STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676121	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Tree Nursing and Rehabilitation Center	930 Roy Richard Dr Schertz, TX 78154

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure assessments accurately reflected the status of the residents for 4 of 24 residents (Residents #54, #57, #81 and #91) reviewed for resident assessments. 1. The facility failed to ensure Resident #54's injection type was accurately reflected on her admission MDS assessment dated [DATE]. 2. The facility failed to document Resident #57's use of antidepressant and scheduled pain medication on the quarterly MDS assessment. 3. The facility failed to ensure Resident #81s active diagnosis of respiratory failure was reflected on his quarterly MDS assessment dated [DATE]. 4. The facility failed to document Resident #91's use of opioids and scheduled pain medication on the quarterly MDS assessment. These deficient practices could place residents at risk of inadequate care. The findings include: 1.Record review of Resident #54's electronic face sheet dated 06/10/2026 reflected an [AGE] year-old female admitted on [DATE]. Her diagnosis included: type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood). Record review of Resident #54's admission MDS assessment dated [DATE] reflected that she could understand others and be understood. She scored 3 of 15 on her BIMS which signified her cognitive status was severely impaired. She required maximum assistance with her ADLs. She was noted to have an active diagnosis of diabetes mellitus. She was noted to have 2 injections in the previous 7 days of the assessment and 2 insulin injections. She was noted to be taking a hypoglycemic (a drug used to help reduce the amount of sugar present in the blood). Record review of Resident #54's comprehensive care plan dated 04/15/2026 reflected Focus, resident has diabetes mellitus, Interventions/Tasks, diabetes medication as ordered by the doctor. Record review of Resident #54's Active Orders as of: 06/10/2026 reflected Liraglutide (a synthetic glucagon-like peptide-1 receptor agonist) Subcutaneous Solution Pen-Injector 18MG/3ML, inject 1.8 milligrams subcutaneously one time a day related to type 2 diabetes mellitus. She was not prescribed insulin. Record review of Resident #54's MAR dated 04/01/2026 to 04/30/2026 reflected that she had 2 subcutaneous injections of Liraglutide and not insulin. During an interview on 06/09/2026 at 12:00 pm, Resident #54 stated she received injections for her diabetes. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/2026 at 1:41 pm, the MDS Nurse stated even though the Liraglutide acted as a diabetic medication, it was not insulin and Resident #54's admission MDS should not have noted insulin injections. She stated MDS accuracy was important because it reflected the resident and care required which could be miscommunicated or missed. 2. Record review of Resident #57's admission sheet dated 01/22/2026, documented an [AGE] year-old female resident with diagnoses including pain in unspecified joint, hypertension (high blood pressure), diabetes mellitus, seizures, hyperlipidemia (high cholesterol), and cognitive communication deficit. Record review of Resident #57's MDS dated [DATE] documented a BIMS score of 3 indicating severe cognitive impairment and recorded the use of anticoagulant, antiplatelet, hypoglycemic, and anticonvulsant medication. The assessment did not include the use of antidepressants in Section N – Medications N0415. High-Risk Drug Classes: Use and Indication. Further review of the MDS revealed the assessment did not record the use of scheduled pain medication in Section J – Health Conditions J0100. Pain Management At any time is the last 5 days, has the resident: A. Received scheduled pain medication regimen? Record review of Resident #57's order summary included active orders for the antidepressant medication Trazodone, the analgesic medication Tylenol, and the anti-inflammatory medication Voltaren. Trazodone was ordered as Trazodone 150 mg, Give 1 tablet by mouth one time a day related to INSOMNIA. Tylenol was ordered as Tylenol 325 mg, Give 2 tablets by mouth two times a day related to PAIN IN UNSPECIFIED JOINT. Voltaren was ordered as Voltaren External gel 1%, Apply to LEFT KNEE topically two times a day for PAIN. Record review of Resident #57's April 2026 and May 2026 MARs documented the resident had been receiving Tylenol and Voltaren as prescribed during the five day lookback period from 4/27/2026 through 5/01/2026. Further review of the April and May MARs, documented the resident had been receiving Trazodone as prescribed during the seven day lookback period from 4/25/2026 through 5/01/2026. Record Review of Resident #57's care plan with an initiation date of 01/27/2026 documented The resident requires antidepressant medication ., Give antidepressant medications as ordered by physician. Further review of the resident's care plan documented The resident has a potential for uncontrolled pain ., Evaluate the effectiveness of pain interventions. 3. Record review of Resident #81's electronic face sheet dated 06/11/2026 reflected a [AGE] year-old male admitted on [DATE]. His diagnosis included: acute and chronic respiratory failure with hypoxia (the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function). Record review of Resident #81's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored a 10 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required minimal to moderate assistance with ADLs. Respiratory failure was not noted to be an active diagnosis. Record review of Resident #81's comprehensive care plan dated 07/18/2025 reflected Focus, resident has oxygen therapy and nebulizer related to ineffective gas exchange, respiratory illness, Interventions/Tasks, give medication as ordered. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #81's Active Orders as of: 05/01/2026 reflected acetazolamide oral tablet 250mg, give one tablet by mouth one time a day for respiratory failure, start date 10/30/2024. Observation on 06/09/2026 at 11:30 am of Resident #81 revealed he was sitting in his room in a wheelchair. An oxygen concentrator was near his bed with oxygen tubing unbagged secured around the top. During an interview on 06/09/2026 at 11:32 am, Resident #81 stated he used oxygen at night to help him to breathe because of his respiratory failure. During an interview on 06/12/2026 at 1:41 pm, the MDS Nurse stated Resident #81 did have an active diagnosis of respiratory failure and received medications. She stated she did not know how it was missed on the quarterly MDS assessment. She stated MDS accuracy was important because it reflected the resident and care required which could be miscommunicated or missed. During an interview on 06/12/2026 at 2:30 pm, the DON who was new at the facility stated the MDS painted a picture of the resident and their care and drove the care plan. The DON stated an inaccurate MDS could lead to a lack of care. During an interview on 06/12/2026 at 2:40 pm, the ADM stated MDS accuracy was important for reimbursement, and care planning. The ADM stated that an inaccurate MDS could result in missed care. 4. Record review or Resident #91's admission sheet dated 8/05/2022 with an original admission date of 02/26/2020 documented a [AGE] year-old male resident with diagnoses including cerebral infarction (stroke), diabetes mellitus, chronic pain, and right hand contracture (a condition causing the shortening and stiffening of soft tissues, such as muscles, tendons, and ligaments). Record review of Resident #91's MDS assessment dated [DATE] documented a BIMS score of 7 indicating severe cognitive impairment and recorded the use of antidepressant, anticoagulant, diuretic, and anticonvulsant medication. The assessment did not include the use of opioids in Section N – Medications N0415. High-Risk Drug Classes: Use and Indication. Further review of the MDS revealed the assessment did not record the use of scheduled pain medication in Section J – Health Conditions J0100. Pain Management At any time is the last 5 days, has the resident: A. Received scheduled pain medication regimen? Record review of Resident #91's order summary included an active order for the opioid medication Tramadol. Tramadol was ordered as Tramadol 50 mg, Give 1 tablet by mouth two times a day related to OTHER CHRONIC PAIN. Record review of Resident #91's May 2026 MAR documented the resident was receiving Tramadol as prescribed during the five day lookback period from 5/10/2026 through 5/14/2026. Record review of Resident #91's care plan with an initiation date of 9/22/2021, documented The resident has a potential for uncontrolled pain ., with interventions including Evaluate the effectiveness of pain interventions. During an interview with the MDS Nurse on 6/12/26 at 1:41 PM, the MDS Nurse stated she was responsible for ensuring the accuracy of the information included on the MDS. The MDS Nurse stated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the assessment should be accurate because it was the regulation and a picture of resident care. The MDS Nurse stated if the MDS was inaccurate, resident care could not be delivered correctly and something could be missed. Record review of the facility's policy and procedure titled Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy dated August/2025 reflected The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews, and record reviews, the facility failed to develop and implement a comprehensiveperson-centered care plan for each resident, consistent with the resident rights, which includes measurable objective andtimes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in thecomprehensive assessment for 3 Residents (Resident #7, Resident #44, Resident #54, and Resident #81) of 32 residents reviewed forcare plans. 1.The facility failed to reflect Resident #7's hospice services in her comprehensive care plan. 2.The facility failed to reflect Resident #44 used a sensor pad in his comprehensive care plan. 3.The facility failed to reflect Resident #81 would take off his oxygen canula and put it on. These deficient practices place residents at risk of missed or miscommunicated care.The findings include: 1.Record review of Resident #7's electronic face sheet dated 06/10/2026 reflected a [AGE] year-old female admitted on [DATE]. Her diagnoses included: cerebral infarction (the death of neural (brain) tissue because of ischemia (lack of oxygen), and malignant neoplasm of colon (abnormal cancer cells that begin in the large intestine and can spread). Record review of Resident #7's quarterly MDS assessment dated [DATE] reflected that she could understand others and be understood. She scored 6 of 15 on her BIMS which signified her cognitive status was severely impaired. She required moderate assistance with ADLs. She was noted to have hospice care. Record review of Resident #7's comprehensive care plan dated 02/17/2026 failed to reflect that she received hospice care. Record review of Resident #7's Active Orders as of: 06/10/2026 reflected Admit to Hospice, DX CVA, start dated 02/04/2026. Observation on 06/09/2026 at 11:00 am revealed Resident #7 lying in bed attended by a hospice aide who applied lotion to her legs. During an interview on 06/09/2026 at 11:03 am, Resident #7 stated hospice came and gave her baths and showers. 2. Record review of Resident #44's electronic face sheet dated 06/10/2026 reflected a [AGE] year-old male admitted on [DATE]. His diagnoses included: Parkinsonism (clinical syndrome that presents with various neurodegenerativediseases which manifest motor symptoms such as rigidity, tremors, and unstable posture, leading to gait impairment),muscle spasms (sudden, involuntary contraction of one or more muscles) and seizures (sudden burst of electrical activityin the brain which can cause changes in behaviors and movement and levels of consciousness). Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected he was able to be understood andable to understand others. He scored 12 of 15 on his BIMS which signified his cognitive status was moderately impaired.He required substantial assistance to total dependence for most of his ADLs. He used a manual wheelchair and required.maximal assistance for locomotion and mobility. Record review of Resident #44's comprehensive care plan dated 05/01/2026 reflected Focus, resident has an ADL selfcare.performance deficit r/t Parkinsons, muscle weakness, Interventions/Tasks, encourage the resident to use call bell forassistance. Resident #44's need for a sensor pad instead of a call bell was not reflected. Observation on 06/09/2026 at 10:45 am of Resident #44 revealed he was sitting in a tall wheelchair in his room.approximately 3 feet away from his bed. His sensor pad was lying on his bed. During an interview on 06/09/2026 at 10:47 am, Resident #44 stated he would use his sensor pad to call someone if heneeded help. 3. Record review of Resident #81's electronic face sheet dated 06/11/2026 reflected a [AGE] year-old male admitted on [DATE]. His diagnosis included: acute and chronic respiratory failure with hypoxia (the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function). Record review of Resident #81's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored a 10 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required minimal to moderate assistance with ADLs. Respiratory failure was not noted to be an active diagnosis. Record review of Resident #81's comprehensive care plan dated 07/18/2025 reflected (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus, resident has oxygen therapy and nebulizer related to ineffective gas exchange, respiratory illness, Interventions/Tasks, give medication as ordered. Resident #81's behavior of taking off and putting on his oxygen was not reflected. Record review of Resident #81's Active Orders as of: 05/01/2026 reflected acetazolamide oral tablet 250mg, give one tablet by mouth one time a day for respiratory failure, start date 10/30/2024. Observation on 06/09/2026 at 11:30 am of Resident #81 revealed he was sitting in his room in a wheelchair. An oxygen concentrator was near his bed with oxygen tubing unbagged secured around the top. During an interview on 06/09/2026 at 11:32 am, Resident #81 stated he used oxygen at night to help him to breath because of his respiratory failure. He stated he put his oxygen on and took it off himself. He stated he would turn the concentrator on and off. He stated he was on oxygen between 2 and 4 L/min. During an interview on 06/12/2026 at 12:51, RN C stated Resident #81 could take off his own nasal canula and put it on. She stated she did not know if it was in his care plan. During an interview on 06/12/2026 at 1:41 pm, the MDS Nurse stated Resident #7's hospice services, Resident #44's sensor pad and Resident #81's behaviors of putting on and taking off his oxygen canula needed to be reflected in their care plans, and she did not know why they were not. She stated the wrong type of care or missed care could result with an inaccurate care plan. She stated behaviors needed to be communicated to other direct care staff so they would be aware. During an interview on 06/12/2026 at 2:30 pm, the DON who was new at the facility stated the comprehensive care plan should show what care the residents required and what they could or could not do to include behaviors and preferences. She stated she was accountable for many parts of the care plan process. During an interview on 06/12/2026 at 2:40 pm, the ADM stated care plans needed to show the residents' needs, preferences and goals. Record review of the facility's policy and procedure titled Comprehensive Care Planning (undated) reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights that includes measurable objectives and timeframes to meet resident's medical, nursing, and 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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident and to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 2 of 6 residents (Resident #8 and Resident #20), 1 of 4 medication carts (the 500 hall medication aide cart), and 1 of 2 medication rooms (the long term care unit medication room) reviewed for pharmacy services.1. The facility failed to ensure Resident #8's long-acting insulin was accurately prepared before administration.2. The facility failed to ensure Resident #20's controlled medication log for the opioid medication Hydrocodone-Acetaminophen 7.5-325 mg accurately reflected the number of doses administered.3. The facility failed to ensure the controlled substance reconciliation log for the 500 hall medication aide cart was signed for accuracy of medication quantities at the time of shift change.4. The facility failed to ensure the long-term care unit medication room contained no unexpired supplies.These failures could place residents at risk of not receiving their prescribed medications, of not benefiting from the full therapeutic effect of their medications or treatments, of experiencing untreated pain, and a decreased quality of life.The findings included: 1. Record review of Resident #8's admission sheet dated [DATE] with an original admission date of [DATE], documented a [AGE] year-old male resident with diagnoses including heart failure, high blood pressure, high cholesterol, and type 2 diabetes mellitus. Record review of Resident #8's MDS dated [DATE] documented a BIMS score of 6 indicating severe cognitive impairment and recorded the use of insulin injections in Section N - Medications N0350 Insulin A. Insulin Injections. Record review of Resident #8's order summary included an order for Insulin Glargine Pen-injector 100 UNIT/ML with directions to inject 15 unit subcutaneously one time a day for diabetes. Record review of Resident #8's care plan with an initiation date of [DATE] documented The resident has Diabetes Mellitus ., with interventions including Diabetes medications as ordered by doctor. During an observation of medication pass with LVN D on [DATE] at 7:20 AM, LVN D administered 15 units of Resident #8's Insulin Glargine pen, a long acting insulin used to manage type 1 and type 2 diabetes mellitus. LVN D did not prime the insulin pen prior to administering the medication to Resident #8. During an interview with LVN D on [DATE] at 7:53 AM, LVN D stated it was important to prime insulin pens before use to ensure the pen was working properly. LVN D stated if insulin pens were not primed before administration to residents, the dose might not be as effective or the correct amount, and the resident's blood sugar could be high. During an interview with the DON on [DATE] at 7:59 AM, the DON stated she expects her employees to give therapeutic care to the residents and she would discuss the proper usage of medication pens with the staff. 2. Record review of Resident #20's admission sheet dated [DATE] documented a [AGE] year-old female resident with diagnoses including asthma, depression, high cholesterol, high blood pressure, and sciatica (pain that travels along the path of the sciatic nerve which extends from the lower back through the buttocks down each leg). Record review of Resident #20's MDS dated [DATE] documented a BIMS score of 7 indicating severe cognitive impairment and recorded an active diagnosis of sciatica in Section I - Active Diagnoses I8000 H. Sciatica. Record review of Resident #20's order summary included an order for the opioid medication Hydrocodone-Acetaminophen 7.5-325 mg with orders to give 1 tablet by mouth three times a day for pain. Record review of Resident #20's care plan with an initiation date of [DATE] documented the resident was Allergic to aspirin, codeine, erythromycin/retinoic acid, gabapentin, sulfamethoxazole, Celebrex, Darvocet ., with interventions including Do not administer and/or come in contact with allergen. During an observation of the 700/800 hall nurse cart with LVN D on [DATE] at 9:34 AM, the controlled medication log for Resident #20's opioid medication Hydrocodone-Acetaminophen 7.5-325 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg with directions to give 1 tablet three times a day for pain, did not match the quantity of tablets remaining in the resident's blister pack. The medication log showed 6 tablets should be available; however, the blister pack contained 5 tablets. During an interview with LVN D on [DATE] at 9:37 AM, LVN D stated it was important to log out the tablet immediately after administering the medication. LVN D stated there could be the possibility of double dosing, and a resident could get too much sedation if they were overmedicated or if a pill was missing, the resident may experience pain if their pain medication was unavailable. 3. During an observation of the 500 hall medication aide cart with MA F on [DATE] at 9:48 AM, the controlled medication reconciliation log used to audit the quantities of controlled substances stored in the cart during shift changes had been signed in advance of the next shift change on [DATE]. During an interview with MA F on [DATE] at 9:50 AM, MA F stated the log should not be signed in advance of shift change, because you could leave and a card could get taken away. MA F stated something could go missing and a resident might not get their medication and could experience pain. 4. During an observation of the long-term care unit medication room with LVN D on [DATE] at 10:17 AM, an expired IV tubing with an expiration date of [DATE] was discovered on the shelves containing medication equipment and supplies. During an interview with LVN D on [DATE] at 10:18 AM, LVN D stated there should not be any expired items in the storage room. LVN D stated they do not want to use expired items because they might not work properly, and a resident might not get enough of their medication or could have a reaction. During an interview with the DON on [DATE] at 2:30 PM, the DON stated the facility policy explains the correct way to document the administration of controlled substances on the medication log sheets. The DON stated the do not want any medication errors, or to overdose a resident it they did not think they gave a medication which had already been given. The DON stated if a resident received too much of their medication, the resident could experience a harmful overdose. Regarding controlled substance reconciliation logs, the DON stated the staff should not be signing the logs in advance of shift change should be signed when the cart is handed off to the next employee. The DON stated it was important for the reconciliation logs to be accurate should they need to log a medication error, to prevent drug diversion, and to have a proper accounting of where the keys to the cart are located. Regarding expired supplies, the DON stated her expectation was that there should not be expired supplies in the medication rooms. The DON stated expired items might not be working adequately and could be ineffective, and the resident might not get the therapeutic benefit of their medication. During an interview with the Administrator on [DATE] at 2:56 PM the Administrator stated controlled medication reconciliation logs should not be signed in advance because the log could be inaccurate by the end of the shift. Regarding expired supplies, the Administrator stated expired supplies should not be the medication rooms, and they would not want to use any expired items for resident safety, because they might not be suitable for use. Record review of the Medication Pass Guidelines check off for LVN D dated [DATE] recorded an answer of met by g. Medication dose preparation. Record review of the facility policy titled Insulin Pen Use with a revision date of [DATE] noted Step 3. Perform a Safety test Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: -ensuring that pen and needle work properly, -removing air bubbles A. Select a dose of 2 units by turning the dosage selector. B. Hold the pen with the needle pointing upwards. C. Tap the insulin reservoir so that any air bubbles rise up towards the needle. D. Press the injection button all the way in. Check if insulin comes out of the needle tip. Record review of the facility policy titled Controlled Medications - Administration, dated 2025, noted Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations ., and When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: -Date and time of administration, -Amount administered, -Signature of the nurse administering the dose, completed after the medication is actually administered ., and At each shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 1 of 6 residents (Resident #51), 3 of 4 medication carts (the 700/800 hall nurse cart, the 800 hall medication aide cart, and the 500/600 hall nurse cart) and 1 of 2 medication rooms (the rehabilitation unit medication room) reviewed for medication storage and labeling. The facility failed to ensure the labels of all prescription medications located inside the 700/800 hall nurse cart and the 800 hall medication aide cart, matched the orders in the electronic medical record for Resident #51. The facility failed to ensure all medications located inside the 500/600 hall nurse cart were stored in labeled containers. The facility failed to ensure the refrigerator in the rehabilitation unit medication room contained a locked, affixed container to store controlled medications. These failures could place residents who receive medications at risk of not receiving the intended therapeutic effects of their prescribed medications and experiencing unintended and harmful effects of medications prescribed to others.The findings included: During an observation of medication pass with LVN D on 6/11/2026 at 7:20 AM, LVN D prepared to administer an opioid medication from the 700/800 hall nurse cart to Resident #51 from a blister pack with a prescription label which read Hydrocodone-Acetaminophen 10-325 mg, give 1 tablet by mouth every 6 hours as needed. Upon verification in the EMR, the order was written as Hydrocodone-Acetaminophen 10-300 mg, give 1 tablet by mouth every 6 hours as needed. During an interview with LVN D on 6/11/2026 at 7:21 AM, LVN D stated the order in the EMR did not match the directions on the prescription label of the blister pack. LVN D stated she needed to clarify the order with the prescriber and would check the 800 hall medication aide cart to see if it contained a blister pack with a different order for Resident #51. During an observation of medication pass with LVN E on 6/11/2026 at 7:33 AM, LVN E prepared to administer an opioid medication from the 800 hall medication aide cart to Resident #51 from a blister pack with a prescription label which read Hydrocodone-Acetaminophen 10-325 mg, give 1 tablet by mouth every 6 hours as needed. Upon verification in the EMR, the order was written as Hydrocodone-Acetaminophen 10-325 mg, give 1 tablet by mouth twice daily. During an interview with LVN E on 6/11/2026 at 7:35 AM, LVN E stated the blister pack with a label for PRN dosing should not have been located in the 800 hall medication aide cart. LVN E stated the 800 hall medication aide cart should have had a blister pack with routine dosing for Resident #51's opioid medication. LVN E stated if the label on the blister pack did not match the order in the EMR, double dosing of medication could occur which could cause increased drowsiness and decreased vital signs. During an interview with the DON on 6/11/2026 7:59 AM, the DON stated it was important for the prescription labels on the blister pack to match the orders in the EMR. The DON stated a resident could receive non-therapeutic care for pain if too little medication was given or an overdose if too much medication was given. The DON stated she expected her staff to follow doctors orders, input orders correctly, and to clarify orders with the prescriber when needed. During an observation of the 500/600 hall nurse cart with RN B on 6/12/26 at 9:16 AM, a loose pill was discovered lying in the third drawer of the medication cart. During an interview with RN B on 6/12/2026 at 9:20 AM, RN B stated loose pills should not be in the medication carts, because if they are unlabeled, anyone could take it, and they would not know what it was. RN B stated if a resident consumed an unlabeled pill, it could be dangerous and cause the resident to get sick or have a heart attack. During an observation of the rehabilitation unit medication room with RN G on 6/12/26 at 10:11 AM, the lock box for controlled medication storage was not affixed to the refrigerator. During an interview with RN G on 6/12/2026 at 10:13 AM, RN G stated no one should be able to pick the lock box up and take it out of the refrigerator. RN G stated the box should be affixed to the refrigerator so (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it could not be removed. RN G stated if the lock box was not affixed to the refrigerator, a drug diversion could occur. During an interview with the DON on 6/12/26 at 2:30 PM, the DON stated there should not be loose pills in the medication carts, and it was an infection control issue and unacceptable. The DON stated if there were loose pills in the carts, medications might not be tracked or appropriately wasted. The DON stated a resident might not have received the therapeutic benefit of their medication if it was dropped in the cart and not administered. Regarding the lock boxes, the DON stated all lock boxes for controlled medication storage should be affixed to the refrigerator in the medication rooms. The DON stated if the lock boxes were not affixed, drug diversion could occur and residents might not receive therapeutic care if their medications are unavailable. During an interview with the Administrator on 6/12/26 at 2:56 PM, the Administrator stated his expectation for lock boxes was that they be affixed to the refrigerator and that narcotics needed to be locked up securely for the safety of residents and staff. The Administrator stated his expectation for medication carts was that they contained no loose pills, and that loose pills could indicate a nurse dropped a medication. The Administrator stated if a medication had been dropped in a cart unnoticed, a resident might not get the benefit of their drug, or a resident could experience a negative effect if they received a medication for which they were not prescribed. Record review of Resident #51's admission sheet dated 3/18/2026 with an original admission date of 4/19/2023 documented a [AGE] year-old male resident with diagnoses including depression, anxiety, seizures, and diabetic neuropathy (a common complication of diabetes characterized by nerve damage that can lead to pain, numbness and various dysfunctions in the body). Record review of Resident #51's MDS dated [DATE] documented a BIMS score of 14 indicating intact cognition and recorded the use of opioid medications in Section N - Medications N0415 High-Risk Drug Classes: Use and Indication. Record review of Resident #51's order summary included an order for Hydrocodone-Acetaminophen 10-300 mg with an order date of 5/06/2026 with directions to give 1 tablet by mouth every 6 hours as needed for pain, Hydrocodone-Acetaminophen 10-325 mg with an order date of 6/11/2026 with directions to give 1 tablet by mouth every 6 hours as needed for moderate pain, and Hydrocodone-Acetaminophen 10-325 mg with an order date of 3/20/2026 with directions to give 1 tablet by mouth two times a day for moderate pain. Record review of Resident #51's care plan with an initiation date of 4/23/2026 documented The resident is on Pain medication Therapy ., with interventions including Administer medication as ordered. Record review of the facility policy titled Medication Labels, dated 2025, noted Medications are labeled in accordance with facility requirements, state, and federal laws ., 1. Each prescription medication label includes: Specific direction for use, including route of administration ., Nursing can request a ?refer to order change' sticker to affix to label until updated supply/label is provided. Record review of the facility policy titled Medication Storage in the Facility, dated 2025, noted Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The pharmacy dispenses medications in containers that meet legal requirements including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Record review of the facility policy titled Controlled Medications - Administration, dated 2025, noted Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations ., Medications listed in Schedules II are stored under double lock in a locked cabinet or safe designed for that purpose, separate from all other medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records for each resident that were complete and accurately documented for 2 (Residents #8 and #11) of 32 residents reviewed for complete and accurately documented clinical records, in that: 1. Resident #8's clinical record included an order to notify the Medical Doctor or Nurse Practitioner if the resident's blood sugar level was measured above 250 and an additional order to notify the Medical Doctor or Nurse Practitioner if the resident's blood sugar level was measured above 400. 2. Resident #11's diagnoses of insomnia and anxiety were not included in the resident's list of diagnoses and were therefore not listed on the resident's facesheet. These deficient practices could result in substandard level of care. The findings included: 1. Record review of Resident #8's facesheet, dated 06/12/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: unspecified dementia, type 2 diabetes mellitus, and heart failure. Record review of Resident #8's quarterly MDS, dated [DATE], revealed a BIMS score of 6 which indicated severe cognitive impairment. Record review of Resident #8's care plan, revised 01/23/2020, revealed, The resident has Diabetes Mellitus. Record review of Resident #8's order summary, dated 06/12/2026, revealed an order dated 02/10/2025, [Check blood sugar] two times a day Notify MD/NP if BS [less than] 90 or [greater than] 250. Further review revealed an order dated 12/19/2025, Insulin [brand] Injection Solution (Insulin [brand]) Inject as per sliding scale: if 200 - 250 = 2u; 251 - 300 = 4u; 301 - 350 = 6u; 351 - 400 = 8u; 401+ = 10 units if greater than 400 give 10 units and call md, subcutaneously four times a day for DM. 2. Record review of Resident #11's facesheet revealed the resident was admitted to the facility on [DATE] with diagnoses including: vascular dementia, cerebral infarction, and paranoid personality disorder. Record review of Resident #11's significant change MDS, dated [DATE], revealed a BIMS score of 9 which indicated moderate cognitive impairment. Record review of Resident #11's care plan, revised 05/07/2026, revealed, The resident uses anti-anxiety medications [due to] anxiety disorder. Record review of Resident #11's psychological services progress note, dated 01/05/2026, revealed, Diagnoses: primary insomnia, anxiety disorder. Further review of Resident #11's facesheet revealed the diagnoses of insomnia and anxiety were not listed. During an interview with the DON on 06/12/2026 at 12:25 p.m., the DON confirmed Resident #8's orders to notify the medical doctor or nurse practitioner of potentially high blood sugar levels were conflicting and stated she would contact Resident #8's physician for clarification. The DON on 06/12/2026 at 12:25 p.m., the DON stated Resident #11's diagnoses of insomnia and anxiety should have been included in the resident's list of diagnoses and therefore listed on the resident's facesheet. The DON confirmed that diagnoses from outside providers such as psychological services should be included in the resident's facility clinical record so that the resident's physician and facility care team could coordinate appropriately. The DON also confirmed that the resident's facesheet was utilized as a means of communicating the resident's status to hospitals and other providers outside of the facility and should accurately reflect the resident's status. The DON further stated the facility's annual survey commenced on her second day of employment with the facility and that she would ensure a system of communication and coordination between the facility and outside providers was in place. The facility policy regarding clinical records was requested on 06/12/2026 and was not received by the time of survey exit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide reasonable accommodation for residents.needs for 1of 8 residents (Resident #44) reviewed for quality of care. The facility failed to ensure Resident #44's call sensor pad was within reach. The deficient practice could place residents at risk of not receiving care or attention needed. Findings include: Record review of Resident #44's electronic face sheet dated 06/10/2026 reflected a [AGE] year-old male admitted on [DATE]. His diagnoses included: Parkinsonism (clinical syndrome that presents with various neurodegenerativediseases which manifest motor symptoms such as rigidity, tremors, and unstable posture, leading to gait impairment),muscle spasms (sudden, involuntary contraction of one or more muscles) and seizures (sudden burst of electrical activityin the brain which can cause changes in behaviors and movement and levels of consciousness). Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected he was able to be understood andable to understand others. He scored 12 of 15 on his BIMS which signified his cognitive status was moderately impaired.He required substantial assistance to total dependence for most of his ADLs. He used a manual wheelchair and required.maximal assistance for locomotion and mobility. Record review of Resident #44's comprehensive care plan dated 05/01/2026 reflected Focus, resident has an ADL selfcare.performance deficit r/t Parkinsons, muscle weakness, Interventions/Tasks, encourage the resident to use call bell forassistance. Observation on 06/09/2026 at 10:45 am of Resident #44 revealed he was sitting in a tall wheelchair in his room.approximately 3 feet away from his bed. His sensor pad was lying on his bed. During an interview on 06/09/2026 at 10:47 am, Resident #44 stated he would use his sensor pad to call someone if heneeded help. He stated he could not reach or get to the sensor pad and would have to yell if he needed help. During an interview on 06/12/2026 at 1:03 pm, CNA A, who was assigned to care for Resident #44 on 06/09/2026, shestated she could not remember who helped Resident #44 out of bed, but that he would not be able to reach his sensor pad.if it was on his bed and he was in his chair a few feet away. She stated if he had an emergency, he would not be able toget help. During an interview on 06/12/2026 at 1:16 pm, RN B, who was assigned to care for Resident #44 on 06/09/2026 stated.She did not notice Resident #44's sensor pad placement that morning. She stated it was important for residents to have.their call lights or devices within reach in case they needed help quickly. During an interview on 06/12/2026 at 2:30 pm, the DON who was new at the facility stated residents needed to have call.lights or devices within reach when they were in their rooms in case an emergency arose. During an interview on 06/12/2026 at 2:40 pm, the ADM stated staff needed to check for call light or device placement sothat residents had a way to get help. Record review of the facility's policy and procedure titled Resident Rights (undated) reflected the right to reside andreceive services in the facility with reasonable accommodation of resident needs and preferences except when to do so.would endanger the health or safety of the resident or other residents.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System including. A subset of items upon a resident's transfer, reentry, discharge, and death, for 1 (Resident #83) of 4 residents reviewed for completed MDS data, in that: The facility did not complete, encode, or transmit an MDS assessment upon the discharge of Resident #83. This deficient practice could result in inaccurate MDS data regarding residents reflected in the CMS system. The findings included: Record review of Resident #83's facesheet, dated 06/12/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: other nondisplaced fracture of upper end of right humerus, hyperlipidemia, and nondisplaced fracture of shaft of right clavicle. Record review of Resident #83's facility closed clinical record revealed an entry MDS was completed on 01/12/2026. Further review of Resident #83's facility closed clinical record revealed a signed AMA form, dated 01/12/2026, which indicated the resident discharged from the facility on the same day as admission. Further review of Resident #83's facility closed clinical record revealed a discharge MDS was not completed, encoded, or transmitted. During an interview with the DON on 06/12/2026 at 12:25 p.m., the DON stated a discharge MDS should have been completed, encoded, and transmitted for Resident #83 upon the resident's discharge from the facility. During an interview with the MDS Coordinator on 06/12/2026 at 2:00 p.m., the MDS Coordinator stated a discharge MDS should have been completed, encoded, and transmitted for Resident #83 upon the resident's discharge from the facility and stated the omission was an oversight. Record review of the facility policy, Minimum Data Set (MDS) Policy for MDS Assessment Data Accuracy, dated 08/2025, revealed, Federal regulations.require that: 1. The assessment accurately reflects the resident's status.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) level 1 residents with mental illness were provided with a PASRR level 2 evaluation for 1 of 4 residents (Resident #2), reviewed for resident assessment. Resident #2's PASRR level 1 screening form did not indicate mental illness. This could place residents at risk of not receiving necessary specialized services to meet their individual needs. The findings were:The findings were: Record review of Resident #2's face sheet dated 6/11/26 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #2's diagnoses included encephalopathy unspecified (diffuse disease of the brain that alters brain function or structure), and other schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves and can include a combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning). Record review of Resident #2's admission MDS assessment dated [DATE] revealed A1500 was marked no for Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectualdisability or a related condition? and A1510 for serious mental illness was left blank. The resident had unclear speech, rarely or never understood others and was rarely or never understood by others and had a BIMS score of 00 indicating the resident was severely cognitively impaired. The resident used a manual wheelchair, and section I6000 was marked yes for schizophrenia diagnosis. Record review of Resident #2's undated care plan revealed a focus initiated on 5/13/26 for impaired cognitive function and impaired thought processes, and the resident required anti-psychotic medications with interventions that included monitoring and notifying the resident's physician. Record review of Resident #2's hospital discharge paperwork revealed the resident had been admitted from a different long term care facility, had a history of schizophrenia, was unable to answer questions appropriately, and was calling out for her sister who had previously passed away. Resident #2's on-going treatment list included Schizophrenia. Record review of Resident #2's PASSR level 1 screening dated 5/12/26 was marked no for serious mental illness. Record review of Resident #2's EHR (Electronic Health Record) revealed no corrected PASSR level 1 screening was completed. In an interview on 6/11/26 at 10:17 a.m., the MDS Nurse 2 stated he was unable to know who specifically reviewed Resident #2's PASRR screening for accuracy. MDS Nurse 2 stated it was a negative level 1 prescreening dated 5/12/26 and that a diagnosis of schizophrenia would not require a level 2 evaluation unless the resident had been recently hospitalized for mental illness. The MDS Nurse 2 stated he was unsure who reviewed Resident #2's PASRR level 1 screening. In an interview on 6/12/26 at 1:30 p.m. with the DON and MDS Nurse, the MDS Nurse stated she was responsible for reviewing and ensuring the PASRR level 1 for Resident #2 was completed correctly. The MDS Nurse stated she should have filled out form 1012 to trigger the PASRR level 2 evaluation. The MDS Nurse stated not completing this form 1012 could potentially prevent resident's from receiving specialized services, but in Resident #2's case, there were no potential consequences for this resident due to the resident's payor source, and she would be marked a no by the PASRR level 2 evaluation. Review of the facility policy on PASSR level 1 screening revised 3/6/2019 indicated . 3. The Facility will review the PASRR level 1 Screening form for completion and correctness prior to admission and submit the PL1 form per regulations. The Type of admission is reviewed for correctness. Ensure the Name, SS number, Medicare/Medicaid numbers, and DOB is correct. The Date of the PL1 is correct (i.e., correct day, month, and year) and review each item on the PL1 to ensure accuracy and prevent a regulatory problem.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan for 2 (Residents #1 and #8) of 32 residents reviewed for comprehensive care plans, in that: 1. Resident #1's diagnoses of frequent urinary tract infections, bleeding hemorrhoids, traumatic brain injury, pneumonia, chronic kidney disease, and diverticulitis were not included in the resident's care plan. 2. Resident #8's physician order for biannual blood tests to check drug levels and screen for potential side effects of valproic acid was not included in the resident's care plan. These deficient practices could result in substandard level of care. The findings included: 1. Record review of Resident #1's facesheet, dated 06/12/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: frequent urinary tract infections, bleeding hemorrhoids, traumatic brain injury, pneumonia, chronic kidney disease, and diverticulitis. Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score of 7 which indicated severe cognitive impairment. Record review of Resident #1's care plan, revised 03/05/2026, revealed the resident's diagnoses of frequent urinary tract infections, bleeding hemorrhoids, traumatic brain injury, pneumonia, chronic kidney disease, and diverticulitis were not included in the resident's care plan. 2. Record review of Resident #8's facesheet, dated 06/12/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: unspecified dementia, type 2 diabetes mellitus, and heart failure. Record review of Resident #8's quarterly MDS, dated [DATE], revealed a BIMS score of 6 which indicated severe cognitive impairment. Record review of Resident #8's order summary, dated 06/12/2026, revealed and order dated 01/23/2025 [valproic acid]LEVEL Q 6 MONTHS (OCT, APRIL). Record review of Resident #8's care plan, revised 05/14/2026, revealed the physician order for biannual blood tests to check drug levels and screen for potential side effects of valproic acid was not included in the resident's care plan. During an interview with the DON on 06/12/2026 at 12:25 p.m., the DON stated Resident #1's diagnoses of frequent urinary tract infections, bleeding hemorrhoids, traumatic brain injury, pneumonia, chronic kidney disease, and diverticulitis were being address by the facility and should have been included in the resident's care plan. The DON also stated that Resident #8's physician order for biannual blood tests to check drug levels and screen for potential side effects of valproic acid should have been included in the resident's care plan. During an interview with the MDS Coordinator on 06/12/2026 at 2:00 p.m., the MDS Coordinator stated Resident #1's diagnoses of frequent urinary tract infections, bleeding hemorrhoids, traumatic brain injury, pneumonia, chronic kidney disease, and diverticulitis should have been included in the resident's care plan, that Resident #8's physician order for biannual blood tests to check drug levels and screen for potential side effects of valproic acid should have been included in the resident's care plan, and that the omission was an oversight. Record review of the facility policy, Comprehensive Care Planning, undated, revealed, the resident's care plan will be reviewed.and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 of 32 residents (Resident #7 and Resident #81) reviewed for infection control in that: 1. The facility failed to ensure RN B maintained proper hand hygiene when administering medication through Resident #7's PEG tube (a small, flexible tube placed through the abdominal wall directly into the stomach allowing for the provision of nutrition, fluids, and medications without swallowing). 2. The facility failed to ensure Resident #81's oxygen tubing was bagged when not in use. These facility failures could place residents at risk of cross contamination and the spread of infections. The findings included: 1. Record review of Resident #7's admission sheet dated 02/03/2026 with an original date of 4/29/2025 documented a [AGE] year-old female resident with diagnoses including cerebral infarction (stroke), malignant neoplasm of colon (colon cancer), diabetes mellitus, hyperlipidemia (high cholesterol), hypertension (high blood pressure), and kidney disease. Record review of Resident #7's MDS dated [DATE] documented a BIMS score of 6 indicated severe cognitive impairment and recorded the use of a feeding tube in Section K – Swallowing/Nutritional Status K0520. Nutritional Approaches. Record review of Resident #7's order summary documented an active order for the pain medication Acetaminophen with an order date of 9/04/2025 and an active order for EBP with an order date of 5/06/2025. Acetaminophen was ordered as Acetaminophen 325 mg, Give 2 tablets via PEG-Tube every 6 hours as needed for pain/fever. EPB was ordered as Enhanced Barrier Precautions, every shift. Record review of Resident #7's care plan with an initiation date of 02/17/2026 noted The resident requires tube feeding .Meds and water flushes only ., and The resident has a potential for uncontrolled pain Arthritis / shoulder pain ., with interventions including Administer analgesia (specify medication) as per orders. Further review of the care plan noted the resident is on enhanced barrier precautions ., with a goal of There will not be any transmission of infection from or to the resident. During an observation of medication administration with RN E on 6/10/2026 at 12:37 PM, RN E did not sanitize her hands between glove changes during administration of Resident #7's pain medication through the resident's PEG tube. During an interview with RN E on 6/10/2026 at 12:39 PM, RN E stated she was supposed to sanitize her hands between glove changes when giving medications through a PEG tube. RN E stated it was important to sanitize between glove changes because Resident #7 is on EBP, and when they administer medications, they touch surfaces and could spread germs when they do not sanitize properly. During an interview with the DON on 6/10/2026 at 12:56 PM, the DON stated it was important for staff to sanitize between glove changes to prevent cross contamination when administering medications through a PEG tube. The DON stated she expected her staff to use EBP to protect themselves and (continued on next page)

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	676121	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Tree Nursing and Rehabilitation Center	930 Roy Richard Dr Schertz, TX 78154

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to prevent cross contamination Record review of RN E's Hand Hygiene Checkoff dated 5/15/2026 documented RN E had received training on hand hygiene including hand washing with soap and water, and hand washing with hand sanitizer. Record review of the facility policy titled Fundamentals of Infection Control Precautions, undated, noted Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: Before and after handling peripheral vascular catheters and other invasive devices; After removing gloves. 2. Record review of Resident #81's electronic face sheet dated 06/11/2026 reflected a [AGE] year-old male admitted on [DATE]. His diagnosis included: acute and chronic respiratory failure with hypoxia (the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function). Record review of Resident #81's quarterly MDS assessment dated [DATE] reflected he could understand others and be understood. He scored a 10 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required minimal to moderate assistance with ADLs. Respiratory failure was not noted to be an active diagnosis. Record review of Resident #81's Active Orders as of: 05/01/2026 reflected acetazolamide oral tablet 250mg, give one tablet by mouth one time a day for respiratory failure, start date 10/30/2024. Record review of Resident #81's comprehensive care plan dated 07/18/2025 reflected Focus, resident has oxygen therapy and nebulizer related to ineffective gas exchange, respiratory illness, Interventions/Tasks, give medication as ordered. Observation on 06/09/2026 at 11:30 am of Resident #81 revealed he was sitting in his room in a wheelchair. An oxygen concentrator was near his bed with oxygen tubing unbagged secured around the top. During an interview on 06/09/2026 at 11:32 am, Resident #81 stated he used oxygen at night to help him to breathe because of his respiratory failure. He stated his tubing was not bagged, and staff had not provided him with a bag to put it in when not in use. During an interview on 06/12/2026 at 12:51 pm, RN C stated Resident #81 could take off his own nasal canula and put it on. She stated the importance of bagging the oxygen tubing when not in use to prevent dust or dirt particles from entering and cause an infection. During an interview on 06/12/2026 at 2:30 pm, the DON who was new at the facility stated the oxygen tubing needed to be bagged when not in use or there could be cross contamination. During an interview on 06/12/2026 at 2:40 pm, the ADM stated cross contamination, and infection could occur when oxygen tubing is left unprotected when not in use. Record review of the facility's policy and procedure titled Respiratory Policies and Procedures dated June 1, 2006, reflected replace entire set-up every seven days. Date and store in treatment bag when not in use. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure titled Fundamentals of Infection Control Precautions (undated) reflected A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions, Hand Hygiene, after removing gloves or aprons.