STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676049	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Paris	520 SE 8th St Paris, TX 75460

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to immediately consult with the resident's physician when there was significant change in the resident's physical, mental, or psychosocial status for 2 of 6 residents (Resident # 4 and Resident #30) reviewed for notification of changes. 1.The facility failed to notify the physician for Resident #4's blood sugars above 401 on 01/08/26, 01/16/26, 01/18/26, 01/22/26, and 01/31/26 2.The facility failed to notify the physician for Resident #30's blood sugars above 401 on 01/09/26, 01/17/26, 01/16/26, and 01/22/26. These failures could place residents at risk of their physicians not being aware of the resident conditions and delay treatments for the residents' conditions.Findings included:1.Record review of Resident #4's face sheet dated 02/04/26 indicated he was a [AGE] year-old male admitted on [DATE] with diagnoses which included diabetes (a condition that happens when your blood sugar (glucose) is too high), stroke (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), and kidney failure (occurs when kidneys lose the ability to filter waste from the blood).Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated he understood and was understood by others. The MDS indicated Resident #4 had a BIMS score of 14 which indicated he was cognitively intact. The MDS indicated Resident #4 required assistance with personal hygiene, dressing bed mobility, transfers, toileting, and set up for eating and oral care. The MDS indicated he took insulin medication during the 7-day look-back period. Record review of Resident #4's comprehensive care plan dated 09/03/25 indicated he had a diagnosis of diabetes. The interventions were to give medication as ordered and to monitor, document, and report to the doctor as needed for signs and symptoms of hyperglycemia (high blood sugars).Record review of Resident #4's physician order dated 01/03/26, indicated give Novolin R Injection Solution 100 UNIT/ milliliter (Insulin Regular (Human)) Inject as per sliding scale: if 0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 - 399 = 10 units; 400+ = 12 units and call the doctor, subcutaneously before meals and at bedtime for diabetes.Record review of Resident #4's medication administration record dated January 2026 revealed a high blood sugar over 400 on the following days and times: documented by LVN R, 406 on 01/08/26 at 4:30 pm, 425 on 01/08/26 at 8:00 pm and 408 on 01/16/26 at 8:00 pm, documented by RN P, 422 on 01/18/26 at 11:30 am, and 449 on 01/22/26 at 4:30pm, and documented by LVN Q 420 on 01/31/26 at 4:30 pm. The medication administration record indicated they received the 12 units of insulin ordered but did not indicate if any extra insulin was given on the above dates. Record review of Resident #4's nurses notes did not indicate the doctor was notified when Resident #4's blood sugar was above 401 for the following dates 01/08/26 at 4:30 pm, 01/08/26 at 8:00 pm, 01/16/26 at 8:00 pm, 01/18/26 at 11:30 am, 01/22/26 at 4:30 pm, and 01/31/26 at 4:40 pm. The nurse's notes did not indicate any new orders related to his blood sugar being elevated, any signs or symptoms of hyperglycemia, or hospitalization during the above dates.During an attempted phone interview on 02/05/26 at 1:01 p.m., called LVN R with a message left.During an observation and interview on 02/05/26 at 3:08 p.m., RN P said he was Resident #4's charge nurse at times. He looked at Resident #4's medication administration records (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and indicated he worked 01/18/26, and 01/22/26. He saw where Resident #4's blood sugar was above 401. He said he did not know if he notified the doctor about Resident #4's elevated blood sugar but knew he should have for the safety of the resident to prevent hyperglycemia (high blood sugar). He said Resident #4 was not showing any signs and symptoms of hyperglycemia.During a phone interview on 02/05/26 at 3:11 p.m., LVN Q said she was Resident #4's charge nurse on 01/31/26. She said she recalled him having high blood sugar but does not remember if she called the doctor or not. She said if it was not documented then she did not call him. She said she should document to prove she followed the doctor's order. She said it was important to notify the doctor for blood sugars over 401 because it was his order and in case the doctor wanted to change the resident's medication.2.Record review of Resident #30's face sheet, dated 02/05/26, indicated he was an [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses which included diabetes (a condition that happens when your blood sugar (glucose) is too high),dementia (loss of memory), and high blood pressure.Record review of Resident #30's comprehensive care plan, dated 05/17/22, indicated Resident #30 had a diagnosis of diabetes. The intervention was for staff members to give medication as ordered by the doctor, monitor and document for side effects and effectiveness, and report to the doctor as needed for signs and symptoms of hyperglycemia (high blood sugars).Record review of Resident #30's physician order dated 10/31/25, indicated give Novolin R Injection Solution 100 UNIT/ milliliter (Insulin Regular (Human)) Inject as per sliding scale: if 0 - 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 - 399 = 10 units; 400+ = 12 units and call the doctor, subcutaneously before meals and at bedtime for diabetes.Record review of Resident #30's quarterly MDS assessment, dated 12/02/25, indicated Resident #30 understood and was understood by others. Resident #30's BIMS score was 12, indicating his cognition was moderately impaired. The MDS indicated Resident #30 required assistance with his ADLs, including transfers, dressing, personal hygiene, and bed mobility. The MDS indicated he received insulin during his 7-day look back period. Record review of Resident #30's medication administration record dated January 2026 revealed a high blood sugar over 400 on the following days and times: documented by RN P revealed a high blood sugar over 401 on the following days and times 01/09/26 at 4:30 pm blood sugar was 412,and 01/22/26 at 4:30 am blood sugar was 506, and documented by LVN Q on 01/16/26 at 8:00 pm blood sugar was 405,and 01/17/26 at 4:30 pm blood sugar was 475. The medication administration record indicated they received the 12 units of insulin ordered but did not indicate if any extra insulin was given on the above dates. Record review of Resident #30's nurses notes did not indicate the doctor was notified when Resident #30's blood sugar was above 401 for the following dates 01/09/26 at 4:30 pm, 01/08/26 at 4:30 pm, 01/08/26 at 8:00 pm, 01/16/26 at 8:00 pm, and 01/22/26 at 4:30 pm. The nurse's notes did not indicate any signs or symptoms of hyperglycemia, no new orders related to his blood sugar being elevated, or hospitalization during the above dates.During an observation and interview on 02/05/26 at 1:39 p.m., RN P said he was Resident #30's charge nurse at times. He looked at Resident #30's medication administration records and indicated he worked 01/09/26 and 1/22/26. He said he could not see where he notified the doctor. He said it was important to notify the doctor of any changes, and blood sugar was important because the resident could have a change. He said it should be documented so others would know of his changes.During a phone interview on 02/05/26 at 3:13 p.m., the facility doctor said he expected staff to notify him of blood sugar readings below 60 and above 400. He said usually the staff communicated with him about the resident's blood sugar, but he could not say if he was or was not notified on Resident #4's or Resident #30's blood sugars on the dates mentioned above. He said if he had been notified, he would not have changed their orders. He said untreated hyperglycemia over a period could lead to organ damage.During an interview on 02/05/26 at 3:41 p.m., the DON said the charge nurse should notify the doctor of any blood sugars over 401. She said she and the ADONs were randomly monitoring vital signs. She said the nurses should document in the nurse's notes that they notified the doctor and if they received any (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new orders. The DON said if blood sugar remains uncontrolled a resident could have adverse effects such as high blood sugars. During an interview on 02/05/26 at 4:53 p.m., the Administrator said she expected the charge nurses to notify the doctor of any blood sugar over the parameters. She said nurse managers and the DON should be monitoring blood sugars readings. The Administrator said if the nurses were not notifying the doctor they could be giving the wrong care. The Administrator said they did not have a policy on notification, they followed the nursing clinical policy and procedure.During an attempted phone interview on 02/05/2026 at 5:34 p.m., called LVN R with a message left.Record review of the facility policy for Policy/ Procedure - Nursing Clinical revised 05/2007, indicated, Policy: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 10%, based on 4 errors out of 40 opportunities, which involved 4 of 7 residents (Resident #74, Resident #46, Resident #40 and Resident #3) reviewed for medication administration. The facility failed to ensure LVN E administered Resident #74 Humalog KwikPen (insulin medication) according to the manufacturer's instructions.The facility failed to ensure LVN F primed Resident #46 Novolog KwikPen (insulin medication) according to the manufacturer's instructions. The facility failed to ensure LVN F administer 4 units of Novolog KwikPen to Resident #46 on 02/05/26 according to physician orders.The facility failed to ensure LVN E administered Resident #40 IV Vancomycin (infection medication) according to the manufacturer's instructions.The facility failed to ensure CMA G administration Resident #3 Allopurinol (gout medication) according to the physician orders. These failures could place residents at risk of inaccurate drug administration and not receiving the care and services to meet their individual needs. Finding Including: Record review of Resident #74 face sheet indicated she was a [AGE] year-old female admitted to the facility originally 07/07/23 with the primary diagnosis of TYPE 1 DIABETES MELLITUS WITH HYPERGLYCEMIA (a chronic pancreatic condition that affects the blood sugar).Record review of Resident #74 Comprehensive MDS dated [DATE] indicated she had a BIMS of 14 with no cognitive impairment. Resident #74 was being treated with antidiabetic medications including insulin to control daily blood sugar level. Record review of Resident #74 care plan undated indicated she was care planned for type 1 diabetes mellitus with interventions of Diabetes medication as ordered by doctor, monitor and document for side effects and effectiveness, and finger stick blood sugar as ordered. Record review of Resident #74 order summary dated 02/05/26 indicated she had an order start date of 07/30/24 for HumaLOG KwikPen (prefilled insulin device) Subcutaneous Solution Peninjector100 UNIT/ML (Insulin Lispro) HumaLOG KwikPen Subcutaneous Solution Peninjector100 UNIT/ML (Insulin Lispro) Inject as per sliding scale orders. if 0 - 150 = 0 units;151 - 200 = 2 units;201 - 250 = 4 units;251 - 300 = 6 units;301 - 350 = 8 units;351 - 400 = 10 units;401+ = 12 units call physician, subcutaneously before meals and at bedtime for DM. Record review of Resident #74 order summary dated 02/05/26 indicated she had an order start date of 12/05/25 for HumaLOG KwikPen Subcutaneous Solution Peninjector100 UNIT/ML (Insulin Lispro) Inject as per 10 units before meals Record review of Resident #74 administration report dated 02/05/26 indicated she had received 12 units of HumaLog KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML for a blood sugar of 497 at 11:30 AM. During an observation on 02/05/26 at 10:48 AM, LVN E dialed 22 units of HumaLog and administered in the left arm of Resident #74. LVN E failed to prime the insulin pen prior to administration. During an interview on 02/05/26 at 10:48 AM, LVN E stated that she was not taught to prime the insulin pen prior to injection with the needle on. LVN E stated that priming the pen was to get the air out. LVN E stated that Resident #74 was at risk for not receiving the correct dose of insulin. LVN E contacted the physician with orders to recheck blood sugar. LVN E follow-up phone call reported to the physician a 380 blood sugar. Record review of Resident #46 face sheet indicated he was an [AGE] year-old male originally admitted to the facility on [DATE] with the diagnosis of TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (chronic pancreatic condition that causes inability to regulate blood sugar).Record Review of Resident #46 Comprehensive MDS dated [DATE] indicated a BIMS of 14 revealing little to no impairment. Resident #46 was being treated with insulin injections 7 of the last 7 days with hypoglycemia (including insulin) medication class. Record review of Resident #46 care plan 02/05/26 indicated he was care planned for diabetes mellitus with interventions as diabetes medication as order by doctor, monitor and document for side effects and effectiveness, and fasting serum blood sugar as order by doctor. Record review of Resident #46 order summary dated 02/05/26 indicated he has an order for Novolin R FlexPen inject 4 units (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subcutaneously before meals with a start date of 09/24/25. During an observation on 02/05/26 at 10:38AM, LVN F dialed 6 units of Novolin R FlexPen administering the whole dose to Resident #46 without priming the pen with 2 units to remove air from the needle. During an interview on 02/05/26 at 10:38 AM, LVN F stated although she could not see the 2 units come through the needle to expel air that her intentions were to remove air and that was how her DON taught her.Record review of Resident #40's face sheet indicated she was an [AGE] year-old female originally admitted to the facility on [DATE] with the primary diagnosis of endocarditis, valve unspecified (inflammation of the heart caused by infection).Record review of Resident #40's comprehensive MDS dated [DATE] indicated a BIMS of 12 revealing only minimal cognitive impairment. Resident #40 was being treated with IV medication antibiotics (to treat infection). Record Review of Resident #40's care plan indicated she was care planned for IV therapy required related to endocarditis potential for infection with intervention listed as infuse the fluids and medications as ordered. Record review of Resident #40's order summary indicated she had an order for Vancomycin HCl Intravenous Solution 500 MG/100ML intravenously two times a day for endocarditis. Infuse at 100mL/hr start date 02/03/26. Record review of Resident #40 administration report dated 02/5/26 indicated she received vancomycin 500mg/100mL started on 01/30/26 without missing a dose. During an observation and interview on 02/03/26 at 8:56AM, LVN E administered 500mg of Vancomycin in a 100mL bag at 400mL/hr. The IV vancomycin infused in 15 minutes. After surveyor intervention LVN E disconnected the IV after the medication had infused from the PICC line, flushed with 10mL of normal saline and 5mL of heparin. LVN E then documented the medication error, called the doctor, family representative, pharmacist, and notified the DON. LVN E stated she thought the medication was in a 400mL bag. LVN E stated that this was the first dose of the new order, and she misread the order. LVN E stated that she had recently had an IV check off during her annual competency check off in November. LVN E stated that Resident #40 was at risk of pain to the site and alteration in vital signs. During an interview on 02/03/26 at 9:30AM, DON stated she was conducting a medication error evaluation form and the last training was in November for all skills annual check off for LVN E.Record review of Resident #3's face sheet indicated she was an [AGE] year-old female originally admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia without behavioral disturbance, psychotropic disturbance, mood disturbance, and anxiety.Record review of Resident #3's quarterly MDS dated [DATE] indicated she a BIMS of 09 revealing moderate cognitive impairment. MDS indicated she received scheduled pain medication. MDS indicated she had a diagnosis of low back pain. Record review of Resident #3's care plan indicated she was being care planned for risk for pain related to diabetic neuropathy and gout with interventions to monitor and document side effects of pain medications. Record review of Resident #3's order summary indicated an order for allopurinol oral tablet 100mg; give 2 tablet by mouth one time a day for gout started on 01/16/26. During an observation on 02/03/26 at 9:00AM, CMA G administered 1 100mg tablet of Allopurinol (gout medication) when the order indicated to administer 2 tablets. During an interview on 02/04/26 at 9:13AM, CMA G stated she made a mistake and did not give 2 tablets. CMA stated the resident was at risk of not being fully treated for her gout pain. During an interview on 02/04/26 at 11:32AM, CMA G stated she reported the medication error to her nurse, DON, and doctor with orders to monitor vital signs and symptoms with no changes in the medication order. Record review of progress note dated 02/04/26 at 11:27AM, LVN K documented that she was notified that the resident received 100mg of Allopurinol on 02/03/26 and the order read to give 2 tablets once a day for gout pain. LVN K documented resident representative made aware. Record review of medication administration skills checklist undated completed by ADON revealed medication administration skills checklist requirements met for CMA G. Record review of medication administration skills checklist undated completed by ADON revealed medication administration skills checklist requirements met for LVN E. Record review of orientation and annual skills checklist dated 11/20/25 completed by ADON revealed LVN E revealed her annual skills checked off for medications and treatment passes including IV (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration. Record review of orientation and annual skills checklist dated 11/20/25 completed by ADON revealed LVN F revealed her annual skills checked off for medications and treatment passes. Record review of Nursing Clinical policy dated 02/2022 revealed this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments. Record review of the manufacture's guidelines titled Humalog KwikPen, revised 05/2025 reflected. Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Review of vancomycin hydrochloride, USP VIAL Dosage and Administration | Pfizer Medical - US accessed on 2/10/2026 indicated:DOSAGE AND ADMINISTRATIONInfusion-related events are related to both the concentration and the rate of administration of vancomycin. Concentrations of no more than 5 mg/mL and rates of no more than 10 mg/min are recommended in adults (see also age-specific recommendations). In selected patients in need of fluid restriction, a concentration up to 10 mg/mL may be used; use of such higher concentrations may increase the risk of infusion-related events. An infusion rate of 10 mg/min or less is associated with fewer infusion-related events (see ADVERSE REACTIONS). Infusion-related events may occur, however, at any rate or concentration.Patients with Normal Renal FunctionAdultsThe usual daily intravenous dose is 2 g divided either as 500 mg every 6 hours or 1 g every 12 hours. Each dose should be administered at no more than 10 mg/min or over a period of at least 60 minutes, whichever is longer. Other patient factors, such as age or obesity, may call for modification of the usual intravenous daily dose.Patients with Impaired Renal Function and Elderly PatientsDosage adjustment must be made in patients with impaired renal function. In premature infants and the elderly, greater dosage reductions than expected may be necessary because of decreased renal function. Measurement of vancomycin serum concentrations can be helpful in optimizing therapy, especially in seriously ill patients with changing renal function. Vancomycin serum concentrations can be determined by use of microbiologic assay, radioimmunoassay, fluorescence polarization immunoassay, fluorescence immunoassay, or high-pressure liquid chromatography. If creatinine clearance can be measured or estimated accurately, the dosage for most patients with renal impairment can be calculated using the following table. The dosage of vancomycin hydrochloride for injection per day in mg is about 15 times the glomerular filtration rate in mL/min (see following table).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that residents were free of significant medication errors for 3 of 7 residents review for pharmacy services (Resident #74, Resident #46, and Resident #40.) 1.The facility failed to ensure LVN E administered Resident #74 Humalog KwikPen (insulin medication) according to the manufacturer's instructions.2.The facility failed to ensure LVN F administered Resident #46 Novolog KwikPen (insulin medication) according to the manufacturer's instructions.3.The facility failed to ensure LVN E administered Resident #V Vancomycin (infection medication) according to the manufacturer's instructions. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications.1.Record review of Resident #74 face sheet indicated she was a [AGE] year-old female admitted to the facility originally 07/07/23 with the primary diagnosis of TYPE 1 DIABETES MELLITUS WITH HYPERGLYCEMIA (a chronic pancreatic condition that affects the blood sugar).Record review of Resident #74 Comprehensive MDS dated [DATE] indicated she had a BIMS of 14 with no cognitive impairment. Resident #74 was being treated with antidiabetic medications including insulin to control daily blood sugar level.Record review of Resident #74 care plan undated indicated she was care planned for type 1 diabetes mellites with interventions of Diabetes medication as ordered by doctor, monitor and document for side effects and effectiveness, and finger stick blood sugar as ordered.Record review of Resident #74 order summary dated 02/05/26 indicated she had an order for HumaLOG KwikPen Subcutaneous Solution Peninjector100 UNIT/ML (Insulin Lispro) Inject as per 10 units before meals and HumaLOG KwikPen Subcutaneous Solution Peninjector100 UNIT/ML (Insulin Lispro) Inject as per sliding scale orders.if 0 - 150 = 0 units;151 - 200 = 2 units;201 - 250 = 4 units;251 - 300 = 6 units;301 - 350 = 8 units;351 - 400 = 10 units;401+ = 12 units call physician, subcutaneously before meals and at bedtime for DM.Record review of Resident #74 administration report dated 02/05/26 indicated she had received 12 units of HumaLog KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML for a blood sugar of 497 at 11:30 AM.During an observation on 02/05/26 at 10:48 AM, LVN E dialed unites 22 of HumaLog, administered in the left arm, and failed to prime the insulin pen prior to administration. Resident #74 received 10 united routine and 12 units for blood sugar level per sliding scale.During an interview on 02/05/26 at 10:48 AM, LVN E stated that she was not taught to prime the insulin pen prior to injection with the needle on. LVN E stated that priming the pen is to get the air out.2.Record review of Resident #46 face sheet indicated he was a [AGE] year-old male originally admitted to the facility on [DATE] with the primary diagnosis of ALZHEIMER'S DISEASE WITH LATE ONSET (chronic deterioration of cognitive functioning).Record Review of resident #46 Comprehensive MDS dated [DATE] indicated a BIMS of 14 revealing little to no impairment. Resident #46 was being treated with insulin injections 7 of the last 7 days with hypoglycemia (including insulin) medication class.Record review of Resident #46 care plan 02/05/26 indicated he was care planned for diabetes mellitus with interventions as diabetes medication as order by doctor, monitor and document for side effects and effectiveness, and fasting serum blood sugar as order by doctor.Record review of Resident #46 order summary dated 02/05/26 indicated he has an order for Novolin R FlexPen inject 4 units subcutaneously before meals with a start date of 09/24/25.During an observation on 02/05/26 at 10:38AM, LVN F dialed 6 units of Novolin R FlexPen administering the whole dose without priming the pen with 2 units to remove air from the needle. LVN F should have dialed up 2 units with a new needle pushing it through needle and then dialed up 4 units to administer.During an interview on 02/05/26 at 10:38 AM, LVN F stated although she could not see the 2 units come through the needle to expel air that her intentions were to remove air and that is how her DON taught her.3.Record review of Resident #40's face sheet indicated she was a [AGE] year-old female originally admitted to the facility on [DATE] with the primary diagnosis of endocarditis, valve unspecified (inflammation of the heart caused by infection).Record review of Resident #40's (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive MDS dated [DATE] indicated a BIMS of 12 revealing only minimal cognitive impairment. Resident #40 was being treated with IV medication antibiotics (to treat infection).Record Review of Resident #40's care plan indicated she was care planned for IV therapy required related to endocarditis potential for infection with intervention listed as infuse the fluids and medications as ordered.Record review of Resident #40's order summary indicated she had an order for Vancomycin HCl Intravenous Solution 500 MG/100ML intravenously two times a day for endocarditis. Infuse at 100mL/hr.Record review of Resident #40 administration report dated 02/5/26 indicated she received vancomycin 500mg/100mL started on 01/30/26 without missing a dose.During an observation and interview on 02/03/26 at 8:56AM, LVN E administered 500mg of Vancomycin in a 100mL bag at 400mL/hr. The order stated for LVN E to administer the IV infusion over 100mL/hr for a total of 60 minutes of infusion time. The IV vancomycin infused in 15 minutes. After surveyor intervention LVN E disconnected the IV after the medication had infused from the PICC line, flushed with 10mL of normal saline and 5mL of heparin. LVN E then documented the medication error, called the doctor, family representative, pharmacist, and notified the DON. LVN E stated she thought the medication was in a 400mL bag. LVN E stated that this was the first dose of the new order, and she misread the order.During an interview on 02/03/26 at 9:30AM, DON stated that was conducting a medication error evaluation form. During an interview on 02/05/26 at 3:48PM, DON stated that she expects all residents to be free from significant medication errors including IV medications and insulin. DON stated that Resident #40, Resident #74, Resident #46, and Resident #14 was at risk for adverse reactions to the medication and possibly harm. DON stated that she performs medication pass audits and insulin administration audits randomly. DON stated that she was not aware of incorrect administration of insulin and an in services was to be done. DON stated that she expects insulin to be administered according to manufacturing requirements and medications to be administered according to physician orders. DON stated the last annual all in-services checkoff for LVN E, LVN F was in November completed by the DON. During an interview on 02/05/26 at 4:36PM, the Administrator stated that she expected the DON to oversee and ensure safe administration of high risk medications. The Administrator stated that she expected all nursing staff to report medication errors to the nurse, DON, doctor, and herself the administrator. The administrator stated that when a medication error occurs, she expected nursing to monitor for sign and symptoms of adverse reactions and she stated that Resident#74, Resident #46, and Resident #14 is at risk of negative impacts of the medication error. Record review of Nursing Clinical policy dated 02/2022, revealed the definition of significant medication error one which causes the resident discomfort or jeopardizes his or her health and safety. Significant may be subjective or relative depending on the individual situation and duration. Adverse drug reactions and medication errors with adverse clinical consequences must be reported to the resident's attending physician immediately.*Record review of the manufacture's guidelines titled Humalog KwikPen, revised 05/2025 reflected. Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.Record review of the manufacture's guidelines titled Novolog KwikPen, revised 05/2025 reflected. Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. There was an open can of soda, an uncovered Styrofoam cup, an energy drink and a plastic drink container from unapproved sources observed on a food prep counter in the kitchen. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 02/02/2026 at 9;40 a.m. revealed an open can of soda and an uncovered Styrofoam cup with approximately 4 ounces of dark liquid assumed to be coffee in the kitchen on the food prep counter. Observation on 02/03/2026 at 7:15 a.m. revealed an open 16-ounce energy drink and an open 16-ounce plastic container with tan liquid that appeared to be iced coffee. During an interview on 02/02/2026 at 9:50 a.m., [NAME] M stated she had not noticed the personal drink items on the food prep area and that she would have them removed right away. [NAME] M stated that personal food items are not allowed to be in the kitchen area and should be kept either in the office or the break room. During an interview on 02/03/26 at 7:28 a.m., Dietary Aide N stated that the drink items did not belong to him and that all personal food items should be consumed in the breakroom. During an interview on 02/05/2026 at 1:10 p.m., the Dietary Supervisor stated that she was not aware of the personal drink items in the kitchen and that she had informed all staff that personal food items are not allowed in the kitchen area and must be kept either in the breakroom or the dietary office. The Dietary Supervisor stated she is ultimately responsible to ensure personal food items are not in the kitchen area to prevent risk for food borne illness. During an interview on 02/05/2026 at 3:41 p.m., the DON stated that personal food items are not allowed on the nursing carts or kitchen areas to prevent cross-contamination. The DON stated that it is the responsibility of the Dietary Supervisor to ensure dietary staff do not have personal food and drink items in the kitchen area. During an interview on 02/05/2026 at 4:20 p.m., the Administrator stated that she expects the dietary staff to follow the instructions provided to them regarding not having personal drink items in the kitchen food prep area and that she expects personal food and drink items to be kept in the staff breakroom. The Administrator stated she would have concerns for cross contamination and that while the Dietary Supervisor is responsible for ensuring compliance in the kitchen, the Administrator is ultimately responsible to ensure all policies and procedures are followed. The Administrator stated she would monitor the effectiveness of policy adherence by completing spot checks in the kitchen and daily communication with the Dietary Supervisor. Requested a facility policy for personal food items on 02/05/2026 at 1:45 p.m. and was provided a policy titled Resident Personal Food storage. The facility did not have a policy for personal food storage for staff members food or drink items. Review of the Food Code, U.S. Public Health Service, U.S. FDA (Food & Drug Administration), 2022, U.S. Department of H&HS (Health & Human Services), 2-401.11, revealed, Eating, Drinking or Using Tobacco Products. (A) Except as specified in (B) of this section, an employee shall eat, drink, or use any form of tobacco products only in designated areas where the contamination of exposed food; clean equipment, utensils, and linens; unwrapped single-service and single-use articles; or other items needing protection cannot result.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the facility assessment was reviewed and updated as necessary, and at least annually for 1 of 1 facility. 1. The facility did not update the facility assessment to include Resident #38 gastrostomy (surgical procedure that creates an opening in the stomach, allowing for the insertion of a feeding tube (G-tube) for nutritional support). 2. The facility failed to include on the facility assessment the care of bariatric residents. These failures could affect residents by not having the necessary resources to ensure appropriate care is provided. Findings included: Record review of the facility's assessment reviewed on 06/17/25 reflected zero enteral feeding and did not address bariatric residents. 1. Record review of Resident #38's face sheet, dated 02/04/26, reflected Resident #38 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included gastrostomy. Record review of Resident #38's quarterly MDS assessment, dated 01/22/26, reflected Resident #38 rarely/never made herself understood, and rarely/never understood others. The assessment did not address Resident #38's BIMS score but reflected she had long term and short-term memory problems. The assessment reflected eating was not attempted due to medical condition or safety concerns. Resident #38 had a feeding while a resident of the facility and within the last 7 days. Record review of Resident #38's undated comprehensive care plan reflected Resident #38 required a feeding tube related to dysphagia (difficulty swallowing). The care plan interventions included: provide local care to feeding tube site as ordered and monitor for s/sx of infection. Record review of Resident #38's physician order summary report dated 02/04/26, reflected an active physician order for enteral feed order; Jevity (nutrition formula) 1.5- 1 carton (237 ml) five times a day with a start date 10/23/25. 2. Record review of Resident #44's face sheet, dated 02/04/26, reflected Resident #44 was a [AGE] year-old female, readmitted to the facility 01/14/26 with a diagnosis which included morbid (severe) obesity due to excess calories. Record review of Resident #44's quarterly MDS assessment, dated 12/17/25, reflected Resident #44 made herself understood, and understood others. Resident #44's BIMS score was a 15, which reflected her cognition was intact. The assessment reflected Resident #44 was dependent with toileting, shower/bathe, upper/lower and putting on/taking off footwear. Resident #44 required setup or clean-up assistance with oral/personally hygiene and independent with eating. Record review of Resident #44's updated comprehensive care plan reflected Resident #44 had ADL self-care performance deficit related to self-care deficit and morbid obesity. The care plan interventions included: Resident #44 required total assistance with Hoyer lift times two person assist for transfers at times depending on fatigue level and encouraged to discuss feelings about self-care deficit. Record review of Resident #44's physician order summary report dated 02/04/26 reflected an active order to use mobility bars to aide in east turning and repositioning while in bed every shift related morbid (severe) obesity due to excess calories with a start date 06/18/25. Record review of an undated/untitled sheet given by the Administrator on 02/04/26 at 10:15 a.m., reflected the facility had 4 bariatric residents. During an interview on 02/05/26 at 4:19 p.m., the Administrator stated she was responsible for completing and updating the facility assessment annually or anytime there was a major change in the facility such as the memory care closed or a new department head employee. The Administrator stated those things mentioned above would be updated in the facility assessment annually. The Administrator stated it was important the facility assessment was updated to have a plan of action in care of an emergency. Record review of the facility's policy titled, Facility Assessment revised 04/2025 reflected. the facility will conduct and document a facility-wide assessment, which includes both the resident population and the resources the facility needs to care competently for its residents during both day-to-day operations and emergencies. The facility will (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review and update the assessment at least annually and as necessary whenever there is, or the facility plans for any change that would require a substantial modification to any part of the assessment. 2. The facility assessment will include the following: a. resident population profile including numbers, diseases/conditions.4. The facility will be review and update the assessment annually or whenever the facility plans for any change that would require a modification to any part of the assessment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, based on the comprehensive assessment of a resident, ensure that residents receive treatment and care in accordance with professional standards of practice for 3 of 13 residents (Residents #5, 6, and 15) in that: Residents #5, Resident #6 and Resident #15 had pacemakers/defibrillator and had no specific guidelines for maintenance, precautions and care. The practice guidelines related to the maintenance, precautions and care were not clearly communicated in the EMR. These 3 residents had no specific care plan for pacemaker and defibrillator care or documentation of coordination of care with a cardiologist. These failures could result in residents experiencing cardiovascular problems, improper cardiac monitoring/transmission and follow up care.The findings include: Record review of Resident #5's face sheet dated 02/05/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included presence of an automatic (implantable) cardiac defibrillator (a battery powered device surgically placed under the skin to monitor heart rhythms and prevent sudden cardiac death), Atrial Fibrillation (chronic, rapid and irregular heartbeat), Chronic kidney disease (a long-term condition characterized by gradual loss of kidney function), hypertension (high blood pressure), cardiomyopathy (a heart muscle disease that reduces the hearts ability to pump blood) and congestive heart failure (a chronic condition where the heart cannot pump enough blood to meet the body's needs). Record review of Resident #5's comprehensive MDS dated [DATE] revealed a BIMS score of 9 which indicated moderate cognitive impairment with fluctuating inattention and disorganized thinking. Further review of the comprehensive MDS revealed Resident #5 had upper extremity range of motion impairment, required the use of a walker for mobility, moderate assistance in toileting bathing, dressing and transfers and was independent in bed mobility and gait. Record review of Resident #5's care plan with target date of 04/22/2026 revealed a focus area that indicated Resident #5 has a pacemaker related to Atrial Fibrillation with goal to remain free from signs and symptoms of pacemaker malfunction or failure. and interventions to include, monitor apical pulse daily, monitor for signs and symptoms of pacemaker malfunction, and report resident complaints of dizziness, pair or fatigue to the nurse. Record review of Resident #5's physicians orders revealed orders dated 10/21/2025 to monitor the apical pulse daily for pacemaker use and to monitor for signs and symptoms of pacemaker malfunction. Record review of Resident #5's EMR revealed no specific information regarding the defibrillator to include at a minimum, the make, the model, the last date the defibrillator was checked or the name of cardiologist. Record review of Resident #6's face sheet dated 02/05/2026 revealed a [AGE] year-old female originally admitted [DATE] and readmitted [DATE] with diagnoses that included the presence of a cardiac pacemaker (an implantable device placed under the skin to treat irregular heartbeats by sending painless electrical signals to normalize heart rhythm), atrial fibrillation (chronic, rapid and irregular heartbeat), cerebral infarction (a type of stroke caused by a blockage in a brain artery) and hypertension (high blood pressure), Record review of Resident #6's comprehensive MDS dated [DATE] revealed a BIMS score of 9 which indicated moderate cognitive impairment. Further review of the comprehensive MDS revealed Resident #6 required the use of a wheelchair for mobility, was independent in toileting, bathing, dressing, bed mobility, transfers and wheelchair mobility. Record review of Resident #6's care plan with target date of 05/06/2026 revealed a focus area that indicated Resident #6 has a pacemaker related to Atrial Fibrillation with goal to .remain free from signs and symptoms of pacemaker malfunction or failure. and interventions to include, monitor /document/report to MD PRN any signs or symptoms of altered cardiac output or pacemaker malfunction, dizziness, syncope, difficulty breathing, pulse rate lower than programmed rate, lower than baseline B/P and monitor vital signs as ordered/per facility protocol and record. Record review of Resident #5's physicians orders revealed orders dated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/06/2025 to monitor pulse daily for pacemaker use. Record review of Resident #5's EMR revealed no specific information regarding the pacemaker to include at a minimum, the make, the model, the last date of pacemaker check or the name of the cardiologist. Record review of Resident #15's face sheet dated 02/05/2026 revealed an [AGE] year-old male admitted [DATE] with diagnoses that included presence of a cardiac pacemaker (an implantable device placed under the skin to treat irregular heartbeats by sending painless electrical signals to normalize heart rhythm), atherosclerotic heart disease (plaque buildup in the coronary arteries that restricts blood flow to the heart), heart failure (a chronic condition where the heart cannot pump enough blood and oxygen to meet the body's needs), peripheral vascular disease (narrowing blood vessels due to plaque buildup), and hypertension (high blood pressure). Record review of Resident #15's comprehensive MDS dated [DATE] revealed a BIMS score of 5 which indicated severe cognitive impairment with fluctuating inattention. Further review of the comprehensive MDS revealed Resident #15 required the use of a walker or wheelchair for mobility, supervision with toileting, bathing, dressing, transfers and gait, and was independent in bed mobility. Record review of Resident #15's care plan with target date of 04/30/2026 revealed a focus area that indicated Resident #15 has a pacemaker related to atrial fibrillation with goal to .remain free from signs and symptoms of pacemaker malfunction or failure. and interventions to include, monitor apical pulse daily, monitor for signs and symptoms of pacemaker malfunction, monitor vital signs as ordered and record, report resident complaints of dizziness, pain or fatigue to the nurse. Record review of Resident #15's physicians orders revealed orders dated 01/23/2026 to monitor apical pulse daily for pacemaker use. Record review of Resident #15's EMR revealed no specific information regarding the pacemaker to include at a minimum, the make, the model, the last date of pacemaker check or the name of the cardiologist. During an interview and observation on 02/04/2026 at 11:00 a.m., Resident #5 stated that the staff do check her pulse. There was no equipment to monitor or check the pacemaker present in Resident #5's room. During an interview and observation on 02/04/2026 at 11:15 a.m., Resident #6 stated that the staff do check her pulse. There was no equipment to monitor or check the pacemaker present in Resident #6's room. During an observation on 02/05/2026 at 11:25 a.m., no equipment to monitor or check the pacemaker was present in Resident #15's room. During an interview on 02/05/2026 at 1:20 p.m., LVN O stated she was aware that some residents had a pacemaker because they would have order to monitor the apical pulse daily for pacemaker use. LVN O stated she did not know the specific make, model or cardiologist for Resident #5, Resident #6 or Resident #15 and she would look in the chart to see if she could find it. During an interview on 02/05/2026 at 1:38 p.m., the ADON stated he would look in the EMR to obtain the information and specifics related to the pacemaker by looking at the physicians order, a copy of the pacemaker card that may be uploaded under the miscellaneous files or indicated in the Care Plan. The ADON stated that different manufactures have different guidelines for monitoring of the pacemakers / defibrillators to include when the device should be interrogated (checked). The ADON stated he would look for the manufacturer to obtain the pacemaker specifications and ensure they were accessible in the EMR. The ADON stated that it would be important to know who the cardiologist was and when the last time the pacemaker/defibrillator was checked and risks of not knowing this information could mean the information would not be available in an emergency situation. The ADON stated to his knowledge, the facility does not have a specific policy for pacemakers. During an interview on 02/05/2026 at 1:51 p.m., the DON stated she would reach out to the family member to obtain the specific information regarding the pacemaker to include the make, model and cardiologist for Resident #15 and review for all resident's with a pacemaker / defibrillator. During an interview on 02/05/2026 at 3:10 p.m., the MDS Nurse stated that if a resident was identified as having a pacemaker or defibrillator, the Care Plan would reflect the presence of the device and orders would include monitoring the apical pulse and monitoring for malfunction. The MDS Nurse stated it would be important to know when the pacemaker was last checked but that this information is not always available from the resident, responsible party or identified in the medical (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record when a resident is admitted . The DON stated she was able to obtain and document in Resident #15's EMR the make and model of Resident #15's pacemaker as well as the name of his cardiologist. During an interview on 02/05/2026 at 3:41 p.m., the DON stated she did not feel that knowing the make and model of the pacemaker or defibrillator was important and that she expected the nursing staff to monitor the pulse and pacemaker checks. The DON stated the ADON would be responsible for ensuring the information is present in the orders and the MDS Nurse would be responsible for ensuring the device is annotated in the Care Plan. The DON stated she is ultimately responsible for accuracy of the record. During an interview on 02/05/2026 at 4:20 p.m., the Administrator stated it was important to gather the necessary information regarding a resident's pacemaker and to her knowledge they did have the cardiologist information on all the resident's with a pacemaker. The Administrator stated, it is always important to know about any internal device a resident may have to include the name and contact information for the cardiologist. The Administrator stated that the nursing staff are responsible for obtaining the pacemaker date and ensuring a cardiology follow up appointment is completed. Requested a policy for monitoring pacemakers / defibrillators on 02/05/2026 at 1:38 p.m. and was informed by the DON that the facility did not have a specific policy for pacemakers.

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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** 1.The facility failed to ensure RN P wore PPE (gown) while performing wound care on 02/04/26.2.The facility failed to ensure CNA S wore PPE (gown) while performing care on 02/03/26.3. The facility failed to have Personal Protective Equipment, also known as PPE, (is specialized clothing or equipment worn to protect individuals from hazards in various settings, such as the workplace, and includes items like gloves, safety helmets, masks, and eye protection) outside Resident #64's and Resident #5's rooms, who required enhanced barrier precautions also known as EBP (an infection control strategy that uses gowns and gloves during high-contact care activities to reduce the transmission of multidrug-resistant organisms (MDROs).These failures could place any resident at the facility at risk for cross-contamination and the spread of infection. Finding included: 1.Record review of Resident #78's face sheet, dated 02/06/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses to include left femur fracture (a serious, high-energy injury (e.g., car crashes, severe falls) resulting in a break in the thighbone), muscle weakness (often temporary, reduction in strength causing muscles to feel uncooperative, soft, or incapable of normal movement, distinct from fatigue), and vitamin D deficiency (occurs when the body does not get enough essential nutrients, leading to systemic malfunction and potential long-term health issues). Record review of Resident #78's admission MDS assessment, dated 12/15/25, indicated Resident #78 understood and was understood by others. Resident #78's BIMS score was 13, which indicated her cognition was intact. The MDS indicated Resident #78 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated she had an unhealed pressure ulcer. Record review of Resident #78's comprehensive care plan, revised on 01/12/26, indicated that Resident #78 had a stage 3 pressure ulcer to her left lower lateral leg related to her disease process of immobility. The interventions were for staff to do the wound treatment as ordered. Record review of Resident #78's Physician order dated 01/26/25 indicated, Cleanse wound to the left lateral lower leg with normal saline, then pat dry, then apply pharmacy compounded ointment (3%acetlycysteine and 10% urea and 125u/g collagenase in white petrolatum) over the wound bed then apply calcium alginate then apply a silicone dressing daily. Record review of Resident #78's Physician order dated 12/12/25 indicated, enhance barrier precautions for left hip surgical incision with wound vacuum every shift. During an observation on 02/04/26 at 2:58 p.m., RN P performed wound care for Resident #78. RN P did not wear PPE (gown) while providing wound care. 2.Record review of Resident #64's face sheet, dated 02/05/26, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included diabetes (a chronic condition characterized by high blood sugar also known as hyperglycemia) and high blood pressure. Record review of Resident 64's admission MDS assessment, dated 12/28/25, indicated Resident #64 understood and was understood by others. Resident #64's BIMS score was 14, indicating his cognition was intact. The MDS indicated Resident #64 required assistance with his ADLs, including transfers, dressing, personal hygiene, bed mobility and set up for eating. The MDS indicated application of dressing to his feet. Record review of Resident #64's comprehensive care plan revised 01/12/26 indicated, Resident #64 had a deep tissue pressure injury to his right heel. The intervention was for staff to do treatment as ordered and monitor wound healing. Record review of Resident #64's Physician order dated 12/30/25 indicated, Apply povidone-iodine to the right heel daily. The physician order did not address the use of enhanced barrier precautions. During an interview on 02/03/2026 9:30 a.m., Resident #64 was in his room sitting in his wheelchair. Resident #64 said he had a wound on his buttock and his left leg. During an observation and interview on 02/03/2026 at 5:13 p.m., CNA S went into Resident #64's room to allow the state surveyor to see his buttock. During the process, the state surveyor noted something on his left heel and CNA S said he had a wound to his heel. The surveyor asked if she was supposed to wear anything with residents if they had wounds and she said, Yes. She said she was supposed to wear a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown and gloves when providing care. CNA S said Resident #64 did not have an EBP sign or cart outside his door, so she had not thought about wearing PPE (gown and gloves). She said she did not know why Resident #64 did not have a sign or cart outside his room. She said she knew if they were on EBP she needed to wear gowns and gloves when providing care to prevent the spread of infection. During an interview on 02/04/2026 at 5:08 p.m., RN P said Resident #78 and Resident #64 had wounds. He said his understanding about when to wear EBP was intended for a surgical wound or chronic wound. He said staff should wear gloves and gowns for residents who require EPB. He said LVN Q determined when EBP was required. He said he had been trained on EBP and PPE use. He said the risks of not wearing the correct PPE (gown and gloves) could cause the transmission of Multidrug-resistant organisms also known as MRDO's (a germ that is resistant to many antibiotics). 3.Record review of Resident #5 face sheet dated 02/04/26 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis which included atrial fibrillation (irregular, often rapid heart rate). Record review of Resident #5's quarterly MDS assessment dated [DATE] reflected Resident #5 usually made herself understood and usually understood others. Resident #5's BIMS score was a 7, which reflected her cognition was severely impaired. Record review of Resident #5's undated comprehensive care plan reflected Resident #5 had actual impairment to skin integrity related to ruptured abscess (pus-filled pocket in the body)/venous leg ulcer (chronic, painful open sire that typically form near the ankle due to poor circulation). The care plan interventions included: encourage good nutrition and hydration to promote healthier skin. The care plan did not address the use of enhanced barrier precautions. Record review of Resident #5's order summary report dated 02/04/26 reflected an active physician order to cleanse wound to the left lower leg with normal saline then pat dry, apply a silicone dressing (wound supplies) daily with a start date 01/30/26. The order summary did not address the use of enhanced barrier precautions. During an observation on 02/02/26 at 4:43 p.m., Resident #5 was sitting in her wheelchair, and the surveyor noted a dressing to her lower left leg. Resident #5 had no EBP posting or cart outside her door. During an interview on 02/05/26 at 10:31 a.m., CNA D said she was Resident #5 aide. She said she had provided incontinent care for Resident #5 but had not worn PPE (gown) when she provided care. She said she had not been told to wear PPE (gown) for Resident #5. She said she knew if Resident #5 had a sign on her door, then she was supposed to wear PPE (gown and gloves) when providing care for Resident #5 to prevent infection. During an observation and interview on 02/05/26 at 3:01 p.m., LVN E said she was Resident #5 and Resident #78's nurse. She said she was not aware If they had wounds, she looked down the hall and said there was no sign or cart by their room. She said RN P usually did wound care. She said they had to do wound care over the weekend but could not remember who had wounds or who did not. She said since they had wounds, they should have signage posted and a cart outside of their room. She said staff should wear PPE (gown and gloves) when providing care for the protection of the residents and staff for the transmission of infection. During a phone interview on 02/05/26 at 2:42 p.m., LVN Q said she was the infection preventionist. She said she was responsible for ensuring EBP signage and cart were in place if needed. She said she had read on the Centers for Medicare and Medicaid Services (CMS) website that only residents with chronic or surgical wounds needed to have EBP signage and for staff to wear PPE (gown and gloves). She said she was not aware of what the facility's policy said. She said the reason for EBP was to protect the residents against our germs. She said staff needed to wear a gown and gloves when providing care for residents who required EBP. During an interview on 02/05/26 at 3:44 p.m., the DON said she expected staff to wash their hands and wear proper PPE (gown and gloves) when caring for residents on EBP to prevent infection. She said the ADON oversaw the infection control process. She said if residents had wounds, then they were supposed to have signage on the door and a cart outside of their doors. During an interview on 02/05/26 at 4:53 p.m., the Administrator said she expected any resident who had a wound for staff to wear PPE (gown and gloves) when providing care. She said they should have a sign and a cart outside of the door. She said LVN Q was responsible for ensuring signage and carts were in place. She said (continued on next page)

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	676049	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Paris	520 SE 8th St Paris, TX 75460

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure to wear proper PPE could cause the resident an infection. Record review of the facilities policy titled, IPCP Standard and Transmission-Based Precautions, It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. In Long Term Care (LTC). the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident. It is therefore appropriate to use the least restrictive approach possible that adequately protects the residents and others. #3 Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gowns and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., ?residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs}. PPE: infection. gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with: Wounds-and/or-indwelling -medical-devices known as MDRO infection. Wounds include, but are not limited to chronic Wounds, pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.

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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 interviews and record reviews, the facility failed to treat each resident with respect and dignity and provided care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 26 residents (Resident #44) reviewed for resident rights. The facility did not ensure Resident #44 had the correct size briefs to go to dialysis. This failure could place residents at an increased risk of embarrassment, isolation, and diminished quality of life.Findings included: 1. Record review of Resident #44's face sheet, dated 02/04/26, reflected Resident #44 was a [AGE] year-old female, readmitted to the facility 01/14/26 with a diagnosis which included morbid (severe) obesity due to excess calories. Record review of Resident #44's quarterly MDS assessment, dated 12/17/25, reflected Resident #44 made herself understood, and understood others. Resident #44's BIMS score was a 15, which reflected her cognition was intact. The assessment reflected Resident #44 was dependent with toileting, shower/bathe, upper/lower body dressing and putting on/taking off footwear. Resident #44 required setup or clean-up assistance with personal hygiene and independent with eating. Record review of Resident #44's updated comprehensive care plan reflected Resident #44 had ADL self-care performance deficit related to self-care deficit and morbid obesity. The care plan interventions included: Resident #44 required total assistance with Hoyer lift times two person assist for transfers at times depending on fatigue level and encouraged to discuss feelings about self-care deficit. Record review of an untitled and undated sheet given by Medical Records reflected there were no 3XL briefs in the supply room on 12/09/25, 12/16/25, and 12/23/25. During an interview on 02/02/26 at 11:05 a.m., Resident #44 stated she often missed dialysis due to personal reasons but there was a time she missed because the facility did not have briefs that fit her. Resident #44 stated she wanted to go that day but was told by CNA D that the facility was out of the briefs that would fit her. Resident #44 stated that it made her feel depressed. Resident #44 could not recall the exact date but knew it was sometime in December 2025. During an interview on 02/02/26 at 11:35 a.m., CNA D stated she could not recall the exact day, but the incident happened sometime in December 2025. CNA D recalled that Resident #44 missed dialysis because the facility did not have the correct size briefs. CNA D stated there were other sizes available, but it would not go all around her to fasten. CNA D stated she went and asked the other aides if they had any 3XL briefs on their hall and they stated no. CNA D stated she told the charge nurse (unable to recall name) that there were no briefs to fit Resident #44. CNA D remembered the nurse getting up and going to see if she could find some. CNA D stated the nurse came back and told her there was not any. CNA D stated she went and told Resident #44 the facility was out of the briefs she wore. During an interview on 02/03/26 at 5:43 p.m., Medical Records stated on 12/09/25, 12/16/25, and 12/23/25 there were no 3XL briefs in the supply room. Medical Records stated she did not go and count what was on the linen cart or in the resident's room. Medical Records stated she was unaware there were 4 bariatric residents in the facility. Medical Records stated it was never told to her that Resident #44 had to miss dialysis due to not having the correct size briefs. Medical Records stated not having the correct size briefs in the facility could cause residents to have to wear smaller size briefs which could be uncomfortable. During a telephone interview on 02/04/26 at 8:59 a.m., the Social Worker from the dialysis stated she could not recall the exact day, but she did remember the conversation between her and Resident #44 about her not coming to dialysis because the facility did not have the correct size briefs for her. During an interview on 02/05/26 at 3:30 p.m., the DON stated she was never told by staff nor Resident #44 that Resident #44 missed dialysis because the facility did not have the correct size briefs. The DON stated she was responsible for monitoring and overseeing supplies by asking Medical Records if there were not enough supplies and if she stated yes and she trusted her to do her job. The DON stated wearing smaller size briefs would not contain urine or feces. During an interview on 02/05/26 at 4:19 p.m., the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated she was not aware of Resident #44 missing dialysis due to her not having the correct size briefs. The Administrator stated she expected staff to notify her immediately if that issue occurred. The Administrator stated the DON/designee was responsible for monitoring and overseeing supplies. The Administrator stated this failure was a dignity issue. Record review of the facility's undated policy titled Resident Rights, reflected . It is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. The Resident has the right: 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record review, the facility failed to ensure the resident had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers for 1 of 26 (Resident #44) residents reviewed for psychoactive medications. The facility did not ensure Resident #44 had signed a psychotropic consent for Prozac (antidepressant) 40 mg. This failure could place residents at risk for receiving unnecessary psychotropic medications without informed consent.Findings included: Record review of Resident #44's face sheet, dated 02/04/26, reflected Resident #44 was a [AGE] year-old female, readmitted to the facility 01/14/26 with a diagnosis which included depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #44's order summary report dated 02/04/26 reflected Resident #44 had an order for Prozac 40 mg, 1 tablet by mouth every day for depression with a start date 01/29/26. Record review of Resident #44's quarterly MDS assessment, dated 12/17/25, reflected Resident #44 made herself understood, and understood others. Resident #44's BIMS score was a 15, which reflected her cognition was intact. Resident #44 had little interest or pleasure in doing things 2-6 days and feeling down, depressed or hopeless 12-14 days during the 14-day look-back period. Resident #44 received an antidepressant medication during the look-back period. Record review of Resident #44's undated comprehensive care plan reflected Resident #44 was on antidepressant medication related to depression. The care plan interventions included: give antidepressant medications ordered by the physician, monitor/documents side effects and effectiveness. Record review of the MAR dated 01/01/26-01/31/26 reflected Resident #44 received Prozac 40mg orally daily on 01/29/26, 01/30/26, and 01/31/26. Record review of the MAR dated 02/01/26-02/28/26 reflected Resident #44 received Prozac 40mg orally daily on 02/01/26, 02/02/26, 02/03/26, and 02/04/26. Record review of the facility's electronic charting system on 02/04/26 revealed a consent formfor Prozac 30 mg signed by the resident. During an interview, observation and record review on 02/04/26 at 9:15 a.m., the DON was asked by the state surveyor for Resident #44's most recent consent for Prozac. The DON brought the consent for the 30 mg to the state surveyor. During an interview on 02/04/26 at 2:38 p.m., RN A stated she was the nurse that received the new order for Prozac 40 mg. RN A stated she did complete a consent for the 40 mg and placed it in a folder at the nurse's station. RN A stated it was important to ensure consent forms were obtained to make sure the resident was aware of the dosage change and side effects. During an interview, observation and record review on 02/04/26 at 2:50 p.m., RN A brought a signed consent for Prozac 40 mg to the state surveyor back dated 01/29/26. During an interview on 02/04/26 at 3:00 p.m., the state surveyor went to the dining room and asked Resident #44 if she had signed the consent for Prozac 40 mg on 01/29/26. Resident #44 stated RN A had just brought the paperwork for her to sign today (02/04/26) while she was playing bingo. Resident #44 stated she did not sign a consent on 01/29/26 for the Prozac 40 mg. During an interview on 02/05/26 at 3:30 p.m., the DON stated the nurse that received the change dosage order was responsible for ensuring a consent form was signed prior to administration. The DON stated she was responsible for monitoring and overseeing by reviewing the order listing report on psychotropic medications weekly. The DON stated her last audit was done before 01/29/26. The DON stated it was important to ensure consent forms were obtained to make sure the resident was aware of the medication, side effects and ensure she wanted to take the medication. During an interview on 02/05/26 at 4:19 p.m., the Administrator stated she expected consents to be signed prior to administration. The Administrator stated ultimately the DON was responsible for monitoring and overseeing psychoactive medications. The Administrator stated it was important to ensure consent forms were obtained to make sure the residents were aware of the medication, dosage, and side effects. Record review of the facility's policy titled (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychotropic Drug Use last reviewed on 08/2017, reflected. It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnoses and documented in the clinical record.6 (f). informed consent was obtained prior to medication use.7. Upon change of condition or initiation of a new order for psychoactive medications, the licensed nurses shall complete the verification of informed consent form prior to the initiation of the new medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible, and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Resident #60) reviewed for accident hazards and supervision. The facility did not ensure Resident #60 wore a smoking apron on 02/03/26 at 9:30 a.m. smoke break. This failure could place residents who smoke at risk of physical harm. Findings included: Record review of Resident #60's face sheet dated, 02/04/26, reflected Resident #60 was a [AGE] year-old female, originally admitted to the facility on [DATE] with a diagnosis which included Tourette's disorder (nervous system disorder characterized by involuntary, repetitive movements and sounds known as tics). Record review of Resident #60's quarterly MDS assessment, dated 12/19/25, reflected #60 rarely/never understood others, and rarely/never made herself understood. Resident #60 had a BIMS score of 00, which reflected her cognition was severely impaired. Record review of Resident #60's undated care plan reflected Resident #60 had potential for injury related to smoking. The care plan interventions included: complete smoking assessment, provide 1:1 observation while smoking and utilize smoking apron during smoking activities. Record review of Resident #60's smoking evaluation dated 02/03/26 reflected Resident #60 required a smoking apron. During an attempted interview on 02/02/26 at 1:17 p.m., with Resident #60, she was non-interview able. During an observation on 02/03/26 at 9:30 a.m., Resident #60 was being supervised by Maintenance B while smoking 2 cigarettes without wearing a smoking apron. Resident #60 hands were shaking and not steady while holding the cigarettes. Resident #60 did not have any burn marks on her clothing. During an interview on 02/04/26 at 4:40 p.m., Maintenance B stated Resident #60 required a smoking apron while smoking. Maintenance B stated normally he placed an apron on her, but he forgot. Maintenance B stated this failure put her at risk of burning herself. During an interview on 02/05/26 at 3:30 p.m., the DON stated a clothing protector should be worn for Resident #60 while smoking. The DON stated the staff that took her out there was responsible for ensuring she wore an apron. The DON stated she monitored by random checks and has not seen any issues with staff not ensuring Resident #60 wore a clothing protector. The DON stated Resident #60 has not had any burns in the past. The DON stated this failure put Resident #60 at risk for burns. During an interview on 02/05/26 at 4:19 p.m., the Administrator stated she expected Resident #60 to wear an apron while smoking. The Administrator stated the staff that was scheduled for that break was responsible for ensuring Resident #60 had one on. The Administrator stated this failure put Resident #60 at risk for burns. Record review of a facility's policy titled Smoking and Safety Measures, revised 10/2022, reflected . It is the policy of this facility to provide a smoke-free environment for residents and staff. While our policy is to accommodate smoking opportunities.safety is our utmost concern.2. Residents who desire to smoke will be assessed for safety with smoking materials. (b) the need for protective smoking gear.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 2 of 6 residents (Resident #59 and Resident #54) reviewed for pharmacy services. The facility failed to ensure Resident #59's discontinued wrapped in the back of the narcotic box Diazepam (controlled medication used to treat anxiety) was being accurately reconciled on 02/04/26. The facility failed to ensure Resident #54's discontinued wrapped in the back of the narcotic box Lyrica (controlled medication used for pain) was being accurately reconciled on 02/04/26. These failures could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion.Findings included:1.Record review of Resident #59's face sheet, dated 02/05/26, indicated a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (a neurological condition that can present as issues with muscle tone, posture and/or a movement disorder), impulsive disorder (a group of psychiatric conditions characterized by the inability to resist intense urges or temptations that may harm oneself or others), and high blood pressure. Record review of Resident #59's quarterly MDS assessment, dated 01/10/25, indicated Resident #59 understood and was understood by others. Resident #59's BIMS score was 15, which meant he was cognitively intact. The MDS indicated Resident #59 required help with toileting bed mobility, dressing, transfers, personal hygiene, and set up for eating. The MDS indicated he took antianxiety medication during the 7-day look back period. Record review of Resident #59's comprehensive care plan, undated, indicated he had a diagnosis of anxiety. The interventions were to administer medication as ordered by the physician and monitor/document side effects and effectiveness. Record review of Resident #59's active physician orders dated 02/05/26 indicated: diazepam Oral Tablet 5 MG (Diazepam) Give 2.5 mg by mouth at bedtime for anxiety with a start date of (01/13/26).Physician order summary did not address Diazepam 5mg tablet take one tablet by mouth at bedside dispensed on 12/27/25 which was in the narcotic lock box on observation. Record review of Resident #59's administration record February 2026 indicated Diazepam Oral Tablet 5 MG (Diazepam) Give 2.5 mg by mouth at bedtime for Anxiety administered daily at 2000(8:00PM) without missing a dose. The administration record did not address Diazepam 5mg tablet take one by mouth at bedtime which was in the narcotic lock box on observation which was last signed out with an illegible signature 0.5 tab and given on 1/14/26 at 2000 (8:00PM). 2. Record review of Resident #54's face sheet, dated 02/05/26 indicated Resident #54 was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included low back pain. Record review of Resident #54's quarterly MDS assessment, dated 01/17/26, indicated Resident #54 was understood and was understood by others. Resident #54's BIMs score was 15, which indicated she was cognitively intact. Resident #54 required assistance with bathing, eating, toileting, transfer, personal hygiene, bed mobility and independent with dressing. The MDS indicated Resident #54 received pain medication during the 7-day look back period. Record review of Resident #54's comprehensive care plan, undated, indicated Resident #54 had potential for pain related to diagnosis of neuropathy. The intervention was to assess pain every shift and follow pain scale as ordered. Record review of Resident #54's physician's orders dated 01/09/26 indicated, Lyrica Oral Capsule 150 MG (Pregabalin) Give 1 capsule by mouth at bedtime for pain. Physician orders did not address Pregabalin 75mg take one capsule by mouth twice daily which was in the narcotic lock box on observation. Record review of Resident #54's of MAR indicated Lyrica Oral Capsule 150 MG (Pregabalin) Give 1 capsule by mouth at bedtime for pain given daily for the month of February 2026 at 2000 (8:00PM). MAR did not reflect an order for Pregabalin 75mg take one capsule by mouth twice daily last administered 1/9/26 at 12:00PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which was in the narcotic lock box on observation. During an observation and interview on 02/04/26 at 2:55PM, MA H said Resident #59's Diazepam was last administered on 01/14/26. Resident #59's diazepam card was noted at the back of the narcotic lock box, in the medication cart, wrapped in the narcotic count sheet order noted to take one tablet by mouth at bedtime. MA H revealed Resident #54's Pregabalin was last administered 01/09/26 signed out with an illegible signature. Resident #54's pregabalin card was noted at the back of the narcotic lock box wrapped in the narcotic count sheet order to take one capsule by mouth twice daily. MA H stated that she had no idea those were there and that the medications should have been given to the DON when discontinued. MA H stated that Resident #59 was at risk of theft of medication. Observation revealed Resident #54 pregabalin 75mg 38 tablets with no signs of tamper and Resident #59 diazepam 5mg 9 tablets with no signs of tamper. During an interview on 02/05/26 at 11:05 AM, the Pharmacist stated she expected all narcotics to be reconciled each shift every 8 hours, a log kept when administered, and the narcotics pulled from the cart and refrigerator and immediately given to the DON for destruction when no longer being prescribed by the physician. Pharmacist stated residents are at risk of theft of the medication and harm to the resident. During an interview on 02/05/26 at 3:48 PM, the DON said she performed random chart audits and the pharmacist did audits as well. The DON said the last audit conducted was on Hall 500 by the pharmacist and was dated 01/09/26. The DON stated she expected the Nurse to pull the discounted medication when order changes and immediately brought to the DON for destruction. The DON stated she expects all narcotics that are in the cart to be reconciled. DON stated that the facility was at risk of theft of medications. During an interview on 02/05/26 at 4:36 PM, the Administrator said the DON was responsible for ensuring all medications were locked, stored, distributed according to professional standards and pharmacist recommendations. The Administrator stated that she expected the DON to be responsible for drug destruction and in services regarding medication and medication storage. The administrator stated that she expected the discounted medications to be taken to the DON immediately because the facility was at risk of theft of narcotic medications. Record review of Legend Hall 500 medication cart audit, dated 01/09/26 done by the pharmacist, stated there was no evidence of out of date or discontinued medications on the cart. Record review of the facility policy titled, Nursing Services Drug Storage, dated 01/2022 indicated it is the policy of this facility to ensure the proper and safe storage of drugs and biologicals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676049	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Paris	520 SE 8th St Paris, TX 75460

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 4 medication storage areas (300 hall Medication Cart and medication refrigerator) observed for storage and security. 1. The facility failed to ensure MA H secured the 300 hall Medication Cart, when it was not in use and unattended on 02/02/2026. 2. The facility did not ensure Resident #14's medication named Lorazepam (used for anxiety) was secure in the unlocked refrigerator on 02/04/26. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.Findings included: 1. During an observation and interview starting on 02/02/2026 at 10:31 AM, there was an unlocked, unattended medication cart at the beginning of hall 400. Multiple staff and residents passed by the unlocked, unattended medication cart. At 10:46 AM, the DON observed the surveyor standing by the 300 hall Medication Cart, approached it, and locked it. The DON said the medication carts should not be left unlocked when unattended. The DON said all nursing staff should be conducting rounds to ensure the medication carts were locked. The DON said when a medication cart was left unlocked anybody could get into the medications carts and the residents could take the medications. During an interview on 02/03/2026 at 11:18 AM, MA H said she thought she locked the 300 hall Medication Cart, when she walked away from it on 02/02/2026. MA H said she had gone down the hall, then went outside to take a call, and when she returned, she was told she had left the 300 hall Medication Cart unlocked. MA H said the medication cart should be locked when she walked away from it. MA H said if the medications carts were left unlocked any of the medications could come up missing from the medication cart and the residents could have gotten into the medications. During an interview on 02/03/2026 at 6:19 PM, the Administrator said she expected the medication carts to be locked when unattended. The Administrator said the staff should be making sure the medication carts were locked. The Administrator said the residents could open an unlocked medication cart and take something out of it that was not for them. 2. During an observation and interview on 02/04/26 at 3:56 PM, LVN L revealed that the narcotic refrigerator was unlocked with Resident #14 Lorazepam drops stored inside. LVN L stated he thought he had locked the refrigerator when he counted at shift change 02/04/26 at 2:00PM. LVN L revealed the refrigerator should be locked for the safety of the staff and residents from theft. LVN L stated that he was responsible for ensuring the refrigerator was locked. During an interview on 02/05/26 at 11:05 AM, the pharmacist stated controlled medications should be locked with 2 locks. The medication fridge was required to be locked. During an interview on 02/05/26 at 3:48 PM, the DON stated she expected the nurses during count to ensure the refrigerator was locked and she expected the refrigerator to be locked at all times. DON stated she was responsible for ensuring the nursing staff are securing the medications and locking the refrigerator and each nurse who counts each shift. During an interview on 02/05/26 at 4:36 PM, the Administrator said the DON was responsible for ensuring all medications are locked, stored, distributed according to professional standards and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacist recommendations. The Administration stated that she expects the DON to be responsible for drug destruction and in-services regarding medication and medication storage. Record review of the facility policy titled, Nursing Services Drug Storage, dated 01/2022 indicated it is the policy of this facility to ensure the proper and safe storage of drugs and biologicals. Record review of the facility's policy titled, Pharmacy Services Drug Storage, revised 05/2021, indicated, It is the policy of this facility to ensure the proper and safe storage of drugs and biologicals. Medication and treatment carts will be kept locked when unattended.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 2 of 2 residents (Resident #43, Resident #62) and 1 of 1 lunch meal reviewed for palatability. The facility did not provide palatable food served at an appetizing temperature or taste to Resident #43 and #62 who complained the food was served cold and did not taste good. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings include: During an observation and interview on 02/02/2026 at 11:30 a.m., [NAME] M completed temperature checks for all food textures and meal items prior to the start of the tray line and annotated temperatures in the temperature logbook. All temperatures were within acceptable temperature parameters. [NAME] M stated she checked the temperature at the start of the meal and about halfway through the meal service. [NAME] M stated if a resident complained that the meal items were cold, she would retake the temperature and provide a new tray or item for the resident. During an observation and interview on 02/02/2026 at 12:28 p.m., lunch tray was sampled by the Dietary Manager and 3 surveyors. The sample tray was served on a plate warmer, had a cover and consisted of chicken parmesan, barbecue sausage, and white beans. The Dietary Manager stated the chicken parmesan, sausage and beans were warm and could have been hotter. The surveyors agreed that all the sampled food temperatures could have been hotter. During an interview on 02/02/2026 at 1:06 p.m., Resident #43 stated the food was terrible. When asked to elaborate, he stated it was cold and bland. During an interview on 02/02/2026 at 1:09 p.m., Resident #62 stated the food was not seasoned enough. During an interview on 02/03/2026 at 1:10 p.m., the Dietary Supervisor stated that she had not received any complaints regarding food being cold. The Dietary Supervisor stated that the cook monitors food temperatures throughout the meal service and that she (the Dietary Supervisor) completes spot checks of the temperature logs and spot checks of actual temperature weekly. The Dietary Supervisor stated she monitored the meals by daily rounds in the dining room and random walks on the halls to communicate directly with the residents and asked questions about the food. The Dietary Supervisor stated it was important to ensure food temperatures are monitored when serving food to ensure temperature is acceptable for the residents to prevent poor intake, weight loss or malnutrition. During an interview on 02/05/2026 at 3:41 p.m., the DON stated that no residents have voiced concerns to her regarding food temperature and/or taste. The DON stated the facility used plate warmers on all trays to ensure food is kept as warm as possible. The DON stated that the potential risk is weight loss and unhappy residents. During an interview on 02/05/2026 at 4:20 p.m., the Administrator stated that to her knowledge, no residents have complained of cold food temperatures and that she expects staff to notify the kitchen and obtain a new food item if the resident complained of cold food. The Administrator stated that complaints of cold food could result in residents not eating their meals and weight loss. The Administrator stated the Dietary Supervisor is responsible for ensuring appropriate food temperatures for all tray items prior to serving to the residents and that the Administrator is ultimately responsible for ensuring the Dietary Supervisor monitors the temperatures appropriately. The Administrator stated that she would monitor the food temperatures by randomly requesting a meal tray on a monthly basis. The Administrator stated she expects the meals to be served at an acceptable temperature level and that it was important for the temperatures to be at acceptable levels to prevent potential weight loss and grievances. Record review of the facility policy titled Food Temperatures, undated, indicated, Policy: The temperatures of all food items will be taken and properly recorded prior to service of each meal.Procedure: 3. Temperatures should be taken periodically to assure hot foods stay above 135 degrees Fahrenheit.during the holding and plating process and until food leaves the service area.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observations, interviews, and record review, the facility failed to follow established policy regarding smoking areas, and smoking safety for 1 of 1 facility. 1. The facility failed to provide a metal container with a self-closing cover device. 2. The facility did not ensure smoked cigarettes were extinguished in a fire-retardant receptacle. These failures could place residents and staff at risk of unsafe smoking and injury.Findings included: During an observation on 02/03/26 at 9:30 a.m., there was a 31-gallon galvanized removable lid outdoor trash can with numerous cigarettes butts observed in it. There were numerous cigarette butts laying on the ground. There was no metal ash tray observed in the smoking area. During an interview on 02/04/26 at 4:40 p.m., Maintenance B stated it was ok to dispose of the cigarette butts in the outdoor trash with removable lid because it was a metal container. Maintenance B stated he did not notice the cigarette butts on the ground. Maintenance B stated they should be disposed of in the metal container. Maintenance B stated these failures could potentially cause a fire. During an interview on 02/05/26 at 8:06 a.m., Maintenance C stated cigarette butts should be disposed of in the metal ash tray. Maintenance C stated that it was the correct metal receptacle to dispose of the cigarette butts. Maintenance C stated he was responsible for monitoring the smoking area by rounding every morning. Maintenance C stated these failures could potentially cause a fire. During an interview on 02/05/26 at 4:19 p.m., the Administrator stated the metal container that was out there last month had a self-closing lid, but it had broken, and Maintenance was supposed to replace it. The Administrator stated she expected cigarette butts should be disposed of in the ash tray not on the ground. The Administrator stated the Maintenance Supervisor was responsible for monitoring and overseeing the smoking area, but she did make random rounds monthly. The Administrator stated these failures could potentially cause a fire. Record review of a facility's policy titled Smoking and Safety Measures, revised 10/2022, reflected . It is the policy of this facility to provide a smoke-free environment for residents and staff. While our policy is to accommodate smoking opportunities.safety is our utmost concern.10. Safety code approved ashtrays are provided and are the only approved receptable for disposing of smoking materials.