container of individually packaged sandwiches (5 with meat, 1 with jelly/peanut butter), the sandwiches did not include labels with name, date, and discard date.Interview conducted on 04/10/2026 at 11:31 AM, [NAME] A stated she had worked for the company for 20 years but now she only worked PRN. [NAME] A stated that all dietary staff were responsible for labeling and dating food items. [NAME] A reported that all items must be labeled with an open and a discard date. [NAME] A stated that cooked foods are kept for a maximum of seven days, while dry food items vary depending on the specific product. [NAME] A stated that all staff were responsible for cleaning the dry food storage area, including the walls. [NAME] A stated that the spots observed on the wall looked like mold to her, she stated that maintenance cleaned the area earlier that morning. [NAME] A stated that the potential risk to residents, if the substance was mold, could be serious, including illness or possible death. [NAME] A reported that the process was to notify the manager immediately when any unknown or concerning substance is identified on surfaces.Interview conducted 04/10/2026 at 11:41 AM, the DMA stated she had been with the facility for a year. She stated that food items should be properly labeled and dated, including the product name, date opened, and a discard date of seven days. The DMA reported that food prepared in-house was to be used within seven days in accordance with facility policy. The DMA (continued on next page)

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	stated that the department followed a daily and weekly cleaning schedule. She reported that dry storage area shelves are cleaned approximately once per month. The DMA stated that the black substance observed on the wall in the dry storage area had been previously reported and that efforts had been made to resolve the issue. She reported she was not informed of the exact nature of the substance but stated that maintenance had been addressing it. The DMA stated the area was first treated back in June 2025, at which time a portion of the wall was removed; however, the substance has since reappeared. The DMA stated that the potential risk to residents included cross-contamination related to the presence of the substance.Interview conducted 04/10/2026 at 5:03 PM, the Maintenance Supervisor stated that an unknown substance had previously been present on the kitchen wall and that previous contractors had repaired a hole in the wall at that time. He reported that the cooler located next to the dry storage area does not always close properly due to worn door gaskets, resulting in an improper seal.The Maintenance Supervisor stated that condensation formed because the adjacent area was warmer, which may have contributed to the issue. He reported that a replacement door has been ordered from the manufacturer in [city] and was expected to be installed soon. He stated the new door will fix the issue. The Maintenance Supervisor stated that the potential risk associated with the substance is that it could cause illness if exposure occurred.Review of the facility's policy named Food Storage and Supplies dated 2012, revealed: Procedure:All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin and insects.9. Perishable items that are refrigerated are dated once opened and used within 7 days.Review of the facility's policy named Left -Over Foods, dated 2012 reflected: Left -over foods shall be handled in a manner to ensure the safe use of these foods at a later date.Procedure:1. Left-over foods shall be refrigerated, dated, labeled, and properly covered after meal service.A record review of the FDA's 2022 Food Code reflected the following:2. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.3. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.

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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 provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 3 of 7 residents (Resident #26, Resident #37, and Resident #76) reviewed for infection control. RN Treatment Nurse C did not change contaminated gloves prior to Resident #26's repositioning; contact with clean supplies; and she did not wash her hands after removing gloves post perineal care. RN B did not sanitize her hands between changing gloves while performing indwelling catheter care on Resident #37. ADON LVN F did not sanitize the over-the-bed table prior to setting supplies on it and turned her back to a sterile field multiple times while performing tracheostomy care on Resident #76. These failures could place the residents at risk of infection transmission, sepsis, and hospitalization. Findings included: A. Record review of Resident #26's face sheet, dated 04/10/2026, reflected [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified convulsions (sudden, involuntary, and often violent contractions of muscles, characterized by shaking, rigidity, and potential loss of consciousness), major depressive disorder severe with psychotic symptoms (a serious, common mental health condition characterized by persistent sadness, loss of interest, and low energy), and schizophrenia (a chronic, severe brain disorder causing distorted interpretations of reality, including hallucinations, delusions, and disorganized thinking). Record review of Resident #26's quarterly MDS assessment, dated 03/25/2026, reflected level 3 for cognitive skills for daily decision making indicating the severely impaired - never/rarely made decisions. Resident #26's MDS indicated his total dependance on helper for all efforts or the assistance of 2 or more helpers is required for the resident complete eating, oral hygiene, toileting hygiene, shower/bath and dressing. Record review of Resident #26's comprehensive care plan, dated 09/12/2025, reflected a focus Bowel and bladder incontinence with interventions included Provide peri care after each incontinent episode. Observation of Resident #26's peri care on 04/08/2026 at 1:26 PM. revealed RN Treatment Nurse C did not change gloves between cleaning the front and back perineal (area between the anus and the genital organs) areas of Resident #26 and touched Resident #26's clothes, body, bedding and clean incontinence brief while repositioning him with contaminated gloves. RN Treatment Nurse C removed contaminated gloves after completing Resident #26's peri care and did not wash hands before lowering resident's bed and moving privacy curtains, and opening resident's door. She did not wash her hands before and after leaving his room but sanitized her hands using a wall mount hand sanitizer dispenser in the hallway. During an interview on 4/08/2026 at 1:34 PM, RN Treatment Nurse C stated that she worked at the facility for three years and had an in-service on hand hygiene and infection control sometimes last month and she was supposed to change gloves between front and back peri area and wash hands with soap and water after taking gloves off and before leaving Resident #26's room. She stated that she forgot a hand sanitizer and was nervous during peri care observation by the surveyor. She stated that not washing hands and changing gloves according to the facility's policy could lead to cross contamination and infection control issues that could negatively affect residents. B. Record review of Resident #37's admission record, dated 04/10/2026, reflected a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures (sudden, uncontrolled bursts of electrical activity in the brain that cause temporary changes in behavior, movement, sensation), acute prostatitis (a sudden, severe bacterial infection of the prostate gland requiring prompt medical attention), and acute cystitis without hematuria (an infection of your bladder without blood in urine). Record review of Resident #37's comprehensive care plan, dated 12/02/2025, reflected a focus: indwelling catheter in place (a flexible tube placed in the bladder to continuously drain urine into an external bag, held in place by a water-filled balloon) with indicated interventions: provide catheter care every shift. Record review of Resident #37's orders revealed an order, dated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/12/2024, to provide catheter care every shift. Record review of Resident #37's quarterly MDS, dated [DATE], indicated BIMS level of 7, severe cognitive impairment, and always urinary and bowel incontinent with indwelling catheter in place During an observation on 4/10/2026 at 1:37 PM of Resident #37's indwelling catheter care performed by RN B, RN B completed hand hygiene before donning PPE and provided indwelling catheter care using clean wipe for each stroke when cleaned urinary meatus and catheter tubing. RN B did not sanitize her hands between gloves change and she touched with contaminated gloves the wipes package pulling out some additional wipes that were not out already. During an interview on 04/10/2026 at 1:45 PM, RN B stated that she had an in service on hand hygiene and infection control today. She stated that she did not sanitize her hands between changing gloves and she was not aware of facility's policy to sanitize hands between gloves change. She stated that if proper hand hygiene and infection control policy were not followed, it could negatively affect residents due to cross contamination and causing UTI. During an interview on 4/10/2026 at 9:01 AM, DON stated that she was a DON at this facility for five years. She stated that in-service on hand hygiene and infection control provided to staff on continues basis and nursing management including infection preventionist and herself were responsible for monitoring staff followed the proper protocol for hand hygiene and infection control. She stated that hands need to be washed before going to the resident's room and after completing resident direct care. She stated that hands need to be sanitized between gloves changes to prevent cross contamination. During an interview on 4/10/2026 at 9:36 AM, ADON LVN IPCP E stated she worked as an infection preventionist at the facility for 7-8 years. She stated that she was responsible for monitoring staff following facility infection control policies and providing staff in-services on infection control to protect residents and prevent the cross contamination. She stated that hand washing should be completed before going to resident's room and after completing incontinent care and before exiting the room. She stated that hand hygiene should be performed between gloves' changes. During an interview on 4/10/26 at 9:53 AM, ADM stated that she worked at the facility for 9 months. She stated that she had in-service on hand hygiene and infection control a few months ago. ADM stated that nursing management including ADONs, infection preventionist and DON were responsible for overseeing the staff adhering to proper infection control protocol and educating staff in need of additional training. She stated that hands should be washed during peri care, before touching anything in residents' environment, between gloves change, and before leaving resident's room. She stated that if not following proper infection control policy could negatively impact residents due to their vulnerable status. Review of undated facility policy titled Hand hygiene reflected: You must use soap/water for the following: (alcohol-based hand cleaner is not recommended): before and after assisting a resident with toileting (hand washing with soap and water). Review of facility policy on Perineal Care, dated 4/27/2022, reflected: 24) Doff gloves and PPE. 25) Perform hand hygiene. 26) Provide resident comfort and safety by re-clothing, straightening bedding,.and placing call light within resident's reach. Always perform hand hygiene before and after glove use. C. Record review of Resident #76's admission record, dated 04/08/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Tracheostomy status (a tube inserted into the front of the neck to assist with breathing), hypercapnia (elevated levels of carbon dioxide in the blood), chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (a condition where the respiratory system fails to maintain adequate gas exchange leading to insufficient oxygen and/or excessive carbon dioxide in the blood). Record review of Resident #76's comprehensive MDS, dated [DATE], reflected a BIMS score was not assessed due to Resident #76 was in a persistent vegetative state. Section O - Special Treatments, Procedures, and Programs reflected Resident #76 received tracheostomy care while a resident. Record review of Resident #76's order summary, dated 04/08/2026, reflected Tracheostomy care q shift with a start date of 01/29/2026 and Suction Trach q 6 hours and PRN every 6 hours related to TRACHEOSTOMY STATUS with a start date of 01/29/2026. Record review of Resident #76's comprehensive care plan, dated 01/30/2026 and last revised on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/10/2026, reflected a focus The resident has Tracheostomy with interventions that included Suction as necessary and Use universal precautions. Assist with coughing as needed. During an observation on 04/08/2026 at 09:17 AM, ADON LVN F entered the room, walked to the resident to visually assess Resident #76's respiratory status. She walked to the nightstand in the room and opened the drawer to withdraw supplies. She placed the trach care kit on the over-the-bed table in the room (she did not sanitize the table prior to setting supplies down). ADON LVN F walked to the bathroom and washed her hand then walked out of the room and returned shortly afterward wearing a gown and gloves. ADON LVN F used a pulse oximeter on Resident #76's left index finger. She opened the suctioning supplies including the suction catheter, sterile water bottle (partially used), and the basin for sterile water. ADON LVN F then doffed (took off) the gloves, sanitized her hands, and donned (put on) sterile gloves. ADON LVN F turned around and connected the suction catheter to the suction tubing and pulled the tracheostomy collar away from the tracheostomy site with her back to the sterile field with the supplies for tracheostomy care. She inserted the suction catheter into the tracheostomy and pulled it out. She turned back toward the sterile field to place the tip of the suction catheter inside the previously opened bottle of sterile water that she held with her left hand that was wearing sterile gloves. ADON LVN F turned her back again to the sterile field and inserted the suction catheter into Resident #76's tracheostomy. She turned back to the supplies and inserted the suction catheter into the sterile water bottle that she was stabilizing with her gloved left hand. ADON LVN F turned her back again to the over-the-bed table with supplies on it to insert the suction catheter into the tracheostomy again. She turned back to Resident #76 and removed the dressing around the tracheostomy and disposed of it in the trash bin. ADON LVN F then doffed her sterile gloves, sanitized her hands, and opened the tracheostomy care kit. She sanitized her hands again and opened a new bottle of sterile water. ADON LVN F poured sterile water from the new bottle into the tracheostomy kit's tray. She sanitized her hands and donned new sterile gloves. ADON LVN F grabbed saturated gauze from the tracheostomy care tray and turned her back to the sterile field to use the gauze to clean the area around the tracheostomy then threw the gauze in the trash. ADON LVN F turned her back to the sterile field and removed the inner cannula (plastic tube that goes inside the tracheostomy), she turned back to the sterile field to use the cotton swabs that were in the tracheostomy care kit to clean the inner cannula. ADON LVN F turned back to Resident #76 and inserted the inner cannula into the tracheostomy. ADON LVN F then changed Resident #76's necktie and aerosol line appropriately. During an interview on 04/09/2026 at 01:20 PM, ADON LVN F stated she had worked at the facility for about 7 years. ADON LVN F stated she was trained to use sterile technique when providing tracheostomy care. She stated she recalled briefly turning her back to her sterile field during the tracheostomy care. ADON LVN F stated by turning her back to the sterile field, it would not be considered a sterile field after that. She stated she did not disinfect the over-the-bed table prior to placing the tracheostomy care supplies on it, but she should have. ADON LVN F stated not maintaining sterile technique or disinfecting the surface prior to setting down her supplies could introduce bacteria to the resident. During an interview on 04/10/2026 at 12:03 PM, ADON LVN IPCP E stated she was responsible for the infection prevention and control program and had received specialty training. The ADON LVN IPCP E stated she was trained that a sterile field must remain in front of the staff using it. She stated staff must not turn away from the sterile field. ADON LVN IPCP E stated she expected staff to disinfect surfaces prior to setting supplies down on it, especially when it is a sterile procedure. She stated not disinfecting the surface prior to performing tracheostomy care or turning away from a sterile field could introduce bacteria into a resident's respiratory system if done while performing tracheostomy care. During an interview on 04/10/2026 at 04:42 PM, the Director of Nurses stated she had worked at the facility for about 5 years. She stated she expected staff to follow policy and procedure when performing tracheostomy care to a resident. She stated that staff turning their back to the sterile field was not following policy. The Director of Nurses stated a sterile field needed to be always monitored to ensure it remains sterile. She stated if the sterile field (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is contaminated, then a resident could get an infection. During an interview on 04/10/2026 at 04:50 PM, the Administrator stated she expected staff to follow all infection control protocols when performing tracheostomy care. She stated she did not consider staff turning their back to a sterile field following infection control protocol. She stated staff turning their back to the sterile field could expose a resident to a contaminated source. Review of undated facility policy titled Tracheostomy Care Procedure reflected: Policy:Tracheostomy care will be performed per physician's order. Tracheostomy care is a procedure designed to maintain a patient airway and a sterile/clean area in and around a patient's tracheostomy. This procedure is performed using aseptic [sterile] technique at least every twelve (12) hours and as needed. When the tracheostomy tube holder is changed (usually once per day), the procedure requires two (2) people. Procedure:.4. Wash hands and observe universal precautions.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #26) of 7 residents reviewed for resident rights. The facility failed to encourage and assist Resident #26 with dressing in his preferred personal clothing which was available on-site rather than hospital type gowns during the day. This failure could place residents at risk for diminished quality of life, loss of dignity, and a decrease sense of self-worth. The findings include: Record review of Resident #26's face sheet, dated 04/10/2026, reflected [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified convulsions (sudden, involuntary, and often violent contractions of muscles, characterized by shaking, rigidity, and potential loss of consciousness), major depressive disorder severe with psychotic symptoms (a serious, common mental health condition characterized by persistent sadness, loss of interest, and low energy), and schizophrenia (a chronic, severe brain disorder causing distorted interpretations of reality, including hallucinations, delusions, and disorganized thinking). Record review of Resident #26's quarterly MDS assessment, dated 03/25/2026, with a level 3 for cognitive skills for daily decision making indicating the severely impaired - never/rarely made decisions. Resident #26's MDS indicated his total dependance on helper for all efforts or the assistance of 2 or more helpers is required for the resident complete eating, oral hygiene, toileting hygiene, shower/bath and dressing. Record review of Resident #26's comprehensive care plan, dated 09/12/2025, reflected a focus on ADL Self CarePerformance Deficit and indicated interventions: Dressing: Assist the resident to choose simple comfortable clothing thatmaximizes the president's ability to dress self. Monitor for escalating anxiety, depression or and report immediately to the nurse. Observation of Resident #26 on 04/08/2026 at 09:30 a.m. reflected Resident #26 was wearing hospital gowns during the day between 8 a.m. and 5 p.m. on all three days while he was out of his room watching TV in the common area, therapy sessions and eating meals in the dining room. Nursing staff provided Resident #26 with showers and dressed him in clean hospital gowns and not his personal clothing that was available in his room. Observation of Resident #26 on 04/09/2026 at 11:30 a.m., reflected Resident #26 was wearing hospital gowns during the day between 8 a.m. and 5 p.m. on all three days while he was out of his room watching TV in the common area, therapy sessions and eating meals in the dining room. Nursing staff provided Resident #26 with showers and dressed him in clean hospital gowns and not his personal clothing that was available in his room. Observation of Resident #26 on 04/09/2026 at 1:30 p.m. reflected Resident #26 was wearing hospital gowns during the day between 8 a.m. and 5 p.m. on all three days while he was out of his room watching TV in the common area and eating meals in the dining room. Nursing staff provided Resident #26 with showers and dressed him in clean hospital gowns and not his personal clothing that was available in his room. Observation of Resident #26's closet on 04/09/2026 at 2:21 p.m., revealed a variety of clothing items available in Resident #26's closet. The sign on Resident #26's closet indicated that family was doing his laundry. The laundry hamper was empty at that time. During an interview on 04/08/26 at 11:05 a.m. with RN C during Resident #26's peri care, she stated that to her knowledge this resident did not have personal clothes in his room. During an interview on 04/09/2026 at 1:05 p.m. with CNA P she stated this resident had clothes in his room and she put a hospital gown just because it was easier to put it on in the morning. During interview on 04/09/2026 at 2:05 p.m., Resident #26's family member stated that she washes his clothes on regular basis and Resident #26 had plenty of different clothes to choose from in his room. She stated that Resident #26 liked wearing regular clothes and preferred wearing regular clothes and not a hospital gown. She stated that not wearing regular clothes affected Resident #26's feelings about himself. During an attempted interview (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Resident #26 on 4/09/2026 at 2:15 p pm. to identify his preference of clothes, he was unable to give comprehensive answer regarding him wearing hospital gown during the day. During an interview on 04/10/2026 at 2:15 p.m., ADON LFN F stated that Resident #26 does not always have clean clothes available in his room as his family member does the laundry and do not bring the clean clothes back to the facility. She stated that staff must put personal clothes on Resident #26 when it was available and she was responsible for overseeing nursing staff assisting residents with wearing their personal clothing. She stated that she was aware of Resident #26's RP wanted him to wear his own clothes and not a hospital gown. She stated that wearing clothes of choice was Resident #26's right. During an interview on 04/10/2026 at 9:01 a.m., DON stated that staff should assist residents in dressing in their own clothes including Resident #26 who should be dressed in his own clothes if it's available. She stated that wearing hospital gown during the day was not acceptable if Resident #26 or his RP indicated their preference for wearing personal clothes as all residents have a right to choose their own clothes. During an interview on 04/10/2026 at 9:53 AM, ADM stated that residents have a right to choose their own clothing and staff should provide them with this choice. She stated that Resident #26 should be wearing his own clothes if he has them available. She stated that wearing hospital gown during the day could affect residents' dignity in general. During interview on 04/10/2026 11:26 a.m., The Area Director of Operations stated that residents have a right to choose their own clothes to dress and wearing a hospital gown could affect their dignity. She stated that she heard that Resident #26 resisted staff assisting him with wearing his clothing, but after verifying with nursing staff on 04/10/2026, she stated that staff informed her Resident #26 did not indicate resistance to dressing provided by staff at this time. Review of facility's undated policy Resident Rights revealed residents have the right to retain and use personal possessions, including.clothing. Review of facility's undated policy Dressing and Personal Grooming revealed: The purpose of this procedure are to assist the resident as necessary with dressing and undressing. to encourage the resident to choose the clothes that he or she will wear for that day. Dress the resident in his or her own clothing.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 15 residents (Resident #10) reviewed for resident rights.The facility failed to ensure Resident #10's bathroom was free from dirt on the floor.This failure could place residents at risk of infection and diminished quality of life.Findings include:Record review of Resident #10's admission record, dated 04/10/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included urinary tract infection, depression (a mood disorder with persistent feeling of sadness and loss of interest), and chronic kidney disease (the gradual loss of kidney function).Record review of Resident #10's Quarterly MDS, dated [DATE] reflected a BIMS score of 13, which indicated no cognitive impairment.During an interview and observation on 04/08/2026 at 1:55 PM, Resident #10 stated it made her upset that the facility did not clean her bathroom appropriately on a daily basis. She stated there was a dirt ring around the perimeter of the bathroom floor in her room and she escorted this investigator to the bathroom in question. She stated the staff did not sweep before they mopped in her bathroom. Observation revealed a dark colored dirt/dried mud like substance with debris around the perimeter of the bathroom. During an observation on 04/10/2026 at 9:04 AM, Resident #33's bathroom floor revealed a dark colored dirt/dried mud like substance with debris around the perimeter of the bathroom.During an interview on 04/10/2026 at 12:03 PM, the ADON LVN IPCP E stated she expected resident's rooms, including bathrooms, to be swept and mopped daily. The ADON LVN IPCP E reviewed pictures of Resident #33's bathroom and stated she did not consider the pictures to reflect a clean floor. She stated a resident could get sick if their room/bathroom is not cleaned regularly and if they had an open area then germs could cause an infection.During an interview on 04/10/2026 at 03:59 PM, the housekeeping manager stated she had received training from corporate on how to manage the housekeeping department. She stated she expected her staff to sweep first then mop, including all the corners, of resident's rooms every day. After reviewing the pictures of Resident #33's bathroom floor, she stated she did not consider that to be clean. The housekeeping manager stated if a resident's room was not cleaned appropriately, then if they have an allergy to dust or dirt it can trigger the allergy. She stated the smell could affect the resident or even make the resident sad or depressed.During an interview on 04/10/2026 at 04:42 PM, the Director of Nurses stated she expected housekeeping to keep rooms clean, so the facility can provide the residents with a home-like environment. After reviewing the pictures of Resident #33's bathroom floor, the Director of Nurses stated, that is not a clean environment. She stated a resident could get sick if their environment was not kept clean.During an interview on 04/10/2026 at 04:50 PM, the Administrator stated she expected staff to sweep and mop the Resident's rooms and bathrooms daily. After reviewing the pictures of Resident #33's bathroom floor, the Administrator stated the pictures did not meet her expectations. She stated if the residents' rooms were not cleaned appropriately, then it could expose the residents to an unclean surface and potential infection.Review of undated facility policy titled Resident Rights reflected The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.Self-Determination - The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice.11. The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility may charge the resident for requested services that are more expensive than or in excess of covered services.a. Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: .iv. Room/bed maintenance services.

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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 interviews and record reviews 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 2 (Resident #22 and Resident #52) out of 8 residents reviewed for care plans. The facility failed to update the comprehensive care plan to reflect Resident #22 and Resident #52 received in room activity programs. This failure could have placed residents at risk for not having their needs identified and met. Findings include: Record review of Resident #22's face sheet, dated 04/09/2026, reflected a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), cognitive communication deficit (a communication impairment caused by underlying disruptions such as memory and attention deficit rather than primary speech or language problems), and lack of coordination (the inability to control voluntary muscle movements, resulting in jerky, unsteady, or clumsy motion). Record review of Resident #22's Annual MDS Assessment, dated 01/15/2026 reflected Resident #22 had a BIMS score of 15 indicating her cognition was intact. Resident #22's activity preferences were the following: participate in favorite activities and keep up with the news. Record review of Resident #22's Comprehensive Care Plan, dated 01/26/2026, reflected Resident #22's activity care plan was not revised to meet his current activity preferences. Record review of Resident #52's face sheet, dated 04/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), contracture left and right hand (a common, progressive hand deformity where tissues under the palm skin thicken, forming cords that pull one or more fingers into a permanently bent position), limitation of activities due to disability (a reduction in a person's ability to perform tasks due to physical impairment), and hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (paralysis on the left side of the body due to tissue damage to the brain or spinal cord). Record review of Resident #52's Annual MDS Assessment, dated 06/30/2025 reflected Resident #52 had a BIMS score of 7 indicating his cognition was severely impaired. Resident #52 enjoyed participating in his favorite activities (does not specify his favorite activities). Record review of Resident#52's Quarterly MDS Assessment, dated 3/11/2026, reflected Resident #52 had a BIMS score of 7 indicating his cognition was severely impaired. Record review of Resident #52's Comprehensive Care Plan, dated 04/07/2026, reflected Resident #52's activity care plan was not revised to meet his current activity preferences. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #22 and Resident #52's Activity Participation records reflected they were to receive in room activities in January 2026, February 2026, March 2026 , and April 2026. Interview on 04/08/2026 at 3:00 pm The Activity Director stated Resident #22 and Resident #52 were on in room activity programs. She stated they did not prefer to attend group activities. She stated anytime there was a change in the resident's activity preferences she was expected to revise the care plan. The Activity Director stated Resident #22 and Resident #52's care plan was recently updated sometime in January or February 2026. She stated in-room activities needed to be added to Resident #22 and Resident #52's care plan. She stated if Resident #22 and Resident #52 were having any type of behaviors or felt lonely the staff would not know their activity plan if it was not revised to their current preferences. She stated with Resident #22 and Resident #52's care plan not revised, and this could affect them not having their needs met by staff. She stated it was her responsibility to revise any care plan related to activities. The Activity Director stated in-room activities were not on Resident #22 and Resident #52's current activity care plan. Interview on 04/10/2026 at 9:52 am The Director of Nurses stated anytime a resident's activity preference changed the care plan was expected to be revised. She stated if a resident preferred in room activities the other staff needed to know this information to prevent him from becoming frustrated when staff may invite him to activity programs. The Director of Nurses stated the Activity Director was responsible for discussing the changes in the care plan with the interdisciplinary team and making the revision on the care plan. Interview on 04/10/2026 at 2:30 pm the MDS Coordinator LVN stated if a resident had a change in their activity preference the activity care plan was expected to be revised. She stated the Activity Director was expected to discuss the changes with the interdisciplinary team. The MDS Coordinator, LVN was responsible to make the revision to the care plan. She stated it was very important to revise any changes with the resident to the care plan. She stated the staff would not know what type of care or activities to do with the resident if the care plan was not updated to meet their current needs and preferences. She stated in-room activities were not on Resident #22 or Resident #52's current care plan. Record review of the facility's undated policy titled Comprehensive Care Planning reflected The resident's preferences and goals may change throughout their stay, so facilities should have an ongoing discussion with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical physical, mental and psychosocial needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident # 22 and Resident #52) reviewed for ADL care.The facility failed to ensure Resident #22 and Resident #52's nails were cleaned and did not have any on 04/08/2026 and 04/09/2026. This failure could place residents at risk of not receiving services or care, diminished quality of life , and decreased self-esteem.Findings included: Record review of Resident #22's face sheet, dated 04/09/2026, reflected a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), type 2 diabetes mellitus without complications (a person's body cannot use insulin properly and/or does not make enough insulin. This leads to high blood sugar. Person does not have any physical complications related to diabetes), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis on the right side of the body due to tissue damage to the brain or spinal cord), and lack of coordination (the inability to control voluntary muscle movements, resulting in jerky, unsteady, or clumsy motion).) Record review of Resident #22's Annual MDS Assessment, dated 01/15/2026 reflected Resident #22 had a BIMS score of 15 indicated cognition was intact. Resident #22 required supervision or touching assistance with the following ADLS:Personal hygieneToileting hygieneShowersLower body dressingTransfersBed mobility Record review of Resident #22's Comprehensive Care Plan, dated 01/26/2026, reflected Resident # 22 had ADL self-care performance deficit. Interventions: Assist Resident #22 with personal hygiene. Bathing: Check Resident #22's nail length, trim and clean on bath day and as needed. Observation and interview on 04/08/2026 at 10:00 a.m. revealed Resident #22 was lying on his bed. Resident #22's fingernails on his right hand underneath his forefinger, middle, ring fingernails had a blackish/brownish substance. He had blackish/brownish substance underneath his ring, middle and fore fingernails on his left hand. He stated he asked someone Saturday (04/03/2026) to clean his nails and the person stated they would get someone to clean them on Sunday (04/04/2026). He stated no one came to his room to clean his nails on Sunday. Resident #22 stated he did not recall the staff name. He stated she worked with the nurses.Record review of Resident #52's face sheet, dated 04/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), contracture left and right hand (a common, progressive hand deformity where tissues under the palm skin thicken, forming cords that pull one or more fingers into a permanently bent position), limitation of activities due to disability (a reduction in a person's ability to perform tasks due to physical impairment), and hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (paralysis on the left side of the body due to tissue damage to the brain or spinal cord).Record review of Resident #52's Quarterly MDS Assessment, dated 03/11/2026, reflected Resident #52 had a BIMS score of 7 indicating his cognition was severely impaired. Resident #52 was dependent on staff for the following:Personal hygieneUpper and lower body dressingShowersToileting hygieneShower transfersRecord review of Resident #52's Comprehensive Care Plan, dated 04/07/2026, reflected Resident #52 had an ADL self-care performance deficit. Intervention: Bathing: Resident #52 required assistance by staff with bathing. During bathing check nail length, trim nails, clean nails, and as needed. Assist Resident #52 requires (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with personal hygiene.Observation and interview on 04/09/2026 at 10:30 am revealed Resident # 52 was lying in his bed located in his room. Resident #52's fingernails on his left and right hand underneath his middle and ring fingernails had a blackish/brownish substance. Resident #52 did not want to answer any questions.In an interview on 04/10/26 at 8:02 am, the Administrator stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria, however it would be difficult to determine if the blackish/ brownish substance was bacteria. She stated it was a possibility a resident may become ill with stomach issues such as vomiting and nausea if they ingested the blackish/ brownish substance. She stated the Nurses were responsible for diabetic residents' nails such as cleaning, trimming, and filing. She stated the CNAs were responsible for nail care on all other residents. She stated nail care was completed on shower days, Sundays and as needed. She stated the ADON and DON were responsible for monitoring ADL care which included nail care. The Administrator stated anyone who observed Residents needing any type of nail care was instructed to report to the nurse. She stated an in-service had been given to the staff on nail care. The Administrator stated she did not recall the date. In an interview on 04/10/2026 at 10:20 am, RN L stated the nurses were responsible for all residents' with diagnosis of diabetes nail care such as trimming, cleaning, and filing. She stated the CNAs were responsible for all other residents' nail care. She stated nail care was usually completed on Sundays, as needed and during showers. RN L stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill, such as an infection in the stomach. She stated there was a possibility a resident may have nausea and vomiting. RN L stated if a resident refuses showers, nail care or any type of care the nurses document in the nurse's progress notes. She stated she was not aware of Resident # 22 and Resident #52 refusing nail care. RN L stated she had been in-serviced on nail care, and all staff was to report any nail issues with the resident to the nurse.In an interview on 04/10/2026 at 10:40 am, CNA M stated the nurses were responsible for diabetic nail care. She stated if a CNA observed any problems with a resident's nails the CNA was to report it to the nurse supervisor with any resident. CNA M stated the CNAs complete all nail care for residents without a diabetes diagnosis. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as nausea and diarrhea. CNA M stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. CNA M stated anytime a resident refused any type of care she reported it to the charge nurse and the charge nurse would document it in the resident's medical record. She stated she was not aware of Resident # 22 or Resident #52 refusing nail care. She stated she had been in-service on nail care; however, she did not recall the date.In an interview on 04/10/2026 at 10:55 am, RN B stated the CNAs were responsible to clean and trim all residents' nails except for the residents with diabetes. She stated the nurses were responsible for nail care for diabetic residents. RN B stated the residents' nails were usually cleaned during shower days and on Sundays. She stated she was not an expert on bacteria and could not answer the question if a resident ingested blackish/brownish substance. RN B stated an upper GI doctor would need to respond to that question. She stated how was she to know what may happen to a resident if they ingested feces. She stated this was not in her scope of knowledge on feces or bacteria. RN B refused to respond to any further questions. Record review of the facility's policy on Nail Care, not dated, reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle care and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	common. Ingrown toenails are also common in the elderly. Fungal infections of the toenails, dry, brittle ridges and thickening of the nails all occur in the elderly with some frequency.Goals1. Nail care will be performed regularly and safely.2. The resident will be free from abnormal nail conditions3. The resident will be free from infection. ProcedureShould be performed according to the resident centered plan of care.1. Explain the procedure to the resident.2. Wash hands.3. Immerse hands or feet in a basin of warm soapy water to cleanse and soften the nails for ease incleansing and trimming. Use a soft brush if necessary to cleanse under and around the nails.4. Remove debris from under the nails with an orange stick while soaking.5. Remove the hands or feet from the basin and pat dry.6. Apply lotion and massage into the cuticles and push back with a towel. Avoid cutting anycuticle.7. Trim the nails with a clipper, straight across for the toenails and rounded for the fingernails.8. Smooth the nails with an emery board.9. Apply hose and shoes or slippers as appropriate.10. Discard removed nails, cleanse basin and articles used and store for future use.11. Wash hands.12. Nails that are ingrown, thickened, or infected should be cared for by a podiatrist. Reportconditions immediately to the primary nurse. The nurse will ensure a referral to the podiatrist.13. Cutting should not be any shorter than at the line even with the nail folds on each side.14. When performed at bath time, the nail care can be done following the procedure or as a separateprocedure when needed at the convenience of the resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an ongoing activity program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 (Residents #22, and #52 of 6 residents reviewed for activities. The facility failed to provide activities for Resident #22 and Resident #52 to meet their psycho-social and mental needs for the months of January, February , March and April 2026.This failure could place residents at risks of boredom, depression, behavior, diminished quality of life and decreased cognitive function. Findings include:Record review of Resident #22's face sheet, dated 04/09/2026, reflected a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), cognitive communication deficit (a communication impairment caused by underlying disruptions such as memory and attention deficit rather than primary speech or language problems), and lack of coordination (the inability to control voluntary muscle movements, resulting in jerky, unsteady, or clumsy motion). Record review of Resident #22's Annual MDS Assessment, dated 01/15/2026 reflected Resident #22 had a BIMS score of 15 indicated cognition was intact. Resident #22's activity preferences were the following: participate in favorite activities and keep up with the news. Record review of Resident #22's Comprehensive Care Plan, dated 01/26/2026, reflected Resident #22's activity care plan was not revised to meet his current activity preferences. Record review of Resident #22's Activity Participation records reflected Resident #22 did not receive in-room activities during the months of January 2026, February 2026, March 2026, and April 2026. Observation and interview on 04/08/2026 at 10:00 a.m. revealed Resident #22 was lying on his bed. Resident #22 stated he did not enjoy going to group activities. He stated he preferred someone coming to his room and talking with him. Resident #22 stated he had not received any activity visits from anyone. He stated he remembered telling someone he wanted activities in his room few months ago, but he did not recall the person's name. Resident #22 stated he would go out of his room, but he enjoyed talking to people and wanted someone to come to his room and visit with him about 15 to 20 minutes about 4 days per week. He stated it did not need to be every day. Record review of Resident #52's face sheet, dated 04/09/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety (a medical diagnosis indicating that a person has a clear memory loss and the specific cause and severity have not been determined and does not have any behaviors associated with unspecified dementia), contracture left and right hand (a common, progressive hand deformity where tissues under the palm skin thicken, forming cords that pull one or more fingers into a permanently bent position), limitation of activities due to disability (a reduction in a person's ability to perform tasks due to physical impairment), and hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (paralysis on the left side of the body due to tissue damage to the brain or spinal cord).Record review of Resident #52's Annual MDS Assessment, dated 06/30/2025 reflected Resident #52 had a BIMS score of 7 indicating his cognition was severely impaired. Resident #52 enjoyed participating in his favorite activities (does not specify his favorite activities).Record review of Resident #52's Quarterly MDS Assessment, dated 3/11/2026, reflected Resident #52 had a BIMS score of 7 indicating his cognition was severely impaired.Record review of Resident #52's Comprehensive Care Plan, dated 01/26/2026, reflected Resident #52's activity care plan was not revised to meet his current activity needs. Record (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #52's Activity Participation records reflected Resident #22 was to receive in-room activities. He did not receive in-room activities during the months of January 2026, February 2026, March 2026, and April 2026. Observation and interview on 04/09/2026 at 10:30 am revealed Resident # 52 was lying in his bed he did not have his television on and there was no stimulation in his room. Resident #52 stated no when attempted to ask him any questions.Interview on 04/08/2026 at 3:00 pm The Activity Director stated Resident #22 and Resident #52 were on in room activity programs. She stated both residents did not prefer to attend group activities. She stated she could not explain why Resident #22 and Resident #52 did not receive in-room activities. The Activity Director stated if a resident did not receive activities there was a possibility the resident may become depressed, isolate themselves in their room, not have any stimulation, have a decline in the mental status, and have a decline in their overall well-being. She stated all residents were expected to receive some type of activities. The Activity Director stated she had been working at the facility since August of 2025 and had her certificate of completing required activity courses. She stated she had worked as an activity assistant in a different city. She reviewed the participation records and agreed Resident #22 and Resident #52 did not receive in-room activities during January, February, March and April 2026. She stated both men (Resident # 22 and Resident #52) did not enjoy coming to activity programs outside of their room.Interview on 04/10/2026 at 11:45 a.m. the Administrator stated she expected a variety of activities to be provided for all residents. She stated each resident's activity preference needed to be assessed, and each resident's activity was expected to be planned according to their activity preferences. She stated activities such as independent, in-room, and/or group activities were to be documented on participation records. The Administrator stated she expected all residents to be interviewed, and their activity preferences updated and all care plans to be revised to reflect each resident's activity preferences. She stated if a resident was not receiving activities there was potential a resident would have a decline in their cognition, mental status, physical status and quality of life. She stated a resident with a history of depression may become depressed and isolate themselves in their rooms. The Administrator stated the Activity Director and Activity Assistant were responsible for the activity programming and documentation of all activities department including participation records. She stated she was the Activity Director's supervisor. Record review of the Activity Director's personnel file reflected Activity Director had a National Certification Council for Activity Professionals certificate with expiration date of 09/01/2027.Record review of Activity Participation, group and in- room activities, dated 12/5/2025, reflected Activity Director received this in-service.Record review of the facility policy on Activity Programming, dated 2011, reflected The Activity Director and staff will provide for ongoing activity programs. Programs will be geared to maintain functional ADLS, provide social interaction and, as the same time, protect residents from environmental over stimulation. Those who cannot participate in group settings are provided with individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation or physician ordered bed rest. Record review of the facility's policy on Activity Documentation- General Guidelines, dated 05/06/2025, reflected the following areas are considered documentation responsibilities of the Activity Director and staff and should be completed in a comprehensive and timely manner such as: Resident Participation Records.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lampstand Nursing and Rehabilitation	2001 E 29th St Bryan, TX 77802

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record reviews the facility failed to ensure the resident environment remained as free of accident hazards as is possible for one of three housekeeping carts (Housekeeping Cart #1) reviewed for hazards.The facility failed to ensure Housekeeping Cart #1, with chemicals inside the compartments, was locked when unsupervised. This failure could place residents at risk for injuries, illness, and hospitalization.Findings included:Observation on 04/08/2026 at 9:15 am revealed Housekeeping Cart #1 was located near 100 hall. The compartment where chemicals were stored was not locked. The compartment had glass cleaner, disinfectant cleaner, tub and tile cleaner, and bio waste degrader. Housekeeper G was not standing near the housekeeping cart, and no other staff was near the unlocked housekeeping cart. Housekeeper G was at the end of 100 hall. There were not any residents near the unlocked housekeeping cart.During an interview on 04/08/2026 at 9:25 a.m., Housekeeper G stated the housekeeping cart was expected to be locked anytime housekeeper walked away from the cart. Housekeeper G stated she could not see Housekeeping Cart #1 from the 100 hallway. She stated there was a possibility that if a resident drank some of the chemicals the resident may become sick with stomach issues or have an allergic reaction. She stated it was possible a resident may need to be evaluated at the hospital. She stated she did have a key to the housekeeping cart, but it was difficult to lock the cart.Interview on 4/10/2026 at 8:05 a.m., the Administrator stated he expected the housekeeping cart to be locked at all times when the housekeeper was not obtaining an item from the housekeeping cart. The Administrator stated all housekeeping staff had been in-serviced on locking the housekeeping carts. She stated she checked with the nursing staff and there were not any residents who wandered on the 100 hall. The Administrator stated if a resident drank a chemical there was a possibility a resident may become ill with nausea and vomiting. She stated there was a possibility a resident may need to be transported to the emergency room for further evaluation. Interview on 04/10/2026 at 1:30 p.m., the Housekeeping Supervisor stated if a resident swallowed the chemical the nurse would not know what type of care to give the resident without knowing the name of the chemical. She stated all housekeeping carts were expected to be locked anytime the housekeeper was not standing in front of the cart. The Housekeeping Supervisor stated if a resident ingested some chemicals there was a potential for an allergic reaction, such as burning their throat, stomach and may need to be assessed at the hospital. She stated all housekeeping staff were in-serviced on locking housekeeping carts. She stated there was a possibility if a resident spilled chemical on their skin it may cause irritation to the skin. Review of the Facility's Daily Common Area Cleaning, dated 2026, reflected Housekeeping carts/chemicals must be locked when not within the eyesight of a staff member.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure that a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #16) of three residents reviewed for catheter care. The facility failed to have the appropriate size foley catheter (a medical device used to drain urine from the bladder) in the facility when Resident #16 was complaining of pain from his catheter on 04/08/2026.This failure could place residents at risk for infection, sepsis(a serious condition in which the body responds improperly to an infection, causing organ damage) and hospitalization.Findings included:Review of Resident #16's face sheet, dated 04/09/2026, reflected Resident #16 was a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (a diagnosis of diabetes where high blood sugar exists but had not caused chronic damage to organ systems), benign prostatic hyperplasia with lower urinary tract symptoms (a non-cancerous enlargement of the prostrate - a small gland in the male reproductive system- common in aging men, leading to lower urinary tract symptoms by compressing the urethra- a tube that connects the bladder to the outside of the body, allowing urine to be expelled. Symptoms include weak stream, hesitancy, frequency, urgency of urination), retention of urine (the inability to fully or partially empty the bladder, causing urine to remain in the bladder even after attempting to urinate), and obstructive and reflux uropathy (a blockage in the urinary tract that hinders urine flow, causing backflow (reflux) and kidney injury).Review of Resident #16's admission MDS Assessment, dated 02/04/2026, reflected Resident #16 had a BIMS score of 15 indicating his cognition was intact. Resident #16 had an indwelling catheter.Review of Resident #16's Comprehensive Care Plan dated 2/19/2026 reflected Resident #16 had an indwelling foley catheter. Interventions: Resident #16 had a 16 F 10 ml foley catheter. Position catheter bag and tubing below the level of the bladder in a privacy bag. Change the catheter as ordered. Monitor and document for pain or discomfort due to catheter. Monitor, record and report to MD(medical doctor) for signs and symptoms of UTI.Review of Resident #16's Physician Order dated 02/02/2026 reflected Resident #16 had an order for a foley catheter 16 F with 10 bulb-change for occlusion (blockage , closure, or bringing together of two surfaces),leaking, closed system was compromised as needed. Pain medication was ordered on 04/08/2026 and started on 04/08/2026 at 5:30 pm.Review of the invoice on 04/08/2026 approximately 2:30 pm received from the Medical Record/ Central Supply Manager reflected the wrong size catheter was on the truck for Resident #16.Interview and observation on 04/08/2026 at 1:40 pm revealed Resident #16 was lying in bed and was moaning and had tears in his eyes. Resident #16 stated he was in pain with his catheter. He stated he had been in pain for the past few days. Resident #16 stated he did not report it to anyone until today (04/08/2026). He stated he did report his pain to an aide, and the nurse did come to his room and stated she would change his catheter. Resident #16 stated the nurse returned to his room and explained the facility did not have the size of catheter ordered for him but there was one on the delivery truck. He stated, I hope they hurry and get it changed soon. Resident #16 stated he had Tylenol ordered for pain, but it did not help.Interview on 04/08/2026 at 1:55 pm the Administrator stated she would email the invoice of the order delivered on 04/08/2026 to the facility from the medical supply company.Interview on 04/08/2026 at 2:00 pm LVN J stated she had checked with the Medical Record/Central Supply Manager and was informed she ordered Resident #16 a catheter and it was on the truck. LVN J stated the supply truck had been at the facility since around 12:00 pm today (04/08/2026). She stated she was waiting for the Medical Record/Central Supply Manager to find the catheter and bring it to her so she can change Resident #16's catheter. She stated Resident #16 did have Tylenol ordered for pain. LVN J stated she would call the physician and order him pain medication as needed. Interview on 04/08/2026 at 2:15 pm Resident #16 stated he felt better, and he (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not in pain. He stated he did want his catheter changed sometime today 04/08/2026.Interview on 04/08/2026 at 2:30 pm LVN J stated she had not received the catheter from the supply truck. She stated she explained to Medical Record/ Central Supply Manager Resident #16 was needing the catheter. LVN J stated the Medical Record/ Central Supply Manager stated Resident #16's catheter was on the truck delivered today 04/08/2026. Interview on 04/08/2026 at 2:45 pm LVN J stated she had not received the catheter from the supply truck. She stated she had asked the Medical Record/ Central Supply Manager to locate the catheter for Resident #16. She stated she had not reported it to Director of Nurses.Interview on 04/08/2026 at 3:15 pm LVN J stated she had not received Resident #16's catheter from the supply truck.Interview on 04/08/2026 at 3:45 pm LVN J stated she had not received Resident #16's catheter from the supply truck.Interview on 04/08/2026 at 4:15 pm the Nurse Consultant stated someone was going to a sister facility in the same town and would obtain the catheter Resident #16 needed. She stated the wrong size catheter was delivered to the facility today (04/08/2026) and LVN J realized it was the wrong catheter size when it was given to her from the Central Supply Manager. The Nurse Consultant stated, I went to [Resident #16]'s room few minutes ago and adjusted his catheter until we can obtain the correct catheter from a sister facility.Interview on 04/09/2026 at 8:00 am Resident #16 stated the staff did change his catheter last night (04/08/2026). He stated the catheter was not working properly and the staff came back in and checked it and made adjustments to the catheter and when they made adjustments the urine began to flow better. He stated he was not in pain last night (04/08/2026) or today (04/09/2026).Interview on 04/09/2026 at 8:45 am The Medical Record / Central Supply Manager stated LVN K had come to her office and reported to her that Resident #16 needed a catheter and stated the catheter size was 22 F 10 ml foley catheter. She stated she placed an order on Thursday 04/02/2026. She stated this was the size catheter delivered yesterday on the supply truck and not the size catheter Resident #16 needed. She stated the supply truck did come in on 04/08/2026 approximately 12:00 pm. She stated she did not get the catheter off the truck until around 4:00 pm. The Medical Record/ Central Supply Manager stated LVN J did request for the catheter to be located for Resident #16. She stated she did not recall the time LVN K requested the catheter. The Medical Record/ Central Supply Manager stated she was trying to get all of the supplies off the truck and began delivering the supplies into the facility. She stated she did know LVN J was wanting a catheter, but she did not realize it was important. She stated she did not ask if it was an emergency or if she needed the catheter immediately. The Medical Record/ Central Supply Manager did not respond to any further questions.Interview on 04/09/2026 at 9:45 am Resident #16 stated he was not in pain and stated the catheter was perfect. He stated he should have reported him being in pain sooner, but he thought the pain would get better.Interview on 04/10/2026 at 8:05 am the Administrator stated her expectations were all supplies in the facility to be documented on a form and for the Central Supply Manager to make rounds every day to ensure there was adequate supplies in the facility. She stated the Central Supply Manager needed to locate the catheter immediately when the nurse reported to her about needing the catheter. She stated if the nurses had known it was the wrong catheter size the nurse was expected to contact the physician to determine if a different size catheter could be used and if not, then someone would have purchased the correct catheter at a medical supply store or go to a sister facility in town and obtained the correct size catheter. She stated she had placed Central Supply Manager on a plan and would be monitoring the supplies. The Administrator stated she expected the Central Supply Manager to keep a written copy of supplies and not use her personal phone to take pictures of the supplies. The Administrator stated it was approximately 4:00 pm when the nurse received the catheter from the supply truck and realized at that time it was the wrong size for Resident #16. She stated all staff were being in serviced on how to communicate ensuring there was an adequate amount of supplies in the facility and not to order just one catheter to order several of different sizes. Interview on 04/10/2026 at 9:25 am LVN K stated he did go to Medical Record/ Central Supply Manager and wrote on the board to order a catheter 22 F 10 ml foley catheter for (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another resident. He showed the physician order for the other resident, and it was the same size catheter he stated he requested. LVN K stated when he found out on Thursday the catheter was not in the facility for the other resident he called the Physician and ordered a different size catheter than the facility had in the central supply room. He stated sometimes there was not very good communication in place to communicate with the Medical Record/ Central Supply Manager. LVN K stated writing on the board helps most of the time. Interview on 04/10/2026 at 9:52 am The Director of Nurses stated if a nurse is needing a specific size catheter and there is not one in the facility the nurse was expected to call the physician and discuss the issue with the physician to determine if another size catheter could be ordered. She stated the staff can always go to a sister facility in town and if they have the supplies needed a catheter can be obtained from a sister facility. The Director of Nurses stated if it was an emergency they would call 911 and have the resident transported to the ER. She stated her expectations were to have supplies in the facility at all times. She stated instead of ordering one catheter size to order several catheters in the same size. The Director of Nurses stated she expected the Medical Records/ Central Supply Manager to check the supplies every day and if there is not a certain medical supply she can always go to the supply store in town or a sister facility to ensure the nursing staff has all the supplies they need to care for the residents. She stated there has been a plan developed to ensure the Medical Record/ Central Supply Staff has a better system to ensure there are medical supplies in the facility at all times. She stated there needed to be a better system to ensure the nursing staff had all the supplies they needed. The Director of Nurses stated if a nurse informed the Medical Records/ Central Supply Manager she needed a catheter for a resident she expected the Medical Records/ Central Supply Manager to locate the catheter immediately on the supply truck. She stated obtaining the catheter was top priority. The Director of Nurses stated she was not aware of the situation until later in the afternoon. She stated if she had been informed of the situation, she would have instructed the nurse to call the physician to order a different size catheter, or the staff would have gone to the sister facility sooner and obtained the correct catheter size.Interview on 04/10/2026 at 10:30 am RN C stated when the nursing department needs supplies and they are not available the nursing staff was expected to write it on a board located in Central Supply Room. She stated there are times when someone is required to go to a sister facility or to a medical supply store and obtain the supplies if the facility does not have them in the building. She stated sometimes it is difficult to locate supplies in the central supply room when the Medical Record / Central Supply Manager was not in the facility. She stated, I am unsure how the Medical Record/ Central Supply Manager system of knowing what needed to be ordered and what supplies were in the facility. In an interview on 4/10/2026 at 10: 45 am CNA M stated there were times the facility did not have the supplies needed to care for the residents such as catheters and wipes. She stated she would inform the nurse of the supplies needed to care for the residents and the nurse would report it to the person in charge of ordering supplies. CNA M stated she forgot the title of the person who places orders for supplies, but she knew where her office was located.In an interview on 04/10/2026 at 11:20 am Medical Record/ Central Supply Manager stated LVN K came into her office and requested a 22 F 10 ml catheter on Thursday 04/02/2026. She stated he did write it on the board and did not have a name of the resident needing the catheter. She stated she assumed it was for Resident #16 due to LVN J was requesting a catheter for him. She stated she told LVN J Resident #16 had a catheter on the truck. She stated she assumed it was Resident #16's catheter but she was not 100 percent certain. She stated she did not ask LVN J what size catheter she was needing for Resident #16. Medical Record/ Central Supply Manager stated she did not look for the catheter until she saw it when unloading the truck. She stated it was around 4:00 PM on 04/08/2026 when she found the catheter and the truck did come to the facility on [DATE] approximately 12:00 pm. She stated she realizes now she needed to have located the catheter immediately. She stated she did not report to LVN J the catheter size she ordered. She stated if she had reported what catheter size was on the truck LVN J would have known immediately it was not for Resident #16. Medical Record/ (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Central Supply Manager stated LVN K did not report to her who needed the catheter when he requested the order. She stated she did not have an inventory paper record of how she knows what supplies are in the facility. She stated she did not have any form on any computer. She stated she used her personal phone to make pictures of the supplies. The Medical Record/ Central Supply Manager stated she did not ask if this was appropriate to use her personal phone to take pictures of the supplies. She stated it was easier for her. She stated no one in the facility would know anything about the supplies if she was unable to come to work for a long period of time or if she was on vacation and out of town. She stated there was always a possibility it would be difficult to relay the pictures to anyone in the staff from her personal phone if she was on vacation for a week or had to take a leave of absence for several months. She stated she did not ask the nurses if they needed supplies or ask what resident was needing the supplies. She stated she never asked if it was urgent or thought about going to the supply store or a sister facility and getting the supplies the nurses needed until the order arrived at the facility. She stated she needed a better system to communicate with the nurses and a better system of tracking what supplies were in the facility. She stated she had been trained on ordering supplies, but she thought she was doing a good job. The Medical Record/ Central Supply Manager stated trying to find the catheter on 04/08/2026 should have been her top priority and it was urgent for the nurses to have that catheter and when it was given to LVN J she knew immediately it was the wrong size. She stated there had been a few times when she did not order enough supplies but very few times. She stated there was a new plan developed on 04/09/2026 and given to her from the Administrator on ordering and documenting the supplies. Observation on 04/10/2026 at 11:50 am in the central supply closet revealed it was difficult to know where anything was located and if there were extra supplies forthe empty bins in the supply closet. Record review on 04/10/2026 of notebook paper of the inventory of supplies in the facility showed the facility had adequate supplies for the residents. The Medical Record/ Central Supply Manager completed an inventory of supplies in the facility and documented it on notebook paper. Interview on 04/10/2026 at 2:00 pm Medical Record/ Central Supply Manager stated she did not have an inventory form to document the supplies on, and she had to use notebook paper. She stated it would be difficult to keep up with the supplies using notebook paper. She stated she placed an order on Thursdays, and the shipment arrived on Wednesdays. She stated this is what was recorded on the ordering form. Central Supply Manager stated she was expected to order on Thursday for the supplies to arrive on Wednesdays. Record review of the ordering process of supplies, dated 10/23, reflected an order form with the following information on the form:Items on handItems neededIncontinent suppliesBriefsPull ups/ protective underwearMed Pass suppliesGlovesFoley catheter suppliesFoley catheter sizesPersonal care/ Bedside utensilsSterile Water/ Normal SalineBasic Toiletry suppliesGeri SleevesHipsters Ordering process:If your ship date is Monday, order ThursdayIf your ship date is Tuesday, order FridayIf your ship date is Wednesday, order MondayIf your ship date is Thursday, order TuesdayIf your ship date is Friday, order Wednesday

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one (Resident #33) of two residents reviewed for enteral feeding (a tube is inserted directly through the abdomen to the stomach to provide nourishment). The facility failed to ensure RN D attended to a flow error alarm on a feeding pump for 45 minutes for Resident #33 on 04/08/2026. This failure could place residents at risk of malnutrition, pain, and/or significant changes in condition. Findings included: Record review of Resident #33's admission record, dated 04/08/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included dysphagia following cerebral infarction (difficulty swallowing after blood flow to the brain was blocked causing damage to the brain), Gastrostomy status (a tube is inserted directly through the abdomen to the stomach to provide nourishment and medications), unspecified protein-calorie malnutrition (a condition caused by insufficient intake of protein and calories), and aphasia (a language disorder causing difficulty with communication). Record review of Resident #33's order summary, dated 04/08/2026, reflected Enteral Feed Order two times a day Diabetisource AC 65ml/hr continuous. Start water flushes at 25 ml/hr. May hold for ADL's. Record review of Resident #33's discharge MDS, dated [DATE], reflected under Section C - Cognitive Patterns a BIMS was not conducted. Under Staff Assessment for Mental Status, it reflected Resident #33 had a memory problem with short-term memory and was severely impaired for cognitive skills for daily decision making. Section K - Swallowing/Nutritional Status reflected Resident #33 had a feeding tube while a resident. Record review of Resident #33's comprehensive care plan, dated 02/04/2021 and revised last on 11/20/2024 reflected a focus of Potential Risk for Malnutrition with interventions that included Administer enteral feedings as ordered. Record review of Resident #33's comprehensive care plan, dated 02/04/2021 and revised last on 04/07/2026 reflected a focus of The resident requires tube feeding r/t dysphagia (difficulty swallowing) with interventions that included Feedings as ordered. During an observation on 04/08/2026 at 01:34 PM, Resident #33 was laying in bed with a family at bedside, the feeding machine was alarming with error, Flow error clog in line downstream of pump. During an observation on 04/08/2026 at 01:48 PM, Resident #33 remained laying in bed, the family member had left. The feeding pump continued alarming with error, Flow error clog inline downstream of pump. During an observation on 04/08/2026 at 02:03 PM, Resident #33 remained lying in bed with the feeding pump audibly alarming. RN D was observed standing in a doorway in front of her cart, 3 rooms down from Resident #33's room. During an observation on 04/08/2026 at 02:15 PM, Resident #33's feeding pump remained audibly alarming, and RN D remained standing in front of her medication cart, 3 doors down from Resident #33's room. During an interview on 04/08/2026 at 02:16 PM, RN D stated I'm just filling in today, I don't know if you know that when asked how long a feeding pump was supposed to alarm prior to attending to it. RN D was informed that the feeding pump for Resident #33 had been alarming for about 45 minutes and asked if RN D was responsible for the residents. RN D stated, let me go check on that and stopped the interview and walked off to Resident #33's room. During an interview on 04/10/2026 at 12:03 PM, the ADON LVN IPCP E stated she expected staff to respond to feeding pumps that are audibly alarming immediately. She stated there was no reason for a feeding pump to be audibly alarming for 45 minutes. ADON LVN IPCP E stated a feeding pump should not alarm for extended periods of time because it affects the residents' number of calories received per day, so it affects their nutrition. During an interview on 04/10/2026 at 04:22 PM, the Dietician Consultant stated she was familiar with Resident #33. She stated she would expect anyone who heard the feeding pump alarm to notify the charge nurse and the charge nurse to assess the alarm and re-start the feeding pump if needed. She stated if a feeding pump was alarming for 45 minutes, it wouldn't be a really big (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deal because she is on a slow rate so there was not a significant loss due to the pump alarming. 45 minutes is not that long. She further stated she calculated for the feeding to be less than 24 hours due to the feeding pump being turned off for ADLs. During an interview on 04/10/2026 at 04:42 PM, the Director of Nurses stated she had worked at the facility for about 5 years. She stated she would expect any staff member to attend to a feeding pump that was alarming. She stated if a feeding pump were alarming for 45 minutes, then the resident would not get their full dose feeding and calories as prescribed by the provider. During an interview on 04/10/2026 at 04:50 PM, the Administrator stated she expected staff to respond to feeding pumps immediately if it is alarming. She stated if a feeding pump was alarming for 45 minutes, then it could impact how the resident receives formula or how much they receive. Record review of undated facility policy titled Enteral Nutrition reflected We will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth.Procedure:.5. Problems with the administration of the tub feeding are monitored and corrected by nursing. The dietitian is responsible for evaluating nutritional adequacy and fluid requirements.

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Lampstand Nursing and Rehabilitation	2001 E 29th St Bryan, TX 77802

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 medication carts (Medication Cart #1) reviewed for medication storage. The facility failed to ensure Medication Cart #1 was locked and medications were secure and not accessible to other staff, residents or visitors.This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the-counter medications.Findings include:Observation on 04/09/2026 at 1:03 pm revealed medication cart #1 was unlocked against the wall by the common tv area. The back of the cart was against a half wall with the top open to the tv common area. The drawers of the medication cart were facing the area near the nurse's desk. The locking mechanism was protruding outward on the medication cart. The State Surveyor opened the drawers and captured photos. The med aide responsible (Med Aide O) for the medication cart was in a resident's room on 100 hall. There was not any nursing staff in the area of the unlocked medication cart.Observation on 04/09/2026 at 1:15 pm revealed Med Aide O walked from the 100 hall toward the unlocked medication cart #1.Interview on 04/09/2026 at 1:18 pm, Med Aide O stated she thought she had locked the medication cart before she entered the 100 hall. She stated she could not believe the cart was unlocked. Med Aide O stated she had the only set of keys for that cart. She stated residents and visitors had access to the medications in the medication cart. Med Aide O stated if a resident had ingested another residents' medications there was a possibility the resident may overdose, have an allergic reaction, and may require further care at the hospital. She stated there was a possibility a resident may die from ingesting another residents' medication. She stated she was in-serviced on locking medication carts when she was not obtaining medications from the cart. Med Aide O stated she did not recall the date of the in-service of locking medication carts.Interview on 04/10/2026 at 9:52 am, the Director of Nurses stated the medication carts were expected to be locked unless the nurse was standing at the cart administering medications. She stated if the medication carts were in the hallway and the nurse was not standing at the medication cart it was expected to be locked, no exceptions. She stated a resident had the opportunity to take medications out of the medication cart and if the resident ingested the medications there was a potential a resident may be allergic or overdose on another resident's medications. The Director of Nurses stated there was a possibility the medication could have an interaction with the current medication the resident had been prescribed and may cause a resident to need hospitalization for further assessment and treatment. She stated it was a possibility a resident may die if they were severely allergic to the medication. She stated the staff were in-serviced on locking medication carts. She did not recall the date of the in-service.Record review of the facility's policy on Medication Storage in the Facility, dated 2025, reflected Medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to license personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews, and reviews, the facility failed to provide food that was prepared in a form designed to meet individual needs and by methods that conserve nutritive value and flavor for 4 residents who ate pureed diets from 1 of 1 kitchen reviewed for food and nutrition services.The facility failed to ensure that the lunch meal on 04/09/2026 was served at the correct temperature and was palatable. The facility failed to ensure [NAME] A refrained from adding an unmeasured amount of liquid to fish sticks, pureed meal during lunch service on 4/10/2026. This failure could affect residents at risk for diminished or altered nutritional status and potential weight loss.Email received from the Administrator on 04/09/2026 at 8:23 revealed 4 residents at the facility received a pureed diet. Observation and interview conducted on 04/10/2026 at 10:43 AM revealed [NAME] A placed an unmeasured amount of broth into the puree blender with the fish sticks. She did not measure the broth. [NAME] A proceeded to puree the fish sticks. She stated there were 4 residents on puree diets. [NAME] A stated that pureed food was supposed to be of creamy texture. The pureed fish was of a runny consistency. She stated she had a measuring cup available but did not use it. [NAME] A stated she has prepared pureed diets for over 10 years. The DMA interjected and stated to [NAME] A the texture should be of mashed potato consistency. [NAME] and surveyor went over to the recipe book, the recipe called for a half of cup of broth for 4 servings, it stated to add one half of recommended liquid and puree. The recipe stated to add bread if needed and blend until smooth, adding liquid/thickener as necessary to obtain desired consistency. [NAME] A then added bread to the mixture until it had corrected consistency.Interview conducted on 04/10/2026 at 11:31 AM [NAME] A revealed she has worked for the company for 20 years but now she only worked PRN. She stated she had been trained on pureed diets by previous dietary managers. [NAME] A admitted that because she had done it for so long, she had relied on her own judgement to decide if the food texture was correct. She stated she became nervous when state inspectors are present. [NAME] A stated if food was not the correct consistency, a resident could possibly choke. Interview conducted on 04/10/2026 at 11:41 AM, the DMA stated she had been with the facility for a year. She stated all the cooks had their dietary certificates. The DMA stated some of the cooks were trained by previous dietary managers. She stated she provided ongoing in-service education to the dietary staff. The DMA stated she observed cooks during food preparation and has provided guidance on proper procedures that included standardized recipes and the pureed diet spreadsheets. The DMA stated following the prescribed therapeutic diets ensured safety. She reported that she conducted routine rounds on the tray line to monitor and verify correct food consistency. The DMA stated the potential harm to a resident was increased risk of aspiration if pureed diet was not followed. Interview via telephone conducted on 04/10/2026 at 4:26 PM, the Dietician Consultant stated the DMA trained the cooks on the pureed diet process. She stated she comes to the facility once month. Dietician Consultant stated she looks at the consistency and check off on the textures of the food to ensure compliance with the prescribed diet. She stated all cooks should follow the recipe book. Dietician Consultant stated, not following the pureed recipe could be a potential for swallowing issues, but that would be a speech area. Interview conducted 04/10/2026 at 4:48 PM, the DON stated physician-ordered diets (such as pureed diets) are communicated to nursing and dietary staff. The DON stated the nurses check the trays prior to them being served to the residents. She stated that the diet order was on the meal ticket and nurses are trained to review the tickets. The DON stated that if there was a concern regarding the meals staff are supposed to report her or the DMA. The DON stated pureed consistency should not be runny but solid resembling a baby food consistency. The DON stated that potential harm to a resident would be the risk of aspiration if the food is runny or potential harm of choking if food is too thick.Review of the facility's policy named Consistency Modification, dated 2012, reflected: Procedure:We will adequately meet nutritional needs of the resident and provide food in a consistency (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the resident can tolerate.3. The pureed diet is given to residents with chewing, swallowing or choking problems.The desired consistency for blended foods is that of applesauce to mashed potatoes. Small grains may be present in some foods, but these are acceptable as long as they are no larger than the grains present in applesauce and of a consistent size. If a residentrequires a smoother consistency, per speech therapist recommendation, an order for a strained puree diet can be obtained. Guidelines for pureed diets:1. Eye appeal is important. Items are served attractively on the plate with appropriate garnishes.^^2. Sauces and gravies are used to improve flavor and ease of eating.3. Foods are blended following the regular diet for the day.4. When therapeutic diets are blended, the menu for the day, diet and portion are used.5. Proper holding and serving temperatures are observed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices that are completely and accurately documented for 1 (Resident #26) of 7 residents reviewed for medical records. The facility failed to maintain complete and accurate documentation of provided incontinent care for Resident #26. This deficient practice could place residents at risk for not receiving proper care due to incomplete and inaccurate records.The findings include: During an attempted interview with Resident #26 on 4/09/2026 at 2:15 p pm. to verify if he was changed or needed to be changed, he was unable to give comprehensive answer regarding his incontinent status. Record review of Resident #26's face sheet, dated 04/10/2026, reflected [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: unspecified convulsions (sudden, involuntary, and often violent contractions of muscles, characterized by shaking, rigidity, and potential loss of consciousness), major depressive disorder severe with psychotic symptoms (a serious, common mental health condition characterized by persistent sadness, loss of interest, and low energy), and schizophrenia (a chronic, severe brain disorder causing distorted interpretations of reality, including hallucinations, delusions, and disorganized thinking). Record review of Resident #26's quarterly MDS assessment, dated 03/25/2026, with a level 3 for cognitive skills for daily decision making indicating the severely impaired - never/rarely made decisions. Resident #26's MDS indicated his total dependance on helper for all efforts or the assistance of 2 or more helpers is required for the resident complete eating, oral hygiene, toileting hygiene, shower/bath and dressing. Record review of Resident #26's comprehensive care plan, dated 09/12/2025, indicated a focus: ADL Self CarePerformance Deficit and bowel and bladder incontinence and indicated interventions in place: Check resident every two hours and assist with toileting as needed and provide peri care after each incontinent episode. Review of POC record in electronic resident record revealed in last 14 days there was a lack of documentation for Resident #26'sincontinent care: *03/27/2026 - one time at 3:52 p.m., *r45fvg03/28/2026 - one time at 1:59 p.m., *03/29/2026 - one time at 2:23 a.m., *03/30/2026 - two times at 1:45 a.m. and 9:17 a.m., on *04/03/2026 - two times at 9:56 and 18:56, on *04/04/2026 - two times at 2:37 a.m. and 9:36 p.m., and *04/08/2026 - 2 times at 9:02 a.m. and 2:36 p.m. During interview with DON on 4/10/2026 at 8:45 a.m. she stated that CNAs responsible for documentation of incontinent care every shift (8hours) which would be three entries for each day. She stated that per facility policy nursing staff was not required to document Resident #26 did not require incontinent care due to being dry. She stated that not documenting incontinent care for residents required incontinent care and, Resident #26 specifically, was not acceptable documentation practice. She stated that not documenting incontinent care could cause not able to track urine retention pattern or other nursing concerns including not providing proper care for residents. She stated that facility established a routine peri care rounding for Resident #26 when staff can document rounds every hour in the paper finder available at the nursing station due to POC allowing to document incontinent care only one per shift (8 hours). She stated that CNAs could inform charge nurses regarding additional incontinent care for residents if they did more than one time per shift and charge nurse could document it in nursing notes. During an interview on 4/10/2026 at 9:01 a.m., ADM stated per facility's policy CNAs were responsible for accurate and consistent documentation in POC with daily monitoring of this documentation by nursing management. Management team (DON and ADON) were required to meet and educate CNAs if incontinent care was not documented once a shift. She stated that not documenting incontinent care every shift in POC can lead to miscommunication of abnormal findings. She stated that Resident #26 required every two hours rounding, with documentation in POC and paper log available at the nursing station. She stated that she was ultimately responsible for overseeing the completed documentation (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the facility. Record review of nursing notes for Resident #26 for the last 6 months (09/12/2026 -04/08/2026) did not reflect nursing notes regarding provided incontinent care for Resident #26 on those days. Record review of in-services dated 1/20/2026 revealed Please completed all POC (plan of care) documentation before you leave. Be sure bowel and bladder and locomotion is accurate. When documenting, make sure you are taking your time and documenting correctly on locomotion and bowel and bladder. Record review of Resident #26's Q1 hour checks paper record revealed The following items will be checked every hour: 1. Call light and personal items (e.g., remote, water in easy reach) . positioned with pillows. check for incontinence and assist with clean up as needed. Weekly pages of Resident #26's revealed multiple gaps in documentation of care for Resident #26.