STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676095	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Nursing and Rehabilitation Center	3200 W. Slaughter Lane Austin, TX 78748

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 of 10 residents (Resident #27, Resident #50, and Resident #109) reviewed for resident rights.The facility failed to ensure CNA D knocked on Resident #27's door before entering the resident's room.The facility failed to ensure CNA E knocked on Resident #109's door before entering the resident's room.The facility failed to ensure Resident #50's catheter bag had a privacy cover on.These failures could place residents at risk of feeling like their privacy was invaded or cause psychosocial harm and emotional distress.Findings include:1. Record review of Resident #27's face sheet, dated 02/24/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #27 had diagnoses which included reduced mobility, unsteadiness on feet, dementia (memory, thinking, difficulty), cognitive communication deficit (problems with communication), muscle weakness, cerebral infraction (long term effects of a stroke), Schizophrenia (mental disorder that affects a person's ability to think, feel and behave clearly), and peripheral vascular disease (abnormal narrowing of arteries),Record review of Resident #27's quarterly MDS assessment, dated 01/30/2026, revealed Resident #27 had a BIMS score of 0, which indicated severe cognitive impairment.During an observation of 100-hall on 02/23/2026 at 12:26 p.m., revealed CNA D did not knock on Resident #9's door before entering.During an attempted interview with Resident #27 on 02/23/2026 at 9:53 a.m., revealed she was lying in her bed but would not respond to the state surveyor.2. Record review of Resident #50's face sheet, dated 02/24/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included muscle wasting, neuromuscular dysfunction of bladder (lack of bladder control), hyperthyroidism (excessive production of thyroid hormones), hypertension (high blood pressure), pulmonary embolism without acute cor pulmonale (blood clot in the lungs without difficulty breathing) and tracheostomy status (an incision in the front of the neck to create a direct airway into the trachea.).Record review of Resident #50's quarterly MDS assessment, dated 02/16/2026, revealed Resident #50 had a BIMS score of 0, which indicated severe cognitive impairment.Record review of Resident #50's care plan, dated 02/16/2026, revealed [Resident #50] has a catheter r/t neurogenic bladder. Position catheter bag and tubing below the level of the bladder and away from entrance room door.Record review of Resident #50's Physician orders, dated 2/12/2026, revealed Position Privacy bag and tubing below the level of the bladder.During an observation of Resident #50 on 02/23/2026 at 10:22 a.m., revealed the resident was lying in bed. Resident #50 had a catheter bag that did not have a privacy cover on it.During an attempted interview with Resident #50 on 02/23/2026 at 10:23 a.m., revealed the resident could not respond to questions. Resident #50 was lying in bed and had a trach in her neck.During an interview with CNA D on 02/25/2026 at 10:06 a.m., she said the policy for covering catheter bags was that the catheter bag must always be sealed and covered with a blue bag. She said the CNAs were responsible for ensuring the catheter bags had a privacy cover. She said the resident may feel uncomfortable if the catheter bag did not have a privacy (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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(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 - Some	cover. She said the CNA's monitored to ensure the residents had a privacy cover on their catheter. She said she did not know why Resident #50 did not have the privacy bag on her catheter. During an interview with the DON on 02/25/2026 at 2:14 p.m., she said the policy for covering catheters was staff must cover the catheter with a privacy. She said the catheter should always have a privacy cover on it. She said all staff were responsible for ensuring the catheter had a privacy cover. She said the resident might not like that their catheter bag did not have a privacy cover. She said all staff should monitor to ensure the catheter bags had privacy covers. She said staff monitored the catheter bags by doing rounds on the residents. She said the only thing she could think of was the resident came from the hospital and they did not change the catheter bag. She said the facility had catheter bags with the built in privacy cover.During an interview with the ADM on 02/25/2026 at 3:06 p.m., he said the policy for covering the catheter bags was all catheter bags must have a privacy cover on them. He said the nurses and aids were responsible for ensuring the catheters bags had a privacy cover over them. He said if the catheter did not have a privacy cover on it the resident may feel embarrassed. He said management monitored to ensure the catheter bags had covers on them. He said management monitored by doing morning rounds. He said he did not know why Resident #50 did not have a privacy cover on her catheter bag.Record review of the facility's Indwelling Urinary Catheter Care Policy, dated 12/2025, revealed It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. Cover the drainage bag with a privacy bag to maintain dignity.3. Record review of Resident #109's face sheet, dated 02/24/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #109 had diagnoses which included parkinsonism (syndrome characterized by tremors and postural instability), dementia (memory, thinking, difficulty), major depressive disorder (mental health disorder characterized by persistent depressed mood), and cognitive communication deficit (problems with communication).Record review of Resident #109's quarterly MDS, dated [DATE], revealed Resident #109 had a BIMS of 14, which indicated intact cognitive response.During an observation of 200-hall on 02/23/2026 at 11:45a.m., revealed CNA E did not knock on resident #109's door before entering.During an interview with Resident #109 on 02/23/2026 at 10:36 a.m., she said the staff did not always knock on the door before entering. She said she would like for staff to knock before entering her room. She said knocking was the right thing to do. She said she did not get upset when staff do not knock.During an interview with CNA D on 02/25/2026 at 10:03 a.m., she said she had been trained on resident rights. She said the policy for knocking on the door was to knock before entering the room. She said the CNAs were responsible for knocking on the residents door. She said if staff did not knock on the door before entering the resident may feel uncomfortable or their privacy was invaded. She said the CNAs monitored to ensure staff knocked on the residents' doors. She said staff monitored by observation. She said she did not knock on Resident #27's door because she was distributing lunch.During an interview with CNA E on 02/25/2026 at 10:19 a.m., he said he had been trained on resident rights. He said the policy for knocking was staff were to knock and announce themselves before entering. He said all staff should knock on the door before entering. He said a resident may feel uncomfortable and feel violated if staff did not knock before entering the room. He said the nurse monitored to ensure staff were knocking. He said the nurses monitored by observations. He said he did not know why he did not knock on Resident #109's door. During an interview with the DON on 02/25/2026 at 2:12 p.m., she said she was trained on resident rights. She said the policy for knocking was staff were to knock before entering any residents' room. She said all staff were responsible for knocking on the resident's door. She said if staff did not knock on the door before entering, the resident could get startled. She said the DON and ADM monitored to ensure staff were knocking on residents' doors. She said the DON and the ADM monitored by doing rounds throughout the day. She said she did not know why staff were not knocking on residents' doors before entering. During an interview with the ADM on 02/25/2026 at 2:18 p.m., he said the policy for knocking was staff were to knock before entering and introduce (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	themselves. He said all staff should knock if wanting to enter the resident's room. He said residents' may feel surprised, and shocked if staff did not knock on the door before entering. He said management monitored to ensure staff were knocking on resident doors. He said management did daily rounds and observed staff walking in resident rooms. He also said if management saw staff not knocking the manager would in-service the staff member immediately . He said he did not know why staff did not knock on Resident #27 and Resident #109's doors before entering. Record review of Resident Rights Dignity Policy dated 07/2025 revealed It is the policy of this facility that all residents be treated with kindness, dignity and respect. The right to privacy.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview and record reviews the facility failed to ensure residents had a right to organize and participate in resident groups in the facility for 10 of 10 confidential residents reviewed for resident council.The facility failed to provide the Resident Council with a private meeting area to conduct their monthly meetings. This failure could place residents at risk of not being able to exercise their rights to meet as a group in private. Findings include:During a confidential group interview/observation at an undisclosed date and time the group of ten residents stated they wanted to have a meeting where there were no interruptions. The meeting was in held in the activity room. The residents stated staff walked in while they were conducting their monthly council meeting. The residents' said they had to constantly stop their meeting or vote because people would interrupt. During this confidential group interview the meeting was interrupted by residents and staff six times within the hour-long meeting. The residents stated that it upset them, and they felt like they did not have any privacy.During an interview with the Activity Director on 02/25/2026 at 08:55 a.m., she said she was trained on resident rights. She said the policy for resident council was the facility had to provide a private meeting place for the residents to conduct their meeting. She said she was responsible for ensuring the resident council had a private meeting space. She said if the resident council did not have a private meeting space the residents may get upset, angry or disgruntled when they could not meet privately. She said the ADM monitored to ensure the resident council had a private meeting space. She said he monitored by checking with her and checking and ensuring everything was private and secure. She said she did not know why staff and residents kept interrupting the council meeting she said she put a sign on the door. She said placed a sign on the door. She said that was the only place big enough for the council.During an interview with the ADM on 02/25/2026 at 3:08 p.m., he said he was trained on resident rights. He said the policy for resident council was they met once a month and the facility must provide a private area. He said the Activity Director was responsible for providing a private meeting space for the resident council. He said if the resident council did not have a private meeting space the resident may not feel like their rights were respected. He said the ADM monitored to ensure there was a private meeting space for the resident council. He said the ADM monitored by talking to the Activity Director to ensure they were meeting privately. He said he had not had any complaints about the resident council meeting being interrupted and he was not sure why staff and residents were interrupting the council meeting.Record review of the facility's, undated, Resident Rights Policy revealed, it is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. To organize and participate in resident groups in the Nursing Center and have members of Resident's family meet with.

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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 3 of 6 staff (the DM, CK A and CK B) reviewed for food and nutrition services. The facility failed to ensure the DM, CK A and CK B wore appropriate hairnets so the hair was not exposed. This failure could place residents at risk of having hair in their food as well as ingesting contaminated food leading to illness.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 3 of 6 staff (the DM, CK A and CK B) reviewed for food and nutrition services. The facility failed to ensure the DM, CK A and CK B wore appropriate hairnets so the hair was not exposed. This failure could place residents at risk of having hair in their food as well as ingesting contaminated food leading to illness. Findings include: Observations on 02/23/26 at 09:00 AM revealed CK A's hairnet was not covering their full hair and hair was exposed while preparing lunch for residents in the kitchen. The front and top was covered while the back was exposed and free. Although CK A's hair was in a bun, the back was hanging to the neck. Observation on 02/23/26 at 11:25 AM revealed CK B in the kitchen without a hair net and full head of hair was exposed. CK B's hair was hanging down past the shoulders. Observation on 02/24/26 at 08:45 AM revealed the DM in the kitchen with her hair not fully covered by her hair net. The front and top were covered while the back of her hair was exposed and free. Although the DM's hair was in a bun, the back was hanging to the neck. In an interview with CK A on 02/23/26 at 09:00 AM, she stated the facility had a policy that stated hair nets were to cover the full head. She stated exposed hair placed residents at risk of hair in their food that could make them sick. She stated she was in-serviced on hair restraints about 2 weeks ago (dates not provided). CK A stated the DM was responsible for ensuring staff wore proper hair restraints. The policy on hair restraints was requested from CK A, but she stated she did not know the location of the policy binder. In an interview with CK B on 02/23/26 at 11:35 AM, she stated according to facility policy, hair nets were supposed to be put on before entering the kitchen. CK B stated exposed hair placed residents at risk of hair in their food and added it was an all-around safety issue. She stated she was trained on hair nets in June 2018 when she started, and again a couple of weeks ago (exact date unknown). She stated training included ensuring staff wore hair restraints properly. CK B stated full head should be covered. In an interview with the DM on 02/23/26 at 11:30 AM, she stated there was a facility policy related to hair restraints. She stated the policy stated hair nets had to cover the full head, to include ears with no hair exposed. She stated she had not conducted an in-service with staff, but added according to staff, an in-service was done about 2 months ago (date not provided) by the Dietitian. The DM stated hair falling into food could cause stomach issues and choking. She stated it was her responsibility to ensure staff wore hair restraints properly. The DM stated Surveyor just walked in and caught her with the hairnet partially on. Record review of the facility's, undated, policy Hair Restraints reflected, (a) Except as provided in subsection (b) of this section, food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Record review of SOM - Appendix PP reflected, Hair Restraints/Jewelry/Nail Policy - According to the current standards of practice such as the Food Code of the FDA, food service staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. According to the Food Code, food service staff must wear hairnets when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. Record review of facility's in-services for 90 days was conducted and reflected:*02/23/26 Hairnet: Hairnets on before walking into kitchen. Always! 5 of 6 kitchen staff signed the sign-in sheet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #50, #11, and #99) reviewed for infection control. The facility failed to ensure Resident #50 and Resident #11's catheter drainage bags were positioned correctly and not touching the floor on 02/23/2026 and 02/24/2026.The facility failed to ensure MA performed hand hygiene before preparing medications for Resident #99.The facility failed to ensure the Blood pressure monitor was sanitized after it was picked up from the floor and placed on the medication cart for Resident #99. These failures could place residents at risk for cross contamination and the spread of infection.Findings include: 1. Record review of Resident #50's face sheet, dated 02/24/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included nontraumatic intracerebral hemorrhage in cerebellum (brain bleed), acute respiratory failure with tracheostomy status (surgically created opening in the neck/windpipe to allow air to reach the lungs when normal breathing is impaired), speech and language deficits following cerebral infarction (stroke) and gastrostomy status (feeding tube). Record review of Resident #50's admission MDS Assessment, dated 02/16/2026, reflected no BIMS score because Resident #50 was rarely understood and nonverbal. Resident #50 was completely dependent on all tasks. Resident #50 had an indwelling catheter. Record review of Resident #50's Comprehensive Care Plan, dated 02/11/2026, reflected Resident #50 had a catheter. Interventions included Position catheter bag and tubing below the level of the bladder and away from entrance room door. 2. Record review of Resident # 11's face sheet, dated on 08/21/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #11 had diagnoses which included acute and chronic respiratory failure with hypoxia (low levels of oxygen), tracheostomy status, chronic obstructive pulmonary disease (progressive lung disease), type 2 diabetes mellitus (a condition when the body cannot use insulin correctly and sugar builds up in the blood), lung cancer, and gastrostomy status (feeding tube). Record review of Resident #11's admission MDS Assessment, dated 12/11/2025, reflected Resident #11 had a BIMS score of 14, which indicated his cognition was intact. Resident #11 had an indwelling catheter. Record review of Resident #11's Comprehensive Care Plan, revised 01/13/2026, reflected Resident #11 had a catheter. Interventions included Position catheter bag and tubing below the level of the bladder. During an observation on 02/23/2026 at 12:11 p.m. and 2:56 p.m. revealed Resident #50's catheter drainage bag was hung on the left side of the bed rail with part of the bag touching the floor. During an observation on 02/24/2026 at 8:12 a.m. revealed Resident #11's catheter drainage bag was hung on the left side of the bed rail with the bottom part of the bag touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/24/2026 at 8:56 a.m., LVN F stated she had been trained in foley catheter care and infection control. LVN F stated it was important the urine collection bag be placed below the bladder, draining with gravity, and always kept off the floor. LVN F stated if the bag touched the floor, it could cause cross-contamination, cause the tube to be kinked or block urine from getting into the bag, which could cause an injury to the resident. LVN F stated it was everybody's responsibility to check the placement of the catheter bag anytime they rounded, which would be every two hours, or anytime they provided patient care. The CNAs should inform the nurses if they saw a bag touching the floor. During an interview on 02/24/2026 at 9:03 a.m., RN J stated it was her second day at the facility, and she was in training, but as a nurse, she had knowledge about indwelling catheter care and infection control practices. As a nurse, she was aware the urine collection bag should be placed below the bladder, draining with gravity, and always kept off the floor. She stated the urine bag should never touch the floor due to the risk of bacteria, which could cause the resident to get a urinary tract infection. If the bag was on the floor, it might not drain the urine properly and could cause a backflow into the tubing. RN J stated it was everybody's responsibility to check the placement in the bag anytime they entered the room or provided patient care. RN J stated she would expect CNA's to move the bag off the floor and then report it to a charge nurse. During an interview on 02/24/2026 at 9:07 a.m., CNA C stated she was trained on foley catheter care. CNA C stated she emptied the urine collection bags. She stated the urine bag should be hung on the side of the bed, below the bladder, and it should never touch the floor because that could lead to crossing examination, which could give the residents an infection. She stated if she ever saw the bag on the floor, she would move it off the floor and tell the charge nurse. She stated it was everybody's responsibility to check to ensure the bag was not touching the floor. During an interview on 02/25/2026 at 2:27 p.m., the DON stated she was trained in catheter care and infection control prevention and she was the infection control preventionist. The DON stated the urine collection bag should never touch the floor to prevent infection. She stated it was everybody's responsibility to check to ensure the bag was not touching the floor. The DON stated she would expect staff to move the bag if it was on the floor and Resident #11 and Resident #50's urine collection bag touching the floor would not meet her expectations. During an interview on 02/25/2026 at 3:22 p.m., the ADM stated he had not been trained in catheter care as he did not have a clinical background, but he had been trained in infection control prevention measures. The ADM stated the urine collection bag should never touch the floor due to infection control issues, cross contamination, and bacteria which could cause illness. The ADM stated he would expect staff to move the bag if it was on the floor or report it to the nurse. He was unaware Resident #11 and Resident #50's urine collection bag was touching the floor and that would not meet his expectations. Record review of the facility's Indwelling Urinary Catheter Care Policy, dated 05/2007 and revised 12/2025, reflected It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. Record review of the facility's Catheter Drainage Bag Policy, dated 05/2007 and revised 12/2023, reflected Position the drainage bag below the level of the resident's bladder and without resting on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident # 99's, undated, face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Type 2 diabetes mellitus without complications (chronic high blood sugar where the condition has not yet caused damage to organs, nerves, or blood vessels.), Essential hypertension (chronic elevation of blood pressure without a known, specific cause), and Unspecified dementia (decline in mental abilities). Record review of Resident #99's Quarterly MDS, dated [DATE], reflected a BIMS score of 06, which indicated severe cognitive impairment. Record review of Resident #99's Order Summary Report, dated 05/03/2024, reflected, Amlodipine Besylate Oral Tablet 5 MG Give 1 tablet by mouth one time a day for HTN hold for SBP less than 110 or HR is less than 60 bpm. During observation of medications administration on 02/24/26 at 9:05 a.m. revealed MA prepared to administer medications to Resident #99 on hall 100 (medication cart #100). The MA used the blood pressure monitor on Resident #99 to obtain the resident's blood pressure. The MA dropped the blood pressure monitor on the floor after obtaining Resident 99's blood pressure. The MA picked up the blood pressure monitor from the floor and placed it on the surface of the medication cart without disinfecting it. The MA continued to pull out Resident # 99's medications without performing hand hygiene and proceeded to Resident # 99's room to administer medications. The MA was observed to perform hand hygiene after Resident # 99's medications were administered. During an interview on 02/24/2026 at 9:17 a.m. Resident # 99 stated she was not aware the MA did not sanitize her hands prior to preparing her medications. Resident # 99 stated, It is not good. Not good. During an interview on 02/25/2026 at 2:56 p.m., the MA stated she forgot to disinfect the blood pressure monitor and to perform hand hygiene before administering medications because she was nervous. The MA further stated she received training on infection control. She stated the policy on cleaning reusable equipment (blood pressure monitor) was to sanitize before it was returned to the medication cart. The MA stated this was important because it prevented the spreading of germs between residents. The MA stated the policy on hand hygiene was to perform hand hygiene before preparing medications, before and after administration of medications, this was important to prevent the spread of infections and the negative outcome to residents. During an interview on 02/25/2026 at 3:18 p.m., the DON stated she was trained on infection control and she was the facility's infection preventionist. The DON stated if staff did not conduct proper hand hygiene and disinfect shared equipment before and after it was used. The DON stated failure to do so could cause residents infections. She further stated the nurses and herself monitored to ensure staff followed the infection control procedures. Interview on 02/25/2026 at 3:31 p.m., the ADM stated he was trained on the infection control steps. The ADM stated all management staff expected to monitor staff for proper hand hygiene during all levels of care in the facility. He stated staff members expected to follow the infection control procedures and prevent transmission of infection. The ADM further stated the impact to the residents of not following infection control policies and procedures ultimately was the transmission of germs. Record review of the facility's, Policy and Procedure titled Nursing Clinical, revised on 05/2007 reflected Preparing Non-Unit Dose medications: 1. Wash hands. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Policy and Procedure titled Infection Control reviewed on 05/2021 reflected It is the policy of this facility that all resident care equipment will be cleaned and decontaminated after use and will be prepared for reuse by the same or another resident. Procedures: Equipment is disinfected with EPA-approved product and returned to storage or resident area, ready for reuse

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	676095	A. Building B. Wing	02/25/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 5 residents (Resident #88 and Resident #91) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #91's annual MDS, dated [DATE], accurately reflected his smoking status. 2. The facility failed to ensure Resident #88's admission MDS, dated [DATE], accurately reflected her smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment of smoking status. Findings include: 1. Record review of Resident #91's face sheet, dated 02/25/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #91 had diagnoses which included traumatic brain injury with loss of consciousness, muscle weakness, cognitive communication deficit, need for assistance with personal care, and lack of coordination. Record review of Resident #91's annual MDS, dated [DATE], reflected Resident #91 had a BIMS of 15, which indicated intact cognitive response. The MDS also reflected current tobacco use was marked as no. Record review of Resident #91's Smoking Assessment, dated 03/03/2025 and 12/03/2025, reflected Resident #91 smoked 3-4 times a day and was aware of safety associated with smoking.Record review of Resident #91's care plan, revised 02/13/2026, reflected Resident #91 was a smoker with a remote history of suspected of smoking in his room. Interventions were Remind resident of smoking rules and Resident made aware smoking is only to be during designated times.2. Record review of Resident #88's face sheet, dated 12/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #88 had diagnoses which included obstructive pulmonary disease (chronic progressive lung disease), end stage renal disease, acute and chronic respiratory failure with hypoxia (insufficient oxygen), asthma (condition that causes your airways to swell, narrow and fill with mucus), type 2 diabetes mellitus with diabetic nephropathy (damage to kidneys), and hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke). Record review of Resident #88's care plan, dated 12/03/2025 and revised on 01/30/2026, reflected Resident #88 was not a smoker. Record review of Resident #88's admission MDS, dated [DATE], reflected Resident #98 had a BIMS of 14, which indicated intact cognitive response. The MDS also reflected current tobacco use was marked as no. Record review of Resident #88's Smoking Assessment, dated 12/19/2025, reflected Resident #88 had a dexterity problem, smoked 3-4 times a day, could not light her own cigarette, and aware of safety associated with smoking. During an interview on 02/24/2026 at 4:00 p.m., Resident #88 stated she was a smoker. She stated she smoked daily and was able to smoke independently but needed help with pushing her wheelchair out to the smoking area.During an interview on 02/25/2026 at 1:50 p.m., the SW stated she had been trained in completing her portions of the MDS but did not handle the smoking portion as that was the MDSN responsibility. During an interview on 02/25/2026 at 1:56 p.m., the MDSN stated she was trained on the MDS and the MDS nurse was ultimately responsible for completing the MDS. She stated the MDS should be updated quarterly, annually, and if there was a significant change in the residents' condition. She stated she had fourteen days from admission to complete the MDS. She stated Resident #88's smoking status was supposed to be on the MDS and it was coded no in error. She stated if the resident's smoking status was not coded correctly it would not affect the resident's care. The MDSN was not aware, and she did not know why Resident #91's smoking status was not on the MDS. During an interview on 02/25/2026 at 2:27 p.m., the DON stated she was trained on the MDS and would sometimes complete the MDS, but it was the MDS nurse who was ultimately responsible for signing off on the MDS. She stated the MDS should be updated quarterly, annually, and if there was a significant change in the residents' condition. The DON was unaware the smoking status was incorrect on the MDS for Resident #88 and Resident #91 and stated she was not sure a resident's smoking status went on the MDS. The DON stated Resident #88 was new and she was not aware (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #88 smoked. The DON stated it was the receptionist's responsibility to notify nursing staff if a resident wanted to smoke. The DON stated Resident #91's smoked on and off. The DON could not say how a resident might be affected if the resident's smoking status was not coded correctly on the MDS. During an interview on 02/25/2026 at 3:22 p.m., the ADM stated he had not been trained on MDS's. The ADM stated he did not have a clinical background and he relied on his nursing staff to complete assessments accurately. The ADM stated the MDS nurse was responsible for doing the MDS. The ADM stated incorrect information on the MDS would potentially affect the quality of care and would not reflect an accurate picture of the residents' needs. The ADM stated he was not aware the smoking status for Resident #88 and Resident #91 were incorrect and that would not meet his expectation. Record review of the Smoking Residents list, provided on 02/23/2026, revealed Resident #88 and Resident #91 were smokers.Record review of the facility's Resident Assessment Policy, dated 11/2016 and revised 12/2025, reflected It is the policy of this facility that resident's will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified.

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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, consistent with the residents rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #88) reviewed for care plans. The facility failed to ensure a comprehensive care plan was developed for Resident #88 to include her smoking status when the care plan was completed on 12/03/2025 and revised on 01/30/2026. This deficient practice could place residents at risk of not being provided with the necessary care or services and the implementation of personalized plan of care developed to address their specific needs.The findings include: Record review of Resident #88's face sheet, dated 12/17/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #88 had diagnoses which included chronic obstructive pulmonary disease (progressive lung disease), end stage renal disease, acute and chronic respiratory failure with hypoxia (insufficient oxygen), asthma, type 2 diabetes mellitus with diabetic nephropathy (damage to kidneys), and hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke). Record review of Resident #88's care plan, dated 12/03/2025 and revised on 01/30/2026, reflected no information on smoking. Record review of Resident #88's admission MDS, dated [DATE], reflected Resident #98 had a BIMS of 14, which indicated intact cognitive response. The MDS also reflected current tobacco use was marked as no. Record review of Resident #88's Smoking Assessment, dated 12/19/2025, reflected Resident #88 had a dexterity problem (problem performing tasks with hands), smoked 3-4 times a day, could not light her own cigarette, and aware of safety associated with smoking. Plan of Care updated to reflect this evaluation was marked yes. During an interview on 02/25/2026 at 1:50 p.m., the SW stated she was trained in completing her portions of the care plan but did not handle the smoking portion, as that was the MDSN responsibility. During an interview on 02/25/2026 at 1:56 p.m., the MDSN stated she was trained in completing care plans and the training covered what should be listed on the care plan and the timeframes for completing the care plan. The MDSN stated anything unusual, including smoking, should be listed on the care plan. The MDS nurse was responsible for ensuring the care plan was accurate and ultimately signed off on the review. The MDSN stated the MDS nurse, the DON, and Resources monitored to ensure care plans were done correctly. The MDSN stated she was not aware Resident #88's care plan did not list smoking, and it should have. She stated whoever completed the smoking assessment, should have put it on Resident #88's care plan. She stated she was the one who completed Resident #88's care plan and she was embarrassed that she missed it. She stated if staff were looking at care plans, they would not know what Resident #88's needs would be regarding safety or interventions while smoking. During an interview on 02/25/2026 at 2:27 p.m., the DON stated she was trained in completing care plans and the training covered what should be listed on the care plan and the timeframes for completing the care plan. The DON stated all staff (the DON, MDS nurses, ADONs, Activity Director, SW, DM, and Resources) were responsible for ensuring the care plans were completed and the MDS nurses were responsible for the accuracy. The IDT was responsible for discussing and updating the care plans. The DON stated anything unusual, including smoking, should be listed on the care plan. The DON stated the SW was responsible for adding smoking to the care plan, but the SW was new; therefore, the MDS nurses would handle that. The DON stated she was not aware Resident #88 was a smoker and was not aware it was not on Resident #88's care plan. The DON stated an accurate care plan was needed to ensure the resident's safety during smoking.During an interview on 02/25/2026 at 3:22 p.m., the ADM stated he had not been trained on care plans, but smoking should be listed on a resident's care plan. The ADM stated if the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans did not have a resident's smoking status staff would not be able to identify the resident as a smoker. The ADM stated he did not know why Resident #88's smoking status was not on the care plan and failure to do so could lead to some level of potential harm. The ADM stated smoking assessments were completed by nurses, and it would not meet his expectations to not have smoking listed on the care plan. Record review of the facility's policy titled Comprehensive Person-Centered Care Planning, dated 11/2016 and revised 12/2025, reflected It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person centeredcare plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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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. Based on observation and interview the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 of 1 medication rooms reviewed for pharmacy services.The facility failed to ensure expired and/or discontinued medications removed from use for one medication storage room.This failure could place residents at risk of not receiving the intended therapeutic benefits of medication.Findings include:During observation of medication storage room on 02/23/2026 at 3:03 p.m. revealed one bag of the Lactated Ringer's Injection USP (500mL) solution with an expiration date of 11/2025 stored inside of the box along with 5 unexpired bags of solutions. The DON present at the time of the observation, removed the expired packages from the room. The DON stated medications would be disposed of per facility policy.During an interview on 02/25/2026 at 3:18 p.m., the DON stated her expectation was all nurses were to place expired medications in medication destruction bins. The DON could not explain the expired medication found along with the unexpired medications. The DON stated a nurse might place it there by mistake thinking it was a destruction bin. The supply person monitored the expiration dates when supplies restocked. The DON stated expired medications could potentially cause adverse medication reactions on residents or not be effective for their intended purpose.During an interview on 02/25/2026 at 3:31 p.m., the ADM stated expired medication should properly disposed of. He stated the responsibility for monitoring expired medications was mixed audit of the medication room. He stated use of expired medication was not effective and could be unsafe practice. Record review of the facility's, undated, Policy and Procedure titled Care and Treatment reviewed on 05/2007, 07/2015, 07/2017, 07/2019, 7/2020, 7/2021, 7/2022, 7/2023, 7/2024, 06/2025 reflected Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medications destruction and reordered from the pharmacy, if a current order exist.