STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676073	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Quail Valley	2350 Fm 1092 Missouri City, TX 77459

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 4 residents (Resident #355) reviewed for privacy, in that: - The facility failed to place Resident #355's foley catheter bag inside of a privacy bag on 06/03/2025. These failures placed residents at risk for embarrassment, at risk of loss of dignity and decrease in quality of life. The findings include: Record of Resident #355's Facesheet dated 06/05/2025 reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included but were not limited to benign prostatic hyperplasia (gland enlargement) without lower urinary tract symptoms, sepsis (a life-threatening complication of an infection, and elevated white blood cell count (indicating an active infection or inflammation in the body). Record review of Resident #355's Minimum Data Set (MDS) dated [DATE] reflected he had a Brief Interview for Mental Status (BIMS) of 15 being the highs level of mental cognition. Record review of Resident #355's undated Care Plan reflected; resident had an indwelling catheter, date initiated: 06/02/2025 and revision on: 06/03/2025. Record review of Resident #355's Nursing Progress Notes dated 06/02/2025 at 11:39 p.m., reflected Resident #355 arrived at the nursing facility (NF) from the hospital able to make all his needs known. Resident's admitting diagnosis: sepsis and hypoxia (absence of oxygen to the body's tissue), osteomyelitis (bacterial bone infection). Resident was incontinent of bladder and bowel and had a foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine when normal urination is not possible or desired). Record review of Resident #355's Physician Order Summary dated 06/02/2025 at 11:24 p.m., reflected: Foley catheter . bulb to bedside drainage, diagnosis benign prostatic hyperplasia without lower urinary tract symptoms. Ordered By: MD A. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #355's Physician Order Summary dated 06/02/2025 at 11:24 p.m., reflected: Change foley catheter as needed for obstruction or if closed system was compromised as needed. Ordered By: Medical Doctor (MD) A. Record review of Resident #355's Physician Order Summary dated 06/02/2025 at 11:24 p.m., reflected: Foley catheter output, check every shift related to benign prostatic hyperplasia without lower urinary tract symptoms. Ordered By: MD A. Record review of Resident #355's Nursing Progress Note dated 06/04/2025 at 05:11 a.m., created by LVN B, reflected, incontinent care provided, and foley catheter intact, and patent. Record review of Resident #355's Physician Order Summary dated 06/05/2025 at 10:55 a.m., reflected: Foley catheter to bedside drainage. Ordered By: MD. Record review of Resident #355's Physician Order Summary dated 06/05/2025 at 10:56 a.m., reflected: Foley catheter care every shift and as needed every shift. Ordered By: MD. During an observation/interview on 06/03/2025 at 09:13 a.m., Resident #355 laid in his bed upright. Resident's foley catheter bag had been observed hanging from the left facing side of resident's bed, and urine within visible. Resident stated he had returned from the hospital on [DATE] late evening. He stated he had not been aware that his catheter bag had no cover with urine visible. He stated that he had preferred it have not been left uncovered. In an interview on 06/03/2025 at 09:40 a.m., Registered Nurse (RN), stated that Resident #355 readmitted from the hospital on the late evening of 06/02/2025. She stated that the resident admitted from the hospital with his present catheter system in place and the bag came from the hospital without a privacy cover. She stated it had been the responsibility of the nursing staff to ensure that the resident's catheter bag had a privacy cover once he admitted . She stated since the resident admitted late the evening of 06/02/2025 the nursing staff must have forgotten to cover the foley bag with the privacy cover. She stated that the nursing staff on the 1st shift (6 a.m. to 2 p.m.) should have placed the cover on the bag 06/03/2025, when they noticed it uncovered. She stated that she would place a privacy cover on the resident's foley bag immediately. In an interview on 06/06/2025 at 02:00 p.m., with the Director of Nursing (DON) and Administrator (ADM), the DON stated that Resident #355 had newly admitted from the hospital on [DATE] without a privacy bag on his foley catheter bag. She stated that the NF had an influx of the admissions on 06/02/2025, and because the nursing staff were busy, they had forgotten to place a privacy cover on Resident #355's foley catheter bag. The DON stated that the nursing staff were to have made rounds every 2-hours and it had been their responsibility to ensure that residents with foley catheter bags had privacy covers. The ADM stated that the importance of foley catheter bags to have had privacy bags were to provide the residents with privacy and preserve a resident's dignity. Record review of facility In-service Training Report dated 06/05/2025 reflected that nursing staff received training in the topic area: Incontinent & Foley Care & Foley Positioning). Summary of training session: Proper Incontinent Care/Foley Care. Resident's dignity to be protected. Presented by Assistant Director of Nursing (ADON). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of NF's policy dated 2001 and revised September 2014 and titled, Foley Catheter Insertion, Male Resident Level III Purpose reflected, The purpose of this procedure is to provide guidelines for the aseptic insertion of a urinary catheter. Preparation: 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed. Record review of NF's policy dated 2001 and revised September 2014 and titled, Catheter Care, Urinary Level III. Assemble the equipment and supplies as needed. General Guidelines Following aseptic insertion of the urinary catheter, maintain a closed drainage system.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents receive services in the facility with reasonable accommodation of resident needs for 1 of 8 residents (Resident #11) reviewed for call lights. The facility failed to ensure Resident #11 call light within reach while resident was in bed on 06/03/25. This failure could place residents at risk for a delay in care and services, increased falls, and a decreased quality of life. Findings included: Record review of Resident #11's face sheet dated 06/04/25 revealed a [AGE] year-old female was admitted on [DATE]. Resident #11 had diagnoses which included: atherosclerotic heart disease (thickening or buildup of plaque in the inner lining of an artery), hypertension (when the pressure in the blood vessels is too high), and cardiomegaly (enlarged heart). Record review of Resident #11's admission MDS assessment, dated 04/21/25, revealed the BIMS score was 11, which indicated moderately impaired cognition. Further review of the MDS revealed the resident needed moderate assistance with transfer with one staff assist. Record review of Resident #11's care plan initiated 04/18/25 revealed the resident was at risk for fall related to limited mobility, weakness, and requires assist with mobility. Intervention: be sure call light is within reach and encourage to use it for assistance as needed. During an observation on 06/03/25 at 10:12 a.m., Resident #11 call light was on the floor close to the night. Resident #11 was lying on her right side facing the window. During an observation and interview on 06/03/25 at 10:13 a.m., Resident #11 said she was fine while stretching her hand toward the left side of the bed, and she said she could not reach the call light. During an interview on 06/03/25 at 10:16 a.m., CNA G said she saw Resident #11's call light on the floor towards the nightstand. CNA G said the staff should have clipped Resident #11 call light next to the pillowcase unless the resident wanted the call light pinned on her clothes. CNA G said the resident needed a call light to call for assistance. CNA G said if Resident #11 needed assistance and could not reach the call light, the resident would try to assist herself, and she could fall. CNA G said the aides had in-service call lights and were always educated to place the call light within reach so the resident could reach and use the call light for assistance. She said the nurse monitors the aides throughout the shift to make sure the aides are providing care for the residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/03/25 at 10:29 a.m., CNA K said she was Resident #11's aide for today. CNA K said Resident #11 needed help getting in and out of bed, and she was not the aide who transferred Resident #11 back to bed. CNA K said when the resident was out of bed, she would clip the call light in the middle of the bed. CNA K said if a resident was in bed, the call light should be clipped so the resident could reach it. CNA K said if Resident #11 could not reach the call light, the resident could fall if she tried to get out of bed. CNA K said she had an in-service on-call light and was educated to ensure the call light was always within reach of any resident. CNA K said the nurse monitored the aides throughout the shift. During an interview on 06/03/25 at 1:04 p.m., LVN K said Resident #11's call light should be within reach because Resident #11 would fall or have an emergency because she could not reach the call light. LVN K said the nurse monitored the aides throughout the shift. LVN K said she had an in-service on-call light and was educated to make sure the resident's call was always within reach for the resident to use whenever the resident needed staff assistance. LVN K said the nurse managers monitored the nurses during random rounds. During an interview on 06/05/25 at 4:59 p.m., the ADON said Resident #11's call light should be within reach so she could call for assistance whenever she needed any care from the staff. The ADON said different things could happen to Resident #11, depending on the resident's needs. She said if Resident # 11 wanted to get out of bed and she could not reach the call and she tried to get out of bed by herself, Resident#11 could fall and hurt herself. The ADON said the nurse managers monitored the nurse during random rounds, and the staff had in-service on-call lights. During an interview on 06/06/25 at 10:55 a.m., the DON said Resident #11 call should be within reach while the resident was in bed. The DON said if Resident #11's call light was not within reach, Resident #11 would not be able to call for assistance, and if Resident #11 wanted to go to the restroom, the resident could have an accident on herself. The DON said the aides had in-service on-call lights and were told the call light was the only way to communicate with staff when they needed help while in the room unless during staff rounding. The DON said the nurse monitored the aides throughout the shift, and the nurse managers monitored the nurses during random rounds. Record review of the facility call light policy dated 201 MED - PASS, Inc.(Revised October2010) read in part . The purpose of this procedure is to respond to the resident's requests and needs . General Guidelines . #5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 4 residents (Resident #20 and Resident #78) reviewed for comprehensive care plans. -The facility failed to ensure that Resident #20's requirement for anticoagulants was a focus area in the resident's comprehensive care plan no date provided and no intervention was documented in place. -The facility failed to ensure that Resident #78's requirement for anticoagulants was a focus area in the resident's comprehensive care plan no date provided and no intervention was documented in place. This deficient practice could affect residents by contributing to inadequate care. The findings included: 1. Record review of Resident #20's facility admission record dated 6/5/25 revealed a [AGE] year-old-male admitted on [DATE] with diagnoses that included unspecified sequelae cerebrovascular disease (refers to the long-term effects or complications that arise from a cerebral infarction (stroke) when the specific sequelae are not detailed) and hemiplegia and hemiparesis (both refer to weakness or paralysis on one side of the body). Record review of Resident #20's Annual Minimum MDS dated [DATE] revealed Resident #20 had a BIM score of 6 out of 15 indicating he had severe cognitively impairment. Resident #20 required substantial/maximal assistance with ADL's. Record review of section N (Medications) revealed that he received anticoagulants. Record review of Resident #20's comprehensive care plan revealed there were no care plans to address anticoagulant use. Interview and record review on 6/5/25 at 12:45 PM with the MDS Coordinator who said she was the one that performs the care plans and confirmed there was no comprehensive care plan for Resident # 20 to address anticoagulant use. She said that the RAI manual was used to complete assessments. She said that a negative outcome could be bleeding for Resident #20 and that she was the person responsible for Long Term care plans. 2. Record review of Resident #78's facility admission record revealed a [AGE] year-old male with an original admission date of 8/1/24 and re-admission date of 4/24/25 with diagnoses that included unspecified dementia (a form of dementia where the specific type of dementia cannot be determined or is not specified) and primary osteoarthritis (the gradual breakdown of cartilage in joints due to aging and wear and tear, without a known underlying cause). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #78's admission Minimum MDS dated [DATE] revealed Resident #78 had a BIM score of 10 out of 15 indicating he had moderate cognitive impairment. Resident #78 required substantial/maximal assistance with ADL's. Record review of section N (Medication) revealed that he required anticoagulant. Record review of Resident #78's comprehensive care plan, no date provided revealed there were no care plans to address anticoagulant use. Interview and record review on 6/5/25 at 12:45 PM with the MDS Coordinator who said she was the one that performs the care plans and confirmed no comprehensive care plan for Resident # 78 to address anticoagulant use. She said that the RAI manual was used to complete assessments. She said that a negative outcome could be bleeding for Resident #20 and that she was the person responsible for Long Term care plans. During an interview on 6/5/25 at 12:56 PM with the DON who said that comprehensive care plans were important to provide care to residents. A negative outcome for not having a care plan could be bleeding or bruising. She added that she has oversight for the care plans but did not look at them all. Record review of the facility policy and procedure entitled Care Plans, Comprehensive Person-Centered dated revised December 2016, read in part .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Reflect currently recognized standards of practice for problem areas and conditions .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 each resident received adequate supervision and assistance devices to prevent accidents for 2 out of 32 residents (Resident #93 and Resident #13) reviewed for adequate supervision. - The facility failed to ensure Resident #93 who was on continuous oxygen did not smoke while oxygen was being administered from 03/20/25 through 06/03/25. The facility documented they found cigarettes and a lighter in Resident #93's room on 03/22/25 and was observed smoking while on oxygen in front of the facility on 4/18/25 and 06/03/25. -The facility failed to ensure Resident #13 bed rail/assistance bar was attached to the bed securely. when the rail/assistance bar was observed on the floor on 06/03/25. This deficiency exposed residents living in the facility to potential harm, injury or death due to not being adequately monitored. An Immediate Jeopardy (IJ) was identified on 6/23/2025 at 4:59 PM. The IJ template was provided to the Administrator and DON on 06/23/25 at 4:59 PM. While the IJ was removed on 06/24/25 at 5:19 PM. the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. Findings included: Record review of Resident #93's face sheet dated 06/03/26 revealed an [AGE] year-old male was admitted on [DATE]and readmitted on [DATE]. Resident #93 had diagnoses which included: heart failure (heart cannot pulp enough blood to meet the body's need), hypertension (when the pressure in the blood vessels is too high), and COPD (lung disease that make it hard to breath). Record review of Resident #93's admission MDS assessment, dated 03/24/25, revealed the BIMS score was 12. Record review of Resident #93's care plan initiated 03/20/25 revealed Resident #93 was a current smoker at risk for adverse effects and has noncompliance with policy. Entered Behavioral contract: (refusals. resistive to care, safety rule regarding smoking) resident agreed to follow all safety and regulations. Date Initiated: 03/20/2025. Date revision on 06/03/2025. goal: Resident #93 will not smoke while a resident in facility through the review date initiated: 03/20/2025. target Date: 07/14/2025. Interventions: Discuss residents smoking habits with resident/family date initiated 03/20/2025. Elicit family input for best approaches to resident date initiated: 03/20/2025. Praise resident for demonstrating consistent desired/acceptable behavior date initiated: 03/20/2025. Discuss residents smoking habits with resident/family date initiated 03/20/2025. Elicit family input for best approaches to resident date initiated: 03/20/2025. Revised 06/03/2025. Provide reminders that we are a non-smoking facility which includes the surrounding areas as well. Date initiated: 03/20/2025. Behavior contract: If not followed, resident has agreed to immediate discharge with social worker involvement. date initiated 06/03/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #93's NP progress noted dated 4/8/25 4/15/25,5/20/25, 5/22/25, 5/23/25 and 5/27/25 did not address Resident #93 behavior of noncompliance with smoking policy. Record review of Resident #93's progress notes dated 03/22/25 revealed Resident #1 had cigarette and lighter in his room. Record review of Resident #93's progress notes dated 03/24/25, 03/26/25,04/02/25, 04/03/26, 04/06/25, 04/18/26, 04/19/25, 04/20/25, and 06/03/35 revealed Resident #93 smoked out the facility. During an interview on 06/03/25 at 12:12 p.m., the Corporate Nurse said he observed Resident #93 smoking with his oxygen on and in use in a parking lot of the building next to the NF today (06/03/2025. The Corporate Nurse said he took Resident #93's lighter and cigarette away from him. Corporate Nurse said he was going to initiate Resident #93's discharge today. During an interview on 06/03/25 at 12:24 p.m., Resident #93 said he went to where his friend resides in the building next to the NF to get a cigarette and lighter to smoke. Resident #93 said he was admitted to the NF as a smoker, and the NF was upset with him today because the State was in the building. Resident #93 said the NF and Administrator knew he was a smoker. Resident #93 said he would sign himself out to smoke with the oxygen in his wheelchair. He said since he smoked outside, where the wind blew his smoke away, he did not know that smoking could ignite the oxygen. During an interview on 06/03/25 at 1:00 p.m., LVN K said Resident #93 had not gone out to smoke today, but he had been going out to smoke in the past. LVN K said he had seen Resident #93 smoke in front of the building with his oxygen on in his wheelchair. She said she told the administrator and the DON. She said the Administrator and the DON told Resident #93 that the facility was non-smoking. She said after they had talked to him, Resident #93 started to sign himself out to go and smoke in the parking lot of the building next to the facility with his oxygen on. LVN K said Resident #98 told her once to remove the oxygen because he was going to smoke, and she did remove the oxygen tank. During an interview on 06/03/25 at 3:54 p.m., the DON who said Resident #93 smoked in front of the facility when he was first admitted to the facility. The DON said she and the Administrator told Resident #93 that he could not smoke in front of the facility building because the facility was a non-smoking facility. The DON said staff had told her Resident #93 would sign himself out and go to the next building to smoke while he had his oxygen. She said it was care planned that the resident was a smoker, and the intervention was to educate the resident not to smoke because this was a non-smoking facility. The DON said it was hazardous because he had oxygen, and the smoking could cause the oxygen to blow up. The DON was asked what the facility did when the intervention did not work because he had continued to smoke since March. The DON responded that the facility would discharge him today (06/03/25). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an Interview on 06/03/25 at 5:59 p.m., the Unit Manager who said Resident #93 used to smoke in front of the facility building, and later, he started to go to the next building to smoke with his oxygen. The Unit Manager said Resident #93 signs out when he goes to the next building to smoke. She said it was not safe to smoke with oxygen because it could blow up. The Unit Manager said she had talked to Resident #93 and documented twice. She said the resident was his own responsible party and there was no family member. The Unit manager said Resident #93 had no family members and did not know why the family member was put in the care plan. She did not respond when she was asked what other intervention was put in place since educating the resident did not stop him from smoking. The Unit Manager said the resident oxygen tank could blow up while he was smoking. During an interview on 06/03/25 at 4:21 p.m., the Administrator who said he had not seen Resident #93 smoke, but he heard once that he smoked, and he and the DON had a conversation with him. The Administrator said he told Resident #93 that this building was not a smoking facility. He told him they had another building that was a smoking facility, and they had staff that would go out with residents to smoke. The Administrator said the smoking facility had a smoking blanket and fire extinguisher, but he declined to go to the smoking facility. He said she could not recoil any staff telling him Resident #93 still smoked. The Administrator said he would have Resident #92 sign a behavioral contract that he would not smoke between now and tomorrow, which was his planned discharge. The Administrator said If the staff saw him smoking, he would be discharged immediately. The Administrator said Resident #93 smoking would have been a major issue because the resident could had caught on fire if the oxygen had combusted. During an Interview on 06/03/25 at 6:24 p.m., NP said the facility told her Resident #93 goes out to smoke with his oxygen on. NP said when she talked to the resident, he would say he did not smoke, and she could smell that he smoked on him. NP said the staff had showered her picture where the resident was smoking. Some other staff told her that the resident had sneaked out to smoke, and she said she could not remember the names of the staff members. The NP said the facility should be able to answer what other intervention that was put in place when educating Resident #93 did not stop him from smoke. She said if Resident #93 was smoking with his oxygen on, the oxygen could ignite. During an interview on 06/03/25 at 6:40 p.m., CNA I said she had not seen Resident #93 smoke, but some of the staff had seen him smoking with an oxygen tank. CNA I said she could not remember the names of the staff who told her Resident #93 goes out to the next building park lot to smoke. CNA I said the oxygen could blow up from the cigarette and hurt the resident. On 6/3/25 at 9:14 AM, an observation of Resident #13 he was asleep in his bed covered in blankets and his call light was placed on his bed. There was also a bed rail/assistance bar on the floor by his bed on the right side. Observation and interview with CNA F on 6/3/25 at 9:57 AM revealed that the bed rail that was on the floor had been repaired. She said that she told the Maintenance Director immediately once she saw the bed rail on the floor and he (the Maintenance Director) repaired the bed rail. She said the resident could have rolled out of bed and hurt himself, she added all staff are responsible for reporting repairs needed. She added that Resident #13 was a fall risk, and this was why she had his bed lowered. (continued on next page)

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	676073	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Quail Valley	2350 Fm 1092 Missouri City, TX 77459

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #13's facility admission record revealed an [AGE] year-old male with an original admission date of 9/1/20 and re-admission date of 7/20/24 with diagnoses that included History of Falling (The history of falling is crucial for diagnosis. Falls are the second leading cause of unintentional injury deaths worldwide), Parkinsonism Disease (Parkinson's disease is a progressive movement disorder of the nervous system that causes symptoms such as tremors, stiffness, and difficulty with balance and coordination. It is a brain condition that worsens over time and can also affect mental health, sleep, and other bodily functions) and dementia in other diseases classified elsewhere, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (Dementia describes a group of symptoms affecting memory, thinking and social abilities) (It indicates that a patient has dementia as a result of an underlying disease that is not otherwise specified and without associated behavioral, psychotic, mood, or anxiety symptoms). Record review of Resident #13's Annual MDS dated [DATE] revealed Resident #13 had a BIM score of 7 out of 15 indicating he had severe cognitive impairment. Resident #13 required substantial/maximal to partial/moderate assistance with ADL's. He had an indwelling urinary catheter and was frequently incontinent of bowel. Record review of Resident #13's comprehensive care plan revealed a care plan to address fall risk with the date initiated of 9/9/20 and revised on 8/22/23 and target date of 7/29/25. Interventions included make sure to resident frequently to make sure resident needs are met, low bed, fall mats and ensure floors are free and clear from clutter. Interview on 6/4/25 at 2:15 PM with the Maintenance Director he said the screw fell out of Resident #13's bed rail and he replaced the screw. He said that staff directly told him that the repair to the bed was needed, they also communicated through a email that connected to the Administrator and management team regarding the incident, this alert went to everyone, he said that he was responsible for making repairs and all staff monitored for needed repairs. He added that the resident could have rolled out of bed and hurt himself. Interview on 6/5/25 at 1:15 PM with the Administrator who said that the bed rail could cause the resident to fall, that the Maintenance Director was responsible for repairs, but it was all staff's responsibility to report repairs needed. Interview on 6/5/25 at 2:49 PM with the DON, who said that she was made aware of the broken bedrail and acknowledged that it could be a hazard and could cause injury. She added the Maintenance Director was responsible for repairs, but all staff are responsible for reporting. Record review of the facility admission Packet read a resident may be discharged or transferred if a. Necessary for the resident's welfare and resident's needs cannot be met in the facility. c. The Resident is endangering the safety of other people in the facility. d. The Resident is endangering the health of other individuals in the facility: · ACKNOWLEDGEMENT OF SMOKING POLICY Non-Smoking Facility: I hereby acknowledge that the facility is a NON SMOKING facility, and I was made aware. Residents may not use or keep cigarettes, cigars, matches, or any smoking paraphernalia in their room or on their person at any time during their stay at the facility. Residents must adhere to the smoking schedule and cannot smoke without supervision. Failure to adhere to this policy may result in immediate discharge. (Resident/Responsible Party Initials) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility police on safety and supervision of resident dated 2001 MED- PASS, Inc. (Revised July 2017) read in part .Our facility strives to make the environment as free from accident hazards as possible . Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Individualized, Resident-Centered Approach to Safety . #1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .#4. Implementing interventions to reduce accident risks and hazards shall include the following: 1. Communicating specific interventions to all relevant staff; 2. Assigning responsibility for carrying out interventions; 3. Providing training, as necessary. 4. Ensuring that interventions are implemented; and 5. Documenting interventions . #5. Monitoring the effectiveness of interventions shall include the following: 1. Ensuring that interventions are implemented correctly and consistently; 2. Evaluating the effectiveness of interventions; 3. Modifying or replacing interventions as needed; and 4. Evaluating the effectiveness of new or revised interventions. The following Plan of Removal submitted by the facility was accepted on 6/23/2025 at 8:36 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Plan of Removal F689 June 23rd, 2025. What corrective actions have been implemented for the identified residents? Resident #93 was no longer a resident at the time of this plan of removal. No corrective action is was possible to be taken for resident #93. How were other residents at risk to be affected by this deficient practice identified? An audit of all residents was conducted on 6/23/25 by the DON/designee. No other residents reside in the facility who smoke. All residents who reside in the facility have the potential to be affected by the alleged deficient practice, however, none were affected. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? Resident #93 was no longer a resident of the facility as of 6/23/25. All facility staff, including CNAs, MAs and nurses were in-serviced by DON/Designee on facility actions to be taken for residents who fail to follow facility smoking policies. This was completed 6/6/2025. This includes notifying the administrator, DON and regional support staff in situations of non-compliance with smoking policies. What corrective actions were taken? 1. The following actions were initiated immediately on 6/4/25. a. On 6/4/2025 the Administrator and DON were in-serviced by the Regional [NAME] President of Operations on immediately discharging residents who do not comply with facility smoking policies. b. All facility staff in-serviced by the DON/Designee on 6/4/2025 regarding facility smoking policies and what to do if they witness residents smoking on the facility premises or surrounding areas while utilizing oxygen. c. An ad-hoc QAPI regarding residents who are non-compliant with smoking policies was completed on 6/4/25. The facility medical director was included. d. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility reviewed their smoking policies on 6/4/2025 with the medical director and it remains a non-smoking facility at this time. e. All current residents and their responsible parties were notified of facility smoking policies via the e-alert system on June 4th, 2025. f. All new residents will be educated on facility smoking policies upon admission. How will the system be monitored to ensure compliance? The facility administrator, as part of the morning stand-up process, will review any new issues with residents not following the facility smoking policy and address those concerns on a case-by-case basis. An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 6/23/25 with the Medical Director. The Medical Director has reviewed and agrees with this plan. Monitoring of the plan of removal on 6/24/2025 included: Record review of a facility document titled Daily Census Report, dated 6/20/2025 to 6/22/2025, revealed residents who were non-smoker. The census revealed 104 residents of which all were nonsmokers. Record review of a facility document titled Education of New Residents, not dated, read in part: 1) All referral portals that offer an opportunity to place a notation or ask the question if we offer smoking, are noted appropriately to show that we are a non-smoking facility, 2) Residents are notified prior to admission by our Director of Business Development that we are a non-smoking facility, 3) Residents are provided with a Welcome booklet that states we are a non-smoking facility, 4) During the initial care plan meeting, the Social Services Director asks new admissions if they are a smoker, and shares that we are a non-smoking facility and that we are able to offer nicotine patches or lozenges to assist individuals with quit smoking by providing a controlled release of nicotine into the blood stream, which helps to reduce nicotine withdrawal symptoms and cravings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a facility document titled Ad Hoc Qapi, dated 6/4/2025, revealed: Area of concern identified 1) Resident observed smoking with oxygen in place, 2) Resident leaving facility without signing himself out, 3) Facility not evaluating resident's BIMS's score to asses capability of safety awareness (First BIMS score was documented 12/15), and 4) All staff needing to enforce we are a non-smoking facility and report any infarctions immediately; Investigation of allegations: Resident observed smoking with oxygen in place. Resident observed smoking off premises next door at a local apartment complex. Resident's sign-out log appears that someone else was signing him out and has ditto marks versus actual signatures. Sign-out log also has no signatures for resident's return to the facility to show return; Possible outcome if situation is confirmed: Resident smoking with oxygen in place creates a significant safety concern. Resident leaving our premises without signing himself out and back in upon return is against policy for signing out; Five Whys: Resident smoking with his oxygen on. 1) Resident has history of noncompliance in other areas ie. Care, medication, etc, 2) Resident feels he has the right to smoke, 3) Resident states he will not allow anything to happen as he is [AGE] years old, 4) Resident states the sign on the front of the facility says No smoking in the facility, and 5) Resident has been a habitual smoker for years; Interventions: 1) Resident was offered and accepted, nicotine and lozenges, 2) After resident observed smoking, nicotine patches and lozenges were discontinued for health reason, 3) When resident continued joking about going out to smoke and signed himself out to go smoke, DON and Administrator spoke with resident regarding possible outcomes of safety issues (oxygen catching on fire, E-tank exploding, both of which can cause injury and death)., 4)Resident observed by RVP and Clinical Services Director smoking with his oxygen on, and spoke with resident and provided education on safety issues, and 5) Resident discharged home at his request due to his dislike of our facility policies on smoking. Record review of a facility document titled In-Service Training Report, dated 6/4/2025, revealed that all staff to include the RN's, LVN's, CNA's, MA's Supervisors, Dietary staff and Housekeeping staff were in-serviced by the DON on the smoking policy which read in part If you see a resident smoking you are to come and report it to managers, Administrator etc. You need to tell the resident they cannot smoke here and to put the cigarette out. Always make sure that you report it to the managers. Record review of a facility document titled In-Service Training Report, dated 6/4/2025, revealed that the Administrator and DON were in-serviced by the Regional [NAME] President on the smoking policy revealed in part Resident who are non-compliant with facility smoking policies. Signing out pass. Any resident who is habitually non-compliant with the facility smoking policy needs an immediate discharge from the facility. Documentation of education of facility smoking policies needs to be included in the resident chart. Additionally, residents who go out on pass must be signed out when leaving the facility and signed in when they return. This includes resident who are self-responsible. Interviews with Residents began on 6/24/2025 at 1:00 p.m. Residents #6, # 86, # 167, #169, #170, #171, #172, #174 and # 175 stated they were aware that this nursing facility was a smoke free facility. Interviews with CNA's I, K, M, P, Q, R, S, T, V, W and X; LVN's C, K, P, Q, R and S; MA's A, B, C, and D; RN B; Unit Manager; Dietary Manager; House Keeping Supervisor; House Keeper's A and B on 6/24/2025 beginning at 11:33 a.m. staff were able to explain the smoking policy. Staff stated that this nursing facility was a smoke free facility. Staff stated that if a resident was observed smoking staff should retrieve the cigarette from the resident, inform the resident that this facility was smoke free, and report the incident to the Administrator and/or supervisor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the DON on 6/24/2025 at 4:48 p.m., who stated that staff was in-serviced on the smoking policy on 6/23/2025 and 2 or 3 weeks ago. She stated that staff are aware that this facility is a non-smoking facility. She stated that if staff see any resident smoking, they must report it immediately to management team. She stated staff was expected to ask the resident to put the cigarette out and educate the resident that this nursing facility was a non-smoking facility. Interview with the Administrator on 6/24/2025 at 5:03 p.m. stated that staff were in-serviced on 6/3/2025, 6/4/2025 and 6/23/2025. He stated that staff are aware that this facility was a non-smoking facility. He stated that if staff observe a resident smoking staff should ask the resident to put the cigarette out and educate the resident as to the facilities smoking policy. Staff was expected to report the smoking incident to the Administrator and/or Nursing Supervisor. He stated that if the resident continues to be noncompliant the resident will be discharged . He stated that current residents /and RP's have been educated about the smoking policy. He stated that on 6/4/2025 the smoking policy was texted and emailed to residents and/or RP'S. He stated that that the facility has started a stand up meeting whereby managers discuss any issues to include smoking. He stated that moving forward the smoking policy will be reviewed at the Resident Council meeting. He stated that all staff have been in-serviced on the smoking policy. The Administrator and DON were informed the Immediate Jeopardy was removed on 6/24/2025 at 5:19 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is no immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 residents (Resident #155 and Resident #88) reviewed for incontinent care. 1.The facility failed to ensure CNA M cleaned Resident #155's indwelling Foley catheter properly and followed proper hand hygiene during incontinent care on 6/5/25. 2. The facility failed to ensure C.NA P cleaned Resident #88 properly during incontinent care on 6/5/25 These failures could place residents at risk for pain, infection, injury, and hospitalization. Finding included: Record review of Resident #155's face sheet print date of 6/3/25 reflected date of admission was 5/29/25 the diagnoses included osteomyelitis(infection of the bone), pressure ulcer to sacral area (bedsore) , unspecified stage, retention of urine, unspecified, postmenopausal atrophic vaginitis (thinning drying and inflammation of the vaginal walls that may occur when your body has less estrogen), other specified congenital deformities of hip, metabolic encephalopathy (a brain dysfunction caused by problems with the body's metabolism), cerebellar ataxia(poor muscle control that causes clumsy movements) in diseases classified elsewhere, local infection of the skin and subcutaneous tissue, unspecified, acquired absence of bilateral breasts and nipples, other specified disorders of bone density and structure, unspecified site, functional quadriplegia (a condition where a person loses the ability to move their arms, legs and sometimes even their trunk and head), generalized anxiety disorder, orthostatic hypotension (a condition where your blood pressure drops significantly when you stand up), other recurrent depressive disorder (a mental health condition where someone feels persistently sad, loses interest in things they usually enjoy and experiences other symptoms like difficulty sleeping, low energy and trouble concentrating) and indwelling Foley Catheter (a flexible tube, like a straw that's inserted into the bladder to drain urine when you can't urinate normally or for medical reasons). Record review of Resident #155's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score was blank indicating severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter. Resident #155's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident#155 had an indwelling Foley catheter. Record review of Resident #155's physician order dated from May 2025 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 6/2 . keep catheter from kinks and drainage bag lower than bladder at all times dated 5/29/25. Record review of Resident #155's care plan dated 5/30/25 had her to exhibits ADL Self Care Performance Deficit, and requires assistance with all ADLs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of incontinent /indwelling Foley catheter on 6/5/25 at 12:25 PM , performed by C.NA M to Resident #155 lying in bed with family member at bed side. CNA M did not wash hands, did not use hand sanitizer. C.NA M, don another clean gloves, undo resident #155's soiled brief, using the wet wipes cleaned the groin, F/C was secured, CNA cleaned visible part of the indwelling catheter she did not open Resident #155's labia to cleaned from the insertion site. Resident #155 had large BM , CNA M cleaned in -between the buttocks with BM, did not clean around the buttocks, , she picked up clean brief and fasten it on resident. Interview with C.NA M on 6/5/25 at 1:41PM she said she was nervous, C.NA M said she did not open labia to clean indwelling catheter insertion site. C.NA M said not cleaning indwelling catheter from the insertion site for Resident #155 's her hands could cause UTI , she said she was hired 1 year ago and she had in-service on Foley catheter/incontinent care. Record review of Resident #88's face sheet reflected date of admission was 11/13/24 and re admitted on [DATE] diagnoses include cerebral infarction, unspecified, unspecified atrial fibrillation (heart beating too fast), essential (primary) hypertension(high blood pressure), hypothyroidism (thyroid gland isn't producing enough thyroid hormones), unspecified, edema, unspecified, hemiplegia and hemiparesis(weakness to one side of the body) following cerebral infarction affecting left dominant side, hyperlipidemia (high fat in the blood). Observation of incontinent care on 06/05/25 4:46 PM to Resident #155 done by CNA P and assisted with CNA, U, Res lying in the low bed on her back, CNA did not open the labia to clean, there was pervasive odor when the staff opened the soiled brief with urine. CNA P said Resident was heavy wetter . CNA changed gloves and washed hands. Interview with CNA P on 6/5/25 at 4:52PM who said she started working here 7 months ago and she should have open the labia more to clean and she had training with the IP nurse. Interview with IP nurse on 6/5/25 at 4:52PM said she did the initial training upon hired and the lead C.NA does hands on training when the new hired newly. She then presented the check-off list for C.NA and C.NA P. Interview with DON 6/6/25 at 10:51 AM regarding incontinent care/Foley Care training, who said the (IP) nurse does the initial training and the lead C.NA would monitor while on the unit. DON said she and the IP nurse monitors the CNAs randomly monthly and not performing good incontinent care could result in infection and UTI. Interview with (Lead C.NA) on 6/6/25 at 1:24 PM, who said she had been working with the facility for 2 years, she does round with the nurses aides before the CNA gets on the floor to work. CNA stated she had training and LVN P and LVN M and check them off. Record review of the facility policy for Catheter Care Urinary dated 3/31/2016 revealed: For the female: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	16. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. Record review of the undated facility policy titled Hand Hygiene, provided by the ADM, revealed the following: You may use alcohol based hand cleaner or soap/water for the following: Before and after assisting resident with personal care (e.g., oral care, bathing); Upon and after coming in contact with a resident's intact skin; After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters and urinals; After removing gloves or aprons.

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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 provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and sdministering of all drugs and biologicals to meet the needs of each resident for 1 of 1 medicationstorage room observed for expired medications in that: The facility failed- On 06/03/35 when there were 15 hydrocortisone acetate 25mg (a topical steroid used to treat pain, itching, and swelling in the rectum {the end of the large intestine where stool is stored until it exits the body through the anus} and anus,) suppositories (medication used to insert into the rectum) with an expiration date that read 05/2025. This medication belonged to CR #100 who discharged on 04/12/2025. This failure placed resident at risk for an unwanted adverse drug reaction had the resident not discharged from the facility. Findings included: Record review of CR#100 face sheet dated 06/03/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and was discharged from the facility on 04/12/25. CR's diagnoses included the following: chronic lymphocytic leukemia (a type of cancer of the blood and bone marrow {soft tissue inside of the bones that produces blood cells}), calculus of kidney (kidney stones), and diverticulosis (small, bulging pouches that develop in the intestine) of large intestine. Record review of CR#100's MDS dated [DATE] reflected a BIMS score of 12 indicating that resident cognition was moderately impaired. Record review of CR #100's Comprehensive Care Plan dated 03/24/25 reflected resident was being care planned for potential pain related to .generalized pain r/t aging and disease process. The intervention included: to -Administer pain medication as per MD orders. Record review of CR #100's Physician Order Summary Report for March 2025 reflected the following order: -Ddated 03/24/25 Hydrocortisone acetate 25mg insert one suppository rectally two times a day for rectal pain for 30 days. Record review of CR #100 MAR & and TAR for the month of March 2025 revealed that resident was receiving medication Hydrocortisone acetate 25mg rectally twice a day. Observation on 06/03/25 at 1:53PM of the facility medication storage room with LVN A, it was observed in the fridge, 15 hydrocortisone Acetate 25mg suppositories. The expiration date read 05/2025. The suppositories belong to Resident CR #100 with instructions to administer 1 suppository 2 times a day for 30 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676073	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Quail Valley	2350 Fm 1092 Missouri City, TX 77459

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/25 at 2:10PM with LVN A said she had been working at the facility for 1 year and 6 months on the 6AM-2PM shift. LVN A said it was the responsibility of the ADON to check the medication room for expired medications. LVN A said expired medications pending the medication , placed the resident (s) at risk for gastrointestinal upset, allergic reactions, altered mental status but either way, it was not positive or good for the resident. Interview on 06/03/25 at 2:26PM with the ADON said she was responsible for checking the medication storage room for expired medications. The ADON said the last time she checked the medication room for expired medications was last week but did not remember the day she checked the room. The ADON said expired medications placed the resident (s) at risk for adverse reactions . Interview on 06/03/25 at 2:34PM with the DON who said the ADON checked the medication storage room on a weekly basis for expired medications. The DON said she was responsible in ensuring that the ADON was checking the medication room for expired medications. The DON said expired medications would not be effective for the medication and the resident could have an adverse side effect. Record review of the facility policy on Medication Storage revised April of 2007 reflected in part: .The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional standards for 1 medication storage room. in that: The facility failed- On 06/03/35 when there were 15 hydrocortisone acetate 25mg (a topical steroid used to treat pain, itching, and swelling in the rectum {the end of the large intestine where stool is stored until it exits the body through the anus} and anus,) suppositories (medication used to insert into the rectum) with an expiration date that read 05/2025. This medication belonged to CR #100 who discharged on 04/12/2025. This failure placed resident at risk for an unwanted adverse drug reaction had the resident not discharged from the facility. Findings included: Record review of CR#100 face sheet dated 06/03/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and was discharged from the facility on 04/12/25. CR's diagnoses included the following: chronic lymphocytic leukemia (a type of cancer of the blood and bone marrow {soft tissue inside of the bones that produces blood cells}), calculus of kidney (kidney stones), and diverticulosis (small, bulging pouches that develop in the intestine) of large intestine. Record review of CR#100's MDS dated [DATE] reflected a BIMS score of 12 indicating that resident cognition was moderately impaired. Record review of CR #100's Comprehensive Care Plan dated 03/24/25 reflected resident was being care planned for potential pain related to .generalized pain r/t aging and disease process. The intervention included: to -Administer pain medication as per MD orders. Record review of CR #100's Physician Order Summary Report for March 2025 reflected the following order: -Ddated 03/24/25 Hydrocortisone acetate 25mg insert one suppository rectally two times a day for rectal pain for 30 days. Record review of CR #100 MAR & and TAR for the month of March 2025 revealed that resident was receiving medication Hydrocortisone acetate 25mg rectally twice a day. Observation on 06/03/25 at 1:53PM of the facility medication storage room with LVN A, it was observed in the fridge, 15 hydrocortisone Acetate 25mg suppositories. The expiration date read 05/2025. The suppositories belong to Resident CR #100 with instructions to administer 1 suppository 2 times a day for 30 days. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/25 at 2:10PM with LVN A said she had been working at the facility for 1 year and 6 months on the 6AM-2PM shift. LVN A said it was the responsibility of the ADON to check the medication room for expired medications. LVN A said expired medications pending the medication , placed the resident (s) at risk for gastrointestinal upset, allergic reactions, altered mental status but either way, it was not positive or good for the resident. Interview on 06/03/25 at 2:26PM with the ADON said she was responsible for checking the medication storage room for expired medications. The ADON said the last time she checked the medication room for expired medications was last week but did not remember the day she checked the room. The ADON said expired medications placed the resident (s) at risk for adverse reactions . Interview on 06/03/25 at 2:34PM with the DON who said the ADON checked the medication storage room on a weekly basis for expired medications. The DON said she was responsible in ensuring that the ADON was checking the medication room for expired medications. The DON said expired medications would not be effective for the medication and the resident could have an adverse side effect. Record review of the facility policy on Medication Storage revised April of 2007 reflected in part: .The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Deficiency Text Not Available

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 2 residents (Resident #155) and 1 of 2 staff (CNA M) reviewed for incontinent care and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #71) of 28 residents reviewed for infection control. The facility failed to ensure CNA M washed or sanitized her hands and performed glove changes appropriately while providing incontinence care to Resident #155 on 06/05/25. The facility failed to ensure Resident #71's foley catheter drainage bag was not resting on the resident's floor mat on 06/03/25. This deficient practice placed residents at risk for cross contamination and the spread of infection.Finding included: Record review of Resident #155's face sheet print date of 6/3/25 reflected date of admission was 5/29/25 the diagnoses included osteomyelitis(infection of the bone), pressure ulcer to sacral area (bedsore) , unspecified stage, retention of urine, unspecified, postmenopausal atrophic vaginitis (thinning drying and inflammation of the vaginal walls that may occur when your body has less estrogen), other specified congenital deformities of hip, metabolic encephalopathy (a brain dysfunction caused by problems with the body's metabolism), cerebellar ataxia(poor muscle control that causes clumsy movements) in diseases classified elsewhere, local infection of the skin and subcutaneous tissue, unspecified, acquired absence of bilateral breasts and nipples, other specified disorders of bone density and structure, unspecified site, functional quadriplegia (a condition where a person loses the ability to move their arms, legs and sometimes even their trunk and head), generalized anxiety disorder, orthostatic hypotension (a condition where your blood pressure drops significantly when you stand up), other recurrent depressive disorder (a mental health condition where someone feels persistently sad, loses interest in things they usually enjoy and experiences other symptoms like difficulty sleeping, low energy and trouble concentrating) and indwelling Foley Catheter (a flexible tube, like a straw that's inserted into the bladder to drain urine when you can't urinate normally or for medical reasons). Record review of Resident #155's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score was blank indicating severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter. Resident #155's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident#155 had an indwelling Foley catheter. Record review of Resident #155's physician order dated from May 2025 read in part . change Foley catheter with 18 inch catheter and 10cc bulb on the 1st of each month dated 6/25 . keep catheter from kinks and drainage bag lower than bladder at all times dated 5/29/25 Record review of Resident #155's care plan dated 5/30/25 had her to exhibits ADL Self Care Performance Deficit, and requires assistance with all ADLs. Observation of incontinent /indwelling Foley catheter on 6/5/25 at 12:25 PM, perform by C.NA M, Resident #155 was lying in bed with family member at bed side, CNA M did not wash hands, did not use hand sanitizer. C.NA M had 2 pairs of cleaned gloves, she pulled bed side table from A bed to Resident #155 on the B bed, and place her wet wipes and cleaned gloves on the table, CNA M don clean gloves, adjusted Resident #155 bed, changed gloves, did not wash hands, don another clean gloves, undo Resident #155's soiled brief, using the wet wipes cleaned the groin, resident #155 had large BM, CNA did not change gloves repositioned resident on the left side, use the same glove throughout the procedure to she picked up clean brief and fasten it on resident, repositioned the pillows, covered linen and went to resident dresser to place the remaining wet wipe in it. Interview with C.NA M on 6/5/25 at 1:41PM who said she was nervous and she did not have enough gloves or hand sanitizer. CNA M stated she had been trained on infection, and she did not have enough gloves or hand sanitizer. CNA M stated she had been trained on infection control not in facility but had not been told specifically to wash or sanitize hands when going from a dirty to clean surface. C.NA M stated if she did not wash or sanitize her hands when going from a dirty to clean surface, it could cause cross contamination and a risk of transferring infection. Interview with DON 6/6/25 at 10:51 AM, who stated it was the facility's policy for staff to wash or sanitize hands when going from a dirty to clean surface. She stated staff had been in serviced on infection control and hand hygiene. She stated if hand hygiene or sanitizing was not performed when going from a dirty to clean surface, it could cause an infection. Resident #71 Record of Resident #71's Facesheet dated 06/05/2025 reflected he was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE] and then again on 03/13/2025 with diagnosis that included but were not limited to