STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676096	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Parkway West McKinney, TX 75070

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to maintain medical records that were complete and accurately documented for 2 (Resident #50 and Resident #9) of 16 residents reviewed for resident records.1. The facility failed to accurately document Resident #50's use of a hand splint on 04/07/26 and 04/08/26 when the splint was not applied.2. The facility failed to ensure Resident #9's physician orders had the correct medication administration route for eight medications, which were orders to give medications by mouth, when the resident had a nothing by mouth status. These failures could affect any resident, placing them at risk of inaccurate information and resulting inappropriate care.Findings included: Record review of Resident #50's quarterly MDS Assessment, dated 02/06/26, reflected an [AGE] year-old female admitted [DATE]. Resident #50 had diagnoses which included Diabetes Mellitus (high blood sugar resulting from the body inability to properly use insulin), Hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following nontraumatic intracerebral hemorrhage (stroke) affecting left non-dominant side and cerebral infarction (loss of blood flow to part of the brain). Resident #50's BIMS score was 15, which indicated his cognition was intact. The MDS Section O – Special Treatments, Procedures, and Programs – Restorative Nursing Programs resident was provided with the use of a splint. Record review of Resident #50's care plan, dated 03/12/26, reflected the following: Problem/Strengths: Pain. Interventions: Use non-pharmacological pain interventions to assist with pain management (splint left hand, warm blankets for joint pain, reposition). Problem/Strengths: Limited range of motion upper extremity left hand related to contracture. Goals: Will maintain range of motion of as evidenced by place splint. Will improve range of motion. Interventions: Range of motion by staff. Observe for pain or increased stiffness. Problem/Strengths: Needs assistance with splint to left hand. Goals: Splint will be correctly applied per MD order. Apply splint on day shift for 6 hours per day. Remove splint on second shift. Record review of Resident #50's physician order, dated 09/10/25, reflected the following: SPLINT On Day Shift [Time: Shift 1] LEFT HAND SPLINT ON 6 HOURS PER DAY for Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage . Monitor skin around splint for redness or skin breakdown. Start Date 09/10/25. Record review of Resident #50's April 2026 MAR revealed the splint was in place during the first shift on 04/07/26 and 04/08/26. Observation and interview on 04/07/26 at 10:47 AM revealed Resident #50 in her room sitting in her wheelchair. Observed Resident #50's left hand to be contracted and she was not wearing her splint. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #50 was able to partially open her hand, no observation of skin issues. Resident was able to gesture her response. Resident #50 gestured she had a splint but had not been asked to wear it. Hand splint was not observed in the room. Observation on 04/07/26 at 12:40 PM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 8:55 AM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 10:05 AM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 12:55 PM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 2:15 PM revealed Resident #50 did not have a splint on her left hand. Interview on 04/08/26 at 2:18 PM, RN D revealed Resident #50 had orders for the use of a splint. She stated it was the responsibility of the nurses or therapy to put on the splint on Resident #50. RN D stated she had not attempted to put on the splint on Resident #50 today (04/08/26) or yesterday (04/07/26). She stated Resident #50 goes to therapy at around 10AM and therapy also puts on the splint. Observed RN D entered Resident #50 room and was searching for the resident splint but was unable to locate it. RN D reviewed the Resident #50's MAR and stated she documented at 12:38 PM that resident had the splint on; however, she did not ask or attempted to place the splint on resident. RN D stated she documented incorrectly and should had documented No to show that the splint was not put on. She stated it was not good care if documentation was incorrect. Interview on 04/08/26 at 2:29 PM, Director of Rehab revealed Resident #50 was not receiving services from therapy. She stated Resident #50 was receiving services from Physical Therapy from 03/01/26 to 04/01/26 due to a fall. She stated Resident #50 had not been seen since 04/01/26. Director of Rehab stated Resident #50 had an order for the use of splint and it was the responsibility of Restorative Aide to put it on. Interview on 04/08/26 at 2:32 PM, Restorative Aide revealed she had not applied any hand splint to Resident #50 in months. She stated she was aware Resident #50 used to wear a splint, but she was not responsible for putting it on. She stated the last time she put on the splint was sometime last year 2025. Follow up interview 04/08/26 at 3:16 PM, Director of Rehab revealed she was not aware Restorative Aide was not putting on the splint on Resident #50. She stated if there was an order then it was the responsibility of the nurses to put on the splint on Resident #50. Interview on 04/09/26 at 3:28 PM, ADON A revealed if there was an order for the use of a splint it was the responsibility of the nurses to put on the splint on the resident. She stated it was a daily check off for the nurses on the MAR and should be applying the splint or attempting too. ADON A stated her expectation was for documentation to be accurate. She stated if the documentation was not accurate then it would be an issue. Interview on 04/09/26 at 4:39 PM, the DON revealed the nurses and CNAs were responsible for putting on hand splints. She stated her expectation was for the nurses to follow physician orders and apply the use of the hand splint. She stated she expected the documentation to be correct and if not documented it did not happen. She stated if documentation was not accurate it would interfere with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the patient care. 2. Record review of Resident #9's Quarterly MDS, dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included aphasia (language disorder resulting from damage to the brain), paraplegia (paralysis affecting the lower half of the body), malnutrition (when the body does not get enough nutrients), and respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body). Further review of the MDS revealed Resident #9 had unclear speech, was usually understood, and usually understood others, was dependent for ADLs, and required a feeding tube, oxygen therapy, suctioning and tracheostomy care. Record review of Resident #9's Care Plan dated 08/28/25 reflected the following:- hydration – gtube with goal of improve or maintain hydration and an intervention that included Gtube for all nutrition- enteral feeding with goal of nutritional needs will be met with no S/SX of aspiration with intervention that included administer feeding tube as ordered Record review of Resident #9's Physician orders revealed the following orders:- order date 06/27/2025 GABAPENTIN 300 MG CAPSULE 1 by mouth Every 8 hours 07:00 AM, 03:00 PM, 11:00 PM - order date 06/27/2025 HYOSCYAMINE SULF 0.125 MG TAB 1 by mouth Every 8 Hours as needed - order date 07/01/2025 DIET: Order – NPO - order date 07/01/2025 MIRALAX 17 GM/1 Dose POWDER FOR SOLUTION by mouth On Day Shift [Time: Shift 1] - order date 07/01/2025 SENNA-LAX 8.6 MG TABLET 1 by mouth One time daily [Time: 8:00 AM] - order date 07/01/2025 ASPIRIN 81 MG TABLET, CHEWABLE 1 by mouth One time daily [Time: 08:00 AM] - order date 08/27/2025 CYMBALTA 60 MG CAPSULE, DELAYED RELEASE for Depression, ([START 08/27/25 16:39] 60 MG by mouth Twice a day [Time: 08:00 AM, 09:00 PM]) - order date 10/16/2025 Buspirone 5 MG TABLET for Depression, unspecified for Anxiety ([START 10/16/25 09:46] 1 tab by mouth Twice a day [Time 08:00 AM, 09:00 PM]) - order date 10/28/2025 METHOCARBAMOL 500 MG TABLET for Pain, unspecified for Pain - Generalized 1 by mouth Three times a day [Time: 10:00 AM, 04:00 PM, 11:00 PM] give at 10AM, 4PM, 11PM Interview and record review on 04/09/26 at 9:22 AM, RN G stated she had never given Resident #9 anything by mouth and had not noticed the orders that said by mouth. RN G pulled up Resident #9's chart and showed surveyor where it said NPO. RN G stated she knew Resident #9 was NPO from report and only the nurse would give meds. She stated if the MA looked, they would see the resident was NPO. She stated it could be a risk if an agency nurse or a new nurse was reading the orders and they did not get report. She said it was probably entered wrong and she would fix it or call her manager. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/09/26 at 12:28 PM, NP E stated all g-tube were nothing by mouth and if orders were incorrect and medications were given by mouth the resident could aspirate. Interview on 04/09/26 at 3:19 PM, ADON A stated she had worked there for about 2.5 weeks. She stated she was now aware that Resident #9's orders had several medication orders that said g-tube and by mouth, and she had made the nurses and DON aware. ADON A stated the nurse, who received the admission orders, would have entered the orders. She stated the ADON was responsible for clarifying the orders the following day. She stated she expected nurses to verify physician orders. She said the risk to the resident could be medication errors. Interview on 04/09/26 at 4:26 PM, the DON stated the admission nurse entered orders when a resident admits and the next nurse on shift and the ADON were supposed to verify them on the next shift and the next day. The DON stated if somebody tried to give Resident #9 anything by mouth she could choke or aspirate. She said in the clinical meeting the previous day's admissions should be reviewed and she did not know why the orders were not reviewed before. Record review of the facility policy titled Physician orders – electronic revised 01/12/2020 revealed Policy 1. The licensed nurse will receive and transcribe the physician's orders according to Practice Guidelines. 2. The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician.Procedure.2. The licensed nurse clarifies and reconciles all orders that may lead to an administration error. 3. The electronically entered order will be automatically transcribed onto the Medication admission Record (MAR) or Treatment Record. Date and initials of the transcriber will be automatically recorded. Record review of facility policy titled Medication Administration Enteral Tubes dated 2007, revealed the following:2. The physician's order must specify the route of administration of any medication via feeding tube. This should be stated in the directions at a minimum as 'per tube' or 'via tube', but certainly the type of tube may be specified.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program to the maximum extent practicable to avoid duplicative testing and effort for 1 of 2 residents (Resident #2) reviewed for PASARR.The facility failed to refer Resident #2 for a PASRR Level II assessment when the facility failed to correct his PASRR level I assessment. This failure could place residents at risk of not receiving specialized services to meet their needs. Findings included:Record review of Resident #2's most recent MDS assessment dated [DATE], revealed at [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of Post-Traumatic Stress Disorder, or PTSD (a mental health condition that's caused by witnessing or being part of an extremely stressful or terrifying event). Further review of the MDS revealed a BIMS score of 15, indicating intact cognition. Record review of Resident #2's PASRR Level 1 Screening form (used to determine whether a resident may have serious mental illness or intellectual disability), dated 03/20/26, revealed no was answered for the following screening question:-Is there evidence or an indicator that the individual has a Mental Illness? Record review of Resident #2's clinical hospital paperwork dated 03/08/26 through 03/16/26 revealed Resident #2 had a diagnosis of post-traumatic stress disorder. Interview on 04/08/26 at 11:20 AM, MDS nurse B stated she only entered PASRR information if a resident was admitted from home. She stated the Admissions Coordinator uploaded the screening forms for other residents. Interview and record review on 04/08/26 at 11:25 AM, the Admissions Coordinator stated he entered PASRR information into Simple (software used by nursing facilities) for residents upon admission. He stated he gets the information when the hospital faxed or emailed it to him. He showed surveyor Resident #2's PASRR screening form from the hospital with no Mental Illness noted on the form. He stated he entered the information exactly as it was on the hospital form into Simple. He said the nurses had access to Simple and could go in and edit if they found an error. Interview on 04/09/26 at 11:50 AM, the DON stated the Admissions Coordinator entered the information from the hospital and he should try to facilitate corrections. She stated if there were corrections, usually MDS or the SW were to go back in and enter the correct information. The DON stated if a resident admitted with a qualifying condition and it was in the paperwork from the hospital and the facility did not get the hospital to change it, then they would have to correct it. She stated if not done it could affect the quality of care and how they approached the resident's care. She stated she was responsible for overseeing PASRR was completed correctly. She said moving forward it would be discussed in the morning clinical meeting and MDS would complete at that time. Interview on 04/09/26 at 5:01 PM, the Administrator stated the facility did not have a policy on PASRR and they followed Texas PASRR guidelines.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 1 of 18 residents (Resident #102) reviewed for baseline care plans. The facility failed to ensure Resident #102 had a baseline care plan, or conversely a comprehensive care plan, within 48 hours of admission. These failures could place the residents at risk of not having their needs and preferences met. Findings included:Record review of Resident #102's 5-day MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included cancer, hypertension (high blood pressure), diabetes, respiratory failure, septic pulmonary embolism (infected blood clots that travel to the lungs causing fever, cough, chest pain, and respiratory distress), and polyneuropathy (damage to multiple peripheral nerves causing numbness, burning pain, and muscle weakness). Resident had a BIMS of 15 which indicated his cognition was intact. The MDS further reflected the resident required supervision for ADLs and was on pain regimen. Record review of Resident #102's progress notes dated 02/06/26 reflected he had discharged home with stable vitals and discharge instructions. Record review of Resident #102's clinical record revealed the resident did not have a care plan completed which included a baseline care plan. Interview on 04/09/26 at 3:39 PM with ADON A revealed she had only been working at the facility since February 2026 before Resident #102 was admitted and it appeared the baseline care plans were not being completed correctly. ADON A said she was told the ADONs were responsible for filling them out, but she said that would not be possible as the ADONs were not always at the facility when new residents were admitted . ADON A said when new residents were admitted the admitting nurse was responsible for opening the baseline care plans and completing as much as they could from the hospital orders and documentation. ADON A further stated baseline care plans should be completed timely because it gave the staff information on the admitting resident and how to care for them and they would implement that soon. Interview on 04/09/26 at 3:53 PM, MDS Nurse B revealed baseline care plans were a group effort between nursing management such as ADONs and the DON. MDS Nurse B said she did not know why Resident #102's baseline care plan was not completed, and she said it was important for the care plans to be completed timely, so the nurses had the resident orders match their plan of care. Interview on 04/09/26 at 4:29 PM, the DON revealed she had recently been hired and been at the facility for a few days. The DON said the baseline care plans should be completed by the nurse that admitted the resident and the ADONs were to overlook them for accuracy. The DON further stated baseline care plans were important to establish a resident's plan of care. Record review of the facility's policy titled Care Plan-Process reviewed 03/2023 reflected the following: .1. Initiate a Baseline Care Plan and complete within forty-eight (48) hours of admission based on the physician's orders and nursing evaluation.

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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 observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #56) reviewed for care plans.The facility failed to ensure Resident #56 had a care plan that addressed the residents' need for oxygen use.This failure could place residents at risk for incomplete assessments which could cause incorrect care and services in oxygen support and could result in a decline in health.Findings included:Record review of Resident #56's quarterly MDS Assessment, dated 02/09/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included Type 2 diabetes mellitus without complications (high blood sugar resulting from the body's inability to properly use insulin), Non-Alzheimer's Dementia (problems with memory and thinking), heart failure, hypertension (high blood pressure) and cancer. Resident #56's BIMS score was 09, which indicated moderate cognitive impairment. The MDS Section J - Health Condition reflected resident had shortness of breath or trouble breathing when lying flat. The MDS Section O - Special Treatments, Procedures, and Programs reflected the resident received oxygen therapy. Record review of Resident #56's care plan dated 03/17/26, revealed the care plan did not address the resident's oxygen use.Record review of Resident #56's physician orders, dated 01/28/26, reflected O2 SAT Check Every Shift [Time: Shift 1, Shift 2, Shift 3] Monitor resident for signs and symptoms of shortness of breath for Essential (primary) hypertension, Paroxysmal atrial fibrillation (a fast, irregular heartbeat), Heart failure, Need HOB elevated to avoid SOB while lying flat.Record review of Resident #56's physician orders, dated 04/05/26, reflected Oxygen Every Shift [Time: Shift 1, Shift 2, Shift 3] for Shortness of breath oxygen via nasal canula.Record review of Resident #56's physician orders, dated 04/06/26, reflected Oxygen wean off oxygen slowly for Shortness of breath. Maintain o2 > 90%. Physician orders did not address how much oxygen Resident #56 should be administered. Record review of Resident #56's April 2026 MAR revealed Resident #56's O2 sats were within normal limits.Observation and interview on 04/07/26 at 10:36 AM, revealed Resident #56 sitting in her room sitting in her wheelchair. Resident #56 was observed to have her oxygen on via nasal cannula. The oxygen concentrator was set at 1.5L. Resident #56 stated she was having a hard time breathing but that the nurse had just checked her oxygen levels and they were normal. Observation and interview on 04/07/26 at 1:03 PM, revealed Resident #56 in the hallway ambulating in her wheelchair. Resident #56 did not have her oxygen on. Resident #56 stated she was feeling better. She stated she used to always receive oxygen but recently oxygen was only provided as needed. Resident #56 stated she could not recall how much oxygen she should be receiving.Observation on 04/08/26 at 10:04 AM, revealed Resident #56 in bed sleeping. She was observed to be receiving oxygen, and it was set at 1.5L. No distress was noted.Interview on 04/09/26 at 1:10 PM, RN D revealed Resident #56 was receiving oxygen and it should be care planned. She stated she was not aware it was not care planned. RN D stated it was the responsibility of MDS Coordinators to update care plans. Interview on 04/09/26 at 2:57 PM, MDS Nurse B revealed the MDS Coordinators were responsible for care plans. She stated residents receiving oxygen should be care planned. MDS Nurse B reviewed Resident #56's care plan and stated she was not aware oxygen was not care planned. MDS Nurse B stated Resident #56's care plan from July 2025 addressed oxygen use; however, when the facility changed systems the care plan was not transferred over. She stated the last care plan meeting was on 02/11/26 and oxygen should have been addressed. MDS Nurse B stated oxygen should be care planned so that the nurses know the reason why it was being used. Interview on 04/09/26 at 3:32 PM, ADON A revealed the charge nurses were responsible for putting (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders in the system and the ADONs were to follow up to ensure the orders were correct. She stated for residents receiving oxygen the order should specify how many liters to provide. ADON A stated multiple people were responsible for care plans. She stated she would have to review the facility's policy to ensure if the use of oxygen should be care planned. Interview on 04/09/26 at 4:31 PM, the DON revealed Resident #56 was receiving oxygen but only as needed and not continuous. She stated Resident #56 was being weaned off the oxygen; however, due to her age and diagnosis it would be best for the resident to be placed back on continuous. The DON stated her expectation was for Resident #56's oxygen orders to specify how many liters to administer even if resident was being weaned off from it. The DON stated she did not know the previous oxygen orders or the liters being administered to Resident #56 prior to being weaned off. The DON stated oxygen should be care planned. She stated she was not aware Resident #56 was not care planned for the use of oxygen. She stated anything being provided to a resident should be care planned. The DON stated any licensed nurse, MDS, ADON and herself were responsible for updating care plans. She stated the potential risk of not care planning oxygen could lead to poor care. Record review of the facility Comprehensive Care Plans policy, revised 02/12/2020, reflected the following: It is the policy of this facility to develop and implementation a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (Resident #28) of 4 residents reviewed for ADLs. The facility failed to ensure Resident #28's fingernails were kept clean.This failure had the potential to affect residents by placing them at risk for poor personal hygiene, odors and a decline in their quality of life. Findings included:Record review of Resident #28's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. Record review of Resident #28's care plan dated 02/10/26 reflected the resident required assistance with personal hygiene related to weakness. Interventions included providing extensive assistance with personal hygiene. During an observation and interview on 04/07/26 at 2:08 PM, Resident #28 was in her bed. The resident's fingernails had a black substance underneath each one. When asked if staff cleaned her nails, she looked at them, smiled, and said, Yes. When asked if she would like to have her fingernails cleaned, she replied, Yes. Observation on 04/09/26 at 10:44 AM revealed Resident #28's fingernails continued to have black substance underneath each one. Interview on 04/09/26 at 1:26 PM, CNA C revealed aides were responsible for cleaning resident fingernails. CNA C said she worked with Resident #28 about two times a week, but she had not noticed the resident's fingernails had been dirty. CNA C said it was important for the residents to have clean fingernails to prevent infections and said she would go in there and clean them.Interview on 04/09/26 at 1:44 PM with the Restorative Aide revealed she had been providing care for Resident #28 that day, 04/09/26, and noticed the day prior the resident's fingernails were dirty but said the resident had refused to have them cleaned as she sometimes did. The Restorative Aide said the aides were responsible for cleaning the resident's fingernails for infection control purposes. Interview on 04/09/26 at 1:46 PM with CNA C revealed she had just left Resident #28's room and the resident had allowed her to clean her fingernails. Interview on 04/09/26 at 1:47 PM with RN D revealed she had only worked with Resident #28 that day and she had not noticed Resident #28's dirty fingernails and no one had reported them to her. Interview on 04/09/26 at 3:36 PM with ADON A revealed nail care should be done by the aides during shower and as needed. ADON A said if the residents refused multiple times, then it should be documented. ADON A further stated the charge nurses should also keep up with resident hygiene and ensure it was being done. ADON A said fingernails should be clean because they contain a lot of bacteria. Interview on 04/09/26 at 4:25 PM with the DON revealed nail care should be done by the aides or the nurses during showers or as needed. The DON said it was important for the residents to have clean fingernails for infection control purposes. Record review of the facility's policy titled Bathing revised on 02/2020 reflected the following: Standard of Practice: Staff will provide bathing services for residents within standard practice guidelines.Procedure:.Perform hand hygiene and perform nail care.

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	676096	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Parkway West McKinney, TX 75070

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 6 residents (Resident #50) reviewed for range of motion. The facility failed to ensure Resident #50 had her hand splint applied to her left hand per physician orders for contracture management. The failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included:Record review of Resident #50's quarterly MDS Assessment, dated 02/06/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included Diabetes Mellitus (high blood sugar resulting from the body's inability to properly use insulin), Hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided muscle weakness) following nontraumatic intracerebral hemorrhage (stroke) affecting left non-dominant side and cerebral infarction (loss of blood flow to part of the brain). Resident #50's BIMS score was 15, which indicated her cognition was intact. The MDS Section O - Special Treatments, Procedures, and Programs - Restorative Nursing Programs reflected resident was provided with the use of a splint. Record review of Resident #50's care plan dated 03/12/26, reflected the following: Problem/Strengths: Pain. Interventions: Use non-pharmacological pain interventions to assist with pain management (splint left hand, warm blankets for joint pain, reposition). Problem/Strengths: Limited range of motion upper extremity left hand related to contracture. Goals: Will maintain range of motion of as evidenced by place splint. Will improve range of motion. Interventions: Range of motion by staff. Observe for pain or increased stiffness. Problem/Strengths: Needs assistance with splint to left hand. Goals: Splint will be correctly applied per MD order. Apply splint on day shift for 6 hours per day. Remove splint on second shift. Record review of Resident #50's physician order, dated 09/10/25, reflected the following: Splint on Day Shift [Time: Shift 1] Left Hand Splint On 6 Hours Per Day for Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage . Monitor Skin Around Splint for Redness or Skin Breakdown. Start Date 09/10/25. Record review of Resident #50's April 2026 MAR revealed the splint was in place during the first shift on 04/07/26 and 04/08/26. Observation and interview on 04/07/26 at 10:47 AM, revealed Resident #50 in her room sitting in her wheelchair. Observed Resident #50's left hand to be contracted and she was not wearing her splint. Resident #50 was able to partially open her hand, with no observation of skin issues. Resident #50 gestured she had a splint but had not been asked to wear it. A hand splint was not observed in the room. Observation on 04/07/26 at 12:40 PM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 8:55 AM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 10:05 AM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 12:55 PM revealed Resident #50 did not have a splint on her left hand. Observation on 04/08/26 at 2:15 PM revealed Resident #50 did not have a splint on her left hand. Interview on 04/08/26 at 2:18 PM, RN D revealed Resident #50 had orders for the use of a splint. She stated it was the responsibility of the nurses or therapy to put the splint on Resident #50. RN D stated she had not attempted to put on the splint on Resident #50 today (04/08/26) or yesterday (04/07/26). She stated Resident #50 goes to therapy at around 10AM and therapy also puts on the splint. Observed RN D entered Resident #50's room and was searching for the resident's splint but was unable to locate it. RN D reviewed Resident #50's MAR and stated she documented at 12:38PM that resident had the splint on; however, she did not ask or attempt to place the splint on resident. She stated the potential risk of not putting on the hand splint would be resident having pain. Interview on 04/08/26 at 2:29 PM, Director of Rehab revealed Resident #50 was not receiving services from therapy. She stated Resident #50 was receiving services from Physical Therapy from 03/01/26 to 04/01/26 due to a fall. She stated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #50 had not been seen since 04/01/26. Director of Rehab stated Resident #50 had an order for the use of splint and it was the responsibility of Restorative Aide to put it on. Interview on 04/08/26 at 2:32 PM, Restorative Aide revealed she had not applied any hand splint to Resident #50 in months. She stated she was aware Resident #50 used to wear a splint, but she was not responsible for putting it on. She stated the last time she put on the splint was sometime last year 2025. Follow up interview on 04/08/26 at 3:16 PM, Director of Rehab revealed she was not aware Restorative Aide was not putting the splint on Resident #50. She stated if there was an order then it was the responsibility of the nurses to put the splint on Resident #50. Interview on 04/09/26 at 3:28 PM, ADON A revealed if there was an order for the use of a splint it was the responsibility of the nurses to put the splint on the resident. She stated it was a daily check off for the nurses on the MAR and should be applying the splint or attempting to. She stated the potential risk of not applying the splint could cause contractures to get worse. Interview on 04/09/26 at 4:39 PM, the DON revealed the nurses and CNAs were responsible for putting on hand splints. She stated her expectation was for the nurses to follow physician orders and apply the hand splint. She stated the potential risk of not applying the splint could cause contractures to get worse. Record review of the facility's Joint Mobility/Range of Motion Program and Splitting - Initiating of the Program policy, dated April 2012, reflected the following: Patients/residents will be assessed for joint mobility limitation upon admission, re-admission, quarterly, annually, and with significant changes throughout the comprehensive nursing assessment. A restorative program will be implemented through the care plan to increase, maintain, or prevent deterioration of joint mobility and to maximize physical function when referral to therapy is not indicated or upon discharge from skilled therapy.Appropriate candidates for the Nursing Restorative Splinting Program may include but are not limited to: Patients/Residents who require a progressive splint or brace wearing schedule in order to build up wearing tolerance. Patients/Residents requiring frequent checks for skin integrity.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on a resident's comprehensive assessment, maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or the resident preferences indicated otherwise for of 1 of 6 residents (Resident #53) reviewed for nutrition. The facility failed to monitor Resident #53's weight when she gained 16 pounds in 20 days, while receiving all her nutrition via a feeding tube. This failure could place the residents at risk of weight loss/gain, and a decline in their physical condition. Findings included:Record review of Resident #53's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old female, admitted on [DATE]. Her diagnoses included diabetes, stroke (when blood flow to part of the brain is blocked or a blood vessel bursts, depriving brain tissue of oxygen) aphasia (language disorder caused by brain damage usually from a stroke or injury), hemiplegia (paralysis of one side of the body), and seizure disorder. The MDS reflected Resident #53's cognitive skills for daily decision making were severely impaired and had no speech. The MDS reflected the resident's weight at the time of the MDS was 144lbs and required a feeding tube due to coughing/choking during meals or when swallowing medications. Record review of Resident #53's care plan, dated 02/10/26, reflected the resident required total assistance with tube feeding. Interventions included to weigh per facility protocol with follow-up as indicated. Observation 04/7/26 at 11:43 AM of Resident #53 she was sitting in her geri-chair in the TV room. The resident was connected to a g-tube that was running at 82ml an hour. The resident was spoken to, and only made short eye contact but was not able to speak. The resident did not appear to be in any discomfort or distress. Record review of Resident #53's monthly physician orders for April 2026, revealed she was on Glucerna 1.2 Cal @ 82ml/hr enteral feeding (delivers liquid nutrition directly into the stomach) with a start date of 07/15/26. Record review of Resident #53's weights for the following dates reflected the following:03/03/26 - 146.4 pounds03/19/26 - 148 pounds03/25/26 - 152.6 pounds04/02/26 - 157.8 poundsObservation on 04/09/26 at 11:17 AM revealed Resident #52 was weighed via hoyer lift and the scale showed 164.6 poundsInterview on 04/09/26 at 11:19 AM, the RD revealed if the weights were correct then Resident #53 had a significant weight gain. The RD said Resident #53 had been stable the previous months and the last time she was the resident was on 03/22/26 but she did not pull the resident's weights. Interview on 04/09/26 at 12:45 PM, RN D revealed she cared for Resident #53, and no one had reported any weight gain to her nor had she noticed any weight gain on the resident. RN D said the Restorative Aide would obtain resident weights and then report inconsistencies to the ADONs or the DON. Interview on 04/09/26 at 12:49 PM, the Restorative Aide revealed she was responsible for getting resident weights and she said Resident #53 had been stable but noticed her weight increase in about the last month. The Restorative Aide said if she noticed weight variances she would report to the charge nurse. The Restorative Aide said she told the resident's previous nurse, but she did not recall the nurse's name, and she no longer worked at the facility. The Restorative Aide further stated she had not noticed any physical changes in the resident because of her weight gain. Interview on 04/09/26 at 2:05 PM, the RD revealed Resident #53 appeared to have a significant weight gain and did not know what caused it. The RD said she tried to make weekly visits to the facility, but no one reported weight concerns with Resident #53. The RD said that if weight concerns were noted they were to let the ADON know or she, the RD, could be contacted via email so she could assess and give recommendations. The RD further stated Resident #53 admitted with a weight of around 160lbs and did not think there were any risks with the resident's current weight. The RD said the resident's ideal weight according to her BMI would be around 130lbs plus or minus 10% . Interview on 04/09/26 at 3:42 PM, ADON A revealed the Restorative Aide got resident weights and if she were to notice a trend of loss or gain, she was to notify the charge nurse (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the ADONs so they could notify the RD. ADON A said she was not over Resident #53's care and the other ADON was out of the state at the time. DON A said it was important to report any inconsistent weight changes so they could assess the cause of the loss or the gain of the resident. Interview on 04/09/26 at 3:54 PM, Resident #53's Family Member revealed they visited often. The Family Member stated they had not noticed any weight gain for Resident #53, and the resident had not appeared to be in any distress during their visits. Interview on 04/09/26 at 4:27 PM, the DON revealed she had only worked at the facility for a few days. She stated the Restorative Aide was responsible for resident weights, and if there was weight gain or loss, the Unit Managers needed to be notified. She stated the Uniter Managers could have the resident weighed again or the resident could be assessed for disease processes. She stated they would then make any necessary nutritional adjustments. The DON stated she was not aware of Resident #53's significant weight gain. Record review of the facility's Weight Monitoring policy, dated May 2023, reflected the following: PolicyResident weights will be recorded and monitored at a minimum frequency of monthly.c) If the weekly weights shows more than a two percent (2%) gain or loss, the resident is reweighed within (24) hours.f) If there is an actual weekly gain or loss of 2%, the resident/family, physician and the Registered Dietitian are notified but the Nursing Department.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 3 residents (Resident #9) reviewed for enteral feeding. 1. The facility failed to ensure RN G mixed each crushed medication with water and administered one medication at a time through Resident #9's g-tube.2. The facility failed to ensure RN G administered Resident #9's g-tube medication by gravity. These failures could place residents at increased risk of aspiration, bloating discomfort, and not receiving the full benefit of the medications administered.Findings included:Record review of Resident #9's Quarterly MDS, dated [DATE], revealed a [AGE] year-old female admitted [DATE] with diagnoses that included aphasia (language disorder resulting from damage to the brain), paraplegia (paralysis affecting the lower half of the body), malnutrition (when the body does not get enough nutrients), and respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body). Further review of the MDS revealed Resident #9 had unclear speech, was usually understood and usually understood others, was dependent for ADLs, and required a feeding tube, oxygen therapy, suctioning and tracheostomy care. Record review of Resident #9's Care Plan, dated 08/28/25, reflected the following:- hydration - gtube with goal of improve or maintain hydration and an intervention that included Gtube for all nutrition- enteral feeding with goal of nutritional needs will be met with no S/SX of aspiration with intervention that included administer feeding tube as orderedRecord review of Resident #9's physician orders reflected the following orders:- order date 07/01/2025 DIET: Order - NPO - order date 07/01/2025 Tube - Flush Order Every Shift [Time: Shift 1, Shift 2, Shift 3] Flush tube with min 30cc before and after feeding administration.- order date 06/27/2025 BACLOFEN 10 MG TABLET Gastrostomy Tube Three times a day 08:00 AM, 12:00 PM, 09:00 PM- order date 07/10/2025 OXYCODONE HCL 5 MG TABLET Pain, unspecified for Pain - Moderate Gastrostomy Tube Three times a day [Time: 08:00 AM, 12:00 PM, 09:00 PM]Observation and interview on 04/08/26 at 12:15 PM revealed RN G had just finished crushing medications at the cart and said she was going to administer baclofen and a pain pill to Resident #9. RN G donned a gown and mask and performed hand hygiene. RN G entered Resident #9's room, provided privacy, donned gloves and stated the baclofen and pain pill were due at 12:00 PM and she would change Resident #9's feed after giving the meds. RN G had placed 3 cups on the bedside table and said she mixed both crushed pills in 20 cc of water, and one cup had 30 cc and one had 45 cc of water to flush. RN G drew up water with the syringe and flushed Resident #9's tube with 30 cc of water, then used the syringe to draw up the medication mixture, connected the syringe and used the plunger to push the mixture down into the tube. RN G then removed the syringe, drew up some water from the other cup and put it in the cup that had the medication mixture, drew that up in the syringe, then connected the syringe back to the tubing and used the plunger to push the fluid down. RN G drew up the remaining water with the syringe, connected it back to the tube and pushed the plunger to flush, then removed the syringe. RN G stated with the last flush she used half of the water and put it back in the med cup to get all the medicine and then used the other half to flush afterwards. Interview on 04/09/26 at 9:22 AM, RN G stated she was trained on the floor to administer g-tube meds and had trained with Resident #9. She stated that Resident #9's meds and food was thick. She said knowing her particular patient, it would not have flowed with gravity and that was why she knew to push the medications with the syringe. She stated if she had not trained with Resident #9, she would have started with gravity. RN G stated if she were to administer by gravity, she would pour each med and flush with 10 cc of water and pour another, but since she was drawing up, she crushed the medications and mixed them with water, then combined them to get enough pressure to push through the tube. She stated there was no physician order to mix or push the meds and she used her nursing judgment. RN G said normally, if (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was an issue it would specify not to mix them together. She stated there was no risk of mixing Oxycodone and baclofen together and there were no interactions between them. She said the most risk would be not giving all of the medication. She said since they were crushing them, it goes from the crush bag and to the cup and whatever was left in the crush bag and the cup was wasted. When asked if there was any risk of pushing the meds instead of using gravity, RN G stated only by pushing anything too fast. She said she mixed water and for example if it was 60mL she would put 10-15 mL at a time then take a break, that way it goes in slower. She said if the Resident was on the feeding pump at 60mL, the pump would be doing the same thing and she would not push a lot of fluid at one time because it could make the resident throw up, or cough. Interview on 04/09/26 at 12:28 PM, NP E stated when administering medications though g-tube it should be done by gravity. Interview on 04/09/26 at 3:19 PM, ADON A stated administering two medications at the same time was inappropriate and she started an in-service on the correct way to administer those medications. She said each pill should be separated and mixed, typically, with 30 mL of water and administered. ADON A stated g-tube medications should be administered by gravity. She said she would not push multiple medications through a syringe because it could get clogged, lessen the effect of the pain meds or there could be a reaction.Interview on 04/09/26 at 4:26 PM, the DON stated her expectation for staff administering medication through a g-tube was that no medications be mixed together and each medication should have their own cup. She stated staff were to flush the tube with water prior to giving the medication, with the syringe connected to the resident, put one medication in at a time and go with gravity and flush with water after the medication. She stated the medications should not be pushed with the syringe because it could irritate the gut and force air in. Record review of facility policy titled Medication Administration Enteral Tubes dated 2007, revealed the following: .10. Crushed medications are not mixed together. The powder from each medication is mixed with water before administration. The souffle cup is rinsed with water to get all of the medication contained within the cup to facilitate the ordered dose. The standard of practice is that crushed medications should not be combined and given all at once via feeding tube.12. Each medication is administered separately to avoid interaction and clumping. The enteral tubing is flushed with water between each medication to avoid physical interaction of the medications.Procedures.2. Prepare medications for administration.b. Crush each immediate-release tablets, one at a time, into a fine powder, and dissolve in water.12. Remove plunger from syringe and insert syringe into tubing.14.c. Allow medication to flow down tube via gravity or per manufacturer's specifications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 (Resident #56) of 6 residents reviewed for respiratory care, in that: The facility failed to obtain a physician order for Resident #56's use of supplemental oxygen.This deficient practice could affect residents who received oxygen therapy continuously placed residents at-risk for respiratory infection, and ineffective treatment.Findings included:Record review of Resident #56's quarterly MDS Assessment, dated 02/09/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #56 had diagnoses which included Type 2 diabetes mellitus without complications (high blood sugar resulting from the body's inability to properly use insulin), Non-Alzheimer's Dementia (problems with memory and thinking), heart failure, hypertension (high blood pressure) and cancer. Resident #56's BIMS score was 09, which indicated moderate cognitive impairment. The MDS Section J - Health Condition reflected resident had shortness of breath or trouble breathing when lying flat. The MDS Section O - Special Treatments, Procedures, and Programs reflected the resident received oxygen therapy. Record review of Resident #56's care plan dated 03/17/26, revealed the care plan did not address the resident's oxygen use.Record review of Resident #56's physician orders, dated 01/28/26, reflected O2 SAT Check Every Shift [Time: Shift 1, Shift 2, Shift 3] Monitor resident for signs and symptoms of shortness of breath for Essential (primary) hypertension, Paroxysmal atrial fibrillation (a fast, irregular heartbeat), Heart failure, Need HOB elevated to avoid SOB while lying flat.Record review of Resident #56's physician orders, dated 04/05/26, reflected Oxygen Every Shift [Time: Shift 1, Shift 2, Shift 3] for Shortness of breath oxygen via nasal canula.Record review of Resident #56's physician orders, dated 04/06/26, reflected Oxygen wean off oxygen slowly for Shortness of breath. Maintain o2 > 90%. Physician orders did not address how much oxygen Resident #56 should be administered. Record review of Resident #56's April 2026 MAR revealed Resident #56's O2 sats were within normal limits.Observation and interview on 04/07/26 at 10:36 AM, revealed Resident #56 sitting in her room sitting in her wheelchair. Resident #56 was observed to have her oxygen on via nasal cannula. The oxygen concentrator was set at 1.5L. Resident #56 stated she was having a hard time breathing but that the nurse had just checked her oxygen levels and they were normal. Observation and interview on 04/07/26 at 1:03 PM, revealed Resident #56 in the hallway ambulating in her wheelchair. Resident #56 did not have her oxygen on. Resident #56 stated she was feeling better. She stated she used to always receive oxygen but recently oxygen was only provided as needed. Resident #56 stated she could not recall how much oxygen she should be receiving.Observation on 04/08/26 at 10:04 AM, revealed Resident #56 in bed sleeping. She was observed to be receiving oxygen, and it was set at 1.5L. No distress was noted. During an observation and interview on 04/08/26 at 10:20 AM, RN D revealed she was Resident #56's assigned nurse. She stated Resident #56 was receiving oxygen; however, the resident had been weaning off the oxygen. She stated Resident #56 was receiving 2 liters of oxygen per minute. RN D reviewed Resident #56's physician orders and stated the resident had orders for weaning off and to keep the resident's oxygen saturation levels above 90%. RN D stated Resident #56's physician orders did not indicate how much oxygen to administer. RN D stated when she reviewed the order to provide the oxygen to Resident #56, she had mistaken the Shift 2 on the order as to give 2 liters. RN D proceeded to enter Resident #56's room, and she looked at Resident #56's oxygen concentrator. She then adjusted oxygen concentrator to deliver 2 liters per minute. RN D stated it was set between 1.5 liters-2 liters. She stated she was not aware that the physician orders did not indicate how much oxygen to give. She stated it was the responsibility of the nurses to put in orders, and the ADON was responsible for reviewing the orders. She stated the potential risk of not having an order specifying how much oxygen to provide would be the resident not receiving the correct amount and could lead to death.Interview on (continued on next page)

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	676096	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baybrooke Village Care and Rehab Center	8300 Eldorado Parkway West McKinney, TX 75070

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/09/26 at 3:32 PM, ADON A revealed the charge nurses were responsible for putting orders in the system and the ADONs were to follow up to ensure the orders were correct. She stated for residents receiving oxygen the order should specify how many liters to provide. ADON A stated the potential risk of not having orders specifying the amount of oxygen to provide could lead to sats levels being off or poisoning if given too much. Interview on 04/09/26 at 4:31 PM, the DON revealed Resident #56 was receiving oxygen but only as needed and not continuous. She stated Resident #56 was being weaned off the oxygen; however, due to her age and diagnosis it would be best for the resident to be placed back on continuous. The DON stated her expectation was for Resident #56's oxygen orders to specify how many liters to administer even if resident was being weaned off from it. The DON stated she did not know the previous oxygen orders or the liters being administered to Resident #56 prior to being weaned off. The DON stated the potential risk of not having a physician order for administering oxygen could lead to death or if given too much could cause other adverse effects. Record review of the facility Applying an Oxygen Delivery Device policy, revised 01/12/2020, reflected the following: Staff will apply oxygen delivery devices in accordance with standard practice guidelines. Procedure: Validate physician orders.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 1 of 1 resident (Resident #58) reviewed for dialysis.The facility failed to ensure post-dialysis assessments were completed for Resident #58. This failure could place residents at risk of inadequate post-dialysis care.Findings included:Record review of Resident #58's admission MDS Assessment, dated 01/01/26, reflected a [AGE] year-old male admitted [DATE]. Resident #58 had diagnoses which End-Stage Renal Disease, hypertension, heart failure, Diabetes Mellitus and hyperlipidemia. Resident #58's BIMS score was 15, which indicated his cognition was intact. The MDS Section O - Special Treatments, Procedures, and Programs reflected the resident received dialysis. Record review of Resident #58's care plan dated 03/19/26 reflected the following: Problem/Strengths: Dialysis. Goal: Improve or maintain current kidney function. Interventions: Dialysis as ordered [Name, address and number]. Check weight frequently and as ordered. Check shunt or access port for dialysis as ordered. Check my vital signs as ordered and as needed.Record review of Resident #58's physician order dated 8/21/25 reflected an order for Resident #58 to Dialysis Every Shift [Time: Shift 1, Shift 2, Shift 3] Monitor shunt/graft/fistula for S/X of infection and adequate circulation Dialysis on Monday and Fridays for Chronic kidney disease, unspecified.Record review of Resident #58's Dialysis Communication (Pre/Post) Dialysis forms dated 01/09/26, 01/16/26, 01/30/26, 02/09/26, 02/20/26, 03/06/26, 03/20/26, 03/23/26, 03/27/26 reflected there was no information documented on the resident assessment and observation post-dialysis sections.Interview on 04/07/26 at 11:02 AM, Resident #58 revealed he was a dialysis patient and would go to dialysis twice a week on Monday and Fridays. He stated his chair time was after lunch. Resident #58 stated he had not missed treatment. He stated he was provided with a form when he went to dialysis, and the dialysis staff documented his chair time. He stated staff would check his vitals before leaving for dialysis treatment but could not recall vitals checks upon return to the facility. Interview on 04/09/26 at 1:04 PM, RN D stated she was the nurse assigned to Resident #58. She stated Resident #58 was a dialysis resident and would go to dialysis twice a week on Mondays and Fridays. She stated Resident #58 left the facility for dialysis after lunch between 12:00 PM and 12:30PM. RN D stated she was not sure what time Resident #58 returned from dialysis. She stated when a resident went to dialysis it was the responsibility of the assigned nurse to provide the resident with a dialysis communication form and complete the pre-assessment prior to the resident going to dialysis. She stated she was responsible for completing the pre-dialysis assessment and the 2:00 PM-10:00 PM nurse was responsible for completing the post dialysis assessment. RN D stated the pre and post dialysis assessment were completed on the dialysis communication forms. RN D reviewed the dialysis communication forms and stated the post dialysis assessments were not completed. She stated monitoring vital signs were important. RN D stated the potential risk of not monitoring or documenting post-dialysis vitals was that it could lead resident to be unconscious or change in his well-being. Interview on 04/09/26 at 3:08 PM with LVN H revealed she was the nurse assigned to Resident #58; however, it was her first time working with him. She stated she had not admitted Resident #58 from dialysis. LVN H stated LVN I was his usual 2-10PM assigned nurse. Interview on 04/09/26 at 3:24 PM with ADON A revealed nursing staff were expected to complete pre- and post-vitals on residents who received dialysis. She stated Resident #58 was not her assigned resident. She stated it was the responsibility of the assigned nurse to complete the pre and post assessments and the responsibility of ADON J to ensure it was being completed. She stated ADON J was out on leave. She stated it was important to monitor vitals because the amount of liquid taken out during the dialysis process could affect the resident health. Interview on 04/09/26 at 4:36 PM with the DON revealed the assigned nurse was responsible for assessing vitals prior to resident going to dialysis and document in the system. She stated the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assigned nurse should send the communication form with the resident, obtain the form upon return and complete the post vitals. She stated she was not aware Resident #58's dialysis communication forms were not being completed. She stated it was the responsibility of the nurses for completing the pre and post dialysis and the ADONs were responsible for reviewing the documentation thought audits. She stated the potential risk of not completing the post-assessments could lead to residual bleeding.An attempt was made to contact LVN I by phone on 04/09/26 at 4:44PM; however, there was no answer.Record review of the facility's Dialysis - Hemodialysis policy reviewed 04/14/23, reflected the following: Policy: Staff will ensure that residents who require dialysis receive such services consistent with standards of practice. 3. The dialysis staff and the community staff will participate in ongoing communication by completing the dialysis collection forms as follows: a. EHR>Resident Data Collection>Dialysis b. Pre-Dialysis: Section A to be completed by the sending community licensed nurse and to accompany patient to the dialysis center. c. Post Dialysis: Community nurse to complete Section B with dialysis center information. Community nurse to assess and complete Section C. d. Place document in the appropriate section of the medical record.

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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, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 of 4 medication carts (Hall 100 and 200 carts) reviewed for pharmacy services. The facility failed to ensure two boxes of fast acting 40% glucose gel, with an expiration date of April 2025, had been removed from the Hall 100 and 200 medication carts. This failure could place residents at risk of receiving medications that were ineffective. Findings included: Observation on 04/08/26 at 10:14 a.m., of the 100-hall medication cart with RN F revealed 1 unopened box of Fast Acting 40% Glucose Gel (concentrated, rapid absorption treatment for low blood sugar) with an expiration date of 04/2025. Observation on 04/08/26 at 10:26 a.m., of the 200-hall medication cart with RN G revealed 1 unopened box of Fast Acting 40% Glucose Gel, with an expiration date of 04/2025. Interview on 04/08/26 at 10:22 a.m., with RN F revealed it was her first day back after being on vacation. RN F stated the 40% Glucose Gel expired in 04/2025. She stated she was not sure where the Glucose Gel came from, but it was used to treat low blood sugar. RN F stated she checked her cart every shift for expired medications but had not done it yet that shift. She stated she did not recall previously seeing the glucose gel in her cart and had not used it. RN F stated it was all nurses' responsibility to check for expired medications. RN F stated the risk of having expired medications in the cart was it could be given to the resident and not function. RN F stated she had done training on checking for expired medications and reviewed the medications expiration date before they were administered to residents. During an interview on 04/08/26 at 10:31 a.m., with RN G, she opened the box of 40% Glucose Gel and stated the expiration date on both the box and bottle was April 2025. RN G stated she was not sure where the Glucose Gel came from or what it was. RN G stated the emergent diabetic medications were typically kept in their emergency kit, not in the carts. RN G stated her medication cart was checked throughout her shift, but she must have missed the expired Glucose Gel. She stated it was nurses' responsibility to ensure there were no expired medications in the carts. RN G stated the risk of having an expired medication on the cart was that it could be used and not work effectively. Interview on 04/09/26 at 11:56 a.m., with ADON A revealed the ADONs were responsible for ensuring there were no expired medications in the carts. ADON A stated she had worked at the facility for 4 weeks and had checked the cart once prior to this week. She stated the medication carts should be reviewed weekly by the ADONs. ADON A stated she did observe the glucose gel in the carts but did not see the expiration date. ADON A stated the medication aides and nurses should be reviewing the carts on their shifts. ADON A stated she had been getting everything more organized and educating the nurses. ADON A stated the risk of having an expired medication on the cart was it could be given and be ineffective. She stated the glucose gel was used to increase blood sugar and it could not function properly. ADON A stated the emergency blood sugar medications were not usually found in the medication carts. ADON A stated she was working on in-services and education to prevent expired medications from remaining in the medication carts. Interview on 04/09/26 at 12:05 p.m., with DON revealed she had worked at the facility for 4 full days. She stated the ADONs were overall responsible to ensure there were no expired medications, but the nurses and medication aides should also be reviewing the expiration dates on all their medications. The DON stated the pharmacist also came at least once a month to review and complete spot checks on the medication carts. The DON stated she was planning a thorough training with the ADONs because everyone was new to the facility. The DON stated the risk of having expired medications was that they could be given and cause a reaction or have no potency. The DON stated she would be putting audits in place, monitoring, and completing in-services for the staff to prevent further issues with expired medications. Interview on 04/09/26 at 12:11 p.m., the Regional Nurse Consultant revealed the Glucose gel was typically found in the emergency kit, so it must have been (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed when medication carts were reviewed. The Regional Nurse Consultant stated the nurses were responsible for ensuring there were no expired medications in the medication carts and the ADONs oversee that. She also stated the pharmacist came monthly and did spot checks on the medication carts. The Regional Nurse Consultant stated the risk of having expired medications was that they could be given to the residents and not work to the full potential. She stated the Glucose Gel was used in emergency low blood sugar situations. Interview on 04/09/26 at 12:40 p.m., NP E revealed that no residents should be given any expired medications, and they should be removed from the medication carts. NP E stated the Glucose Gel was typically a standing order for all diabetic residents and used in situations where blood sugar was very low. She stated the glucose gel would not work properly if it expired in April of 2025. Record review of the facility's Medication Storage policy, revised January 2026, reflected the following: .14. Outdated, contaminated, discontinued, 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 medication disposal, and reordered from the pharmacy.