STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676155	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Courtyards at Pasadena	4048 Red Bluff Road Pasadena, TX 77503

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 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 and administering of all medications to meet the needs of each resident for two of six residents (Resident #37 and Resident #20) reviewed for pharmacy services. 1. The facility failed to ensure LVN B followed the manufacturer's instructions to prime the Humalog pen (Insulin Lispro) (Hormone) prior to dialing in the required amount of Insulin to be administered to Resident #37 on 05/12/26. 2. The facility failed to ensure RN A followed the manufacturer's instructions to prime the Humalog pen (Insulin Lispro) (Hormone) and the Liraglutide (Hormone) prior to dialing in the required amount of Insulin and Glucagon-like peptide-1 hormone to be administered to Resident #20 and failed to ensure RN A held the pen to Resident #20's skin the required amount of time to ensure complete administration of the Humalog on 05/12/26. These failures placed residents at risk of not receiving the full dosage of medication. Findings included: 1. Record review of Resident #37's, Face sheet, dated 05/14/26 reflected a [AGE] year-old female with an admission date of 05/02/26. Resident #37 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy). Record review of Resident #37's Physician's Order for May 2026, reflected, Insulin lispro insulin pen: 100 unit/ml; amt: 4 units; subcutaneous (under the skin) .Three times a Day before Meals. with a start date of 05/02/26. An observation on 05/12/26 at 11:22 a.m. revealed LVN B put on gloves and entered Resident #37's room to obtain a fingerstick blood sugar. The blood sugar reading was 153. LVN B returned to the medication cart and checked the computer to determine the amount of insulin was 4 units of Lispro insulin. LVN B retrieved the insulin pen from the medication cart and attached a needle and dialed in 4 units without priming (means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly) the pen to ensure all air was expelled. LVN B put on gloves and entered Resident #37's room and administered the insulin to Resident #37. During an interview on 05/12/2026 at 11:28 a.m. with LVN B she stated she was not aware she had to prime the Insulin pen. She stated she had not read the manufacturer's instructions on administration but stated going forward she would prime the pen each time. 2. Record review of Resident #20's, Face sheet, dated 05/14/26 reflected a [AGE] year-old male with an admission date of 03/24/26. Resident #20 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) Record review of Resident #20's Physician's Orders for May 2026, reflected, Insulin lispro insulin pen: 100 unit/ml; amt: 12 units; subcutaneous.before Meals. with a start date of 04/28/26. liraglutide pen injector; 0.6 mg/0.1 mL (18 mg/3 mL); amt: 0.6mg; subcutaneous.once a day, with a start date of 05/12/26. During an interview on 05/12/2026 at 10:16 a.m. Resident #20 stated he did not think the staff was injecting his insulin correctly because he could feel it running down his hip some of the time. He stated he had told the staff and the doctor. During an observation on 05/12/26 at 11:30 a.m. revealed RN A put on gloves and entered Resident #20's room to obtain a fingerstick blood sugar. The blood sugar reading was 112. RN A returned to the medication cart, reviewed the orders, and stated Resident #20 gets routine 12 units of Insulin Lispro (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and then additional sliding scale based on his blood sugar. She stated today he would only get his routine dosage of 12 units. She stated the MD had also just ordered another medication to assist with blood sugar control and she would have to go to the medication room to retrieve the Liraglutide pen. RN A returned to the medication cart, then pulled the resident's Humalog (lispro insulin) pen and attached needles to both the Humalog pen and the Liraglutide pen. She then dialed in 12 units on the Humalog pen and 0.6 mg on the Liraglutide pen without priming either pen. RN A then sanitized her hands, put on gloves and entered Resident #20's room. She injected the Humalog in the resident's right lower abdomen, pushed the dose administration button and immediately pulled the pen away from the skin revealing an undetermined amount of insulin running down the resident's abdomen. She then injected the liraglutide in the residents' left lower abdomen, holding the pen against the resident's skin for about 6 seconds. During an interview on 05/12/2026 at 11:40 a.m. with RN A she stated she was not aware she had to prime the insulin pens or the Liraglutide. She stated she did know she was supposed to hold the pen against the resident's skin for 6 seconds and stated she did not realize she had not done that with the Humalog and stated she did not see the insulin run out. She stated the risk was the resident was not getting the proper amount of insulin. She stated going forward she would prime the pens and make sure she was holding the pens against the skin the required amount of time. In an interview with the DON on 05/14/26 at 11:50 a.m. he stated the insulin pen was to be primed with 2 units before each injection to ensure the air was out of the pen and to determine it was working correctly. He stated failure to do so could result in the resident receiving too little medication which could result in ineffective treatments and uncontrolled blood sugars. He stated he had just started with the facility and was not sure what education the nursing staff had received but stated he had already began re-educating the nurses on the proper protocol for priming the insulin pens and the amount of time required to hold the pen against the skin to ensure proper medication administration. He stated in addition their pharmacy consult will do random checks and observation with the staff during their monthly review. Record review of the facility's reference material titled, Insulin Pen Quick Reference Guide, dated 2021, reflected, Humalog (lispro) U100 Kwikpen .Air shot before each use-2 units hold dose knob for 5 seconds.References: Manufacturer Full Prescribing information and/or instructions for use. Review of the manufacture instructions for Lispro obtained from https://www.lillyinsulinlispro.com/ searched on 02/28/26 reflected, .Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps. Review of the manufacturer's instructions for Liraglutide obtained from https// www.Saxenda(R) (liraglutide) injection 3mg on 05/16/26, reflected, . Attach a new needle.Prime (flow check) for a new pen. If it's the first use of a new pen, turn the selector to the flow-check symbol (two dots). Point the needle up and press/hold the dose button until the counter shows 0. Look for a drop at the needle tip. Repeat up to six times if needed; if no drop appears, change the needle and try again. Do not use the pen if a drop still doesn't appear. Set your prescribed dose. Turn the dose selector to the dose your clinician prescribed.Choose and a clean site.Wipe with an alcohol swab and let it air-dry. Rotate locations to give skin time to recover. Insert and inject. Hold the pen so you can see the dose counter. Insert the needle.Press and hold the dose button until the counter shows 0. Keep the needle under the skin for at least 6 seconds to help ensure the full dose is delivered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that: The facility dietary staff failed to ensure temperatures were taken of grilled cheese before serving to residents during lunch meal service on 5/12/26.The facility dietary staff failed to properly sanitize the thermometer while temping each food. The facility dietary staff failed to use proper hand hygiene during lunch service on 5/12/26The facility dietary staff failed to properly wear hair nets during lunch service on 5/12/26. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed and food cross contamination.Findings Include: An observation and interview with Dietary [NAME] G of lunch food service on 5/12/26 at 11:04 am revealed temperatures of food were taken by [NAME] G. Dietary [NAME] G stated they had no sanitizing wipes to wipe the thermometer because they had not come in. Dietary [NAME] G proceeded to grab two connected paper towels, held them under her left arm against her clothing, and put them on the counter. Dietary [NAME] G started taking temperatures by wiping the thermometer on the paper towel she had on the counter and temping each food. Dietary [NAME] G continued to wipe the thermometer with the same paper towel and after she temped the Salsbury steak she dropped the paper towel on the floor and picked it up and put it back on the counter. Dietary [NAME] G then wiped the thermometer with the paper towel and proceeded to put the thermometer into the mixed vegetable and took the temperature. An observation of dietary staff serving trays during lunch service on 5/12/26 at 11:13 a.m. reflected Dietary [NAME] G serving food on the trays and the Dietary Manager assisting on the other side with the food trays. The Dietary Manager was observed with her hair net only covering her ponytail and the hair on the sides of her head and back of her head was exposed. At 11:23 a.m. Dietary [NAME] G took her gloves off after putting the fresh cooked bread rolls in a tray and then put new gloves on without washing her hands. Dietary [NAME] G proceeded to push a cart with the gloves she had on and went to the freezer, returned with the same gloves and proceeded to butter the tray of bread she had gotten out of the oven and put them in another container with the same set of gloves. Once Dietary [NAME] G was finished with putting the bread rolls away she took her gloves off and washed her hands. Dietary [NAME] G then put on some new gloves, got a loaf of bread out to make a grilled cheese, took the gloves off, and did not wash her hands. Dietary [NAME] G put on new gloves, rolled the cart she had gotten from the back and got serving spoons to put in the food trays. At 11:33 a.m. Dietary [NAME] G had discarded her gloves, put new gloves on without washing her hands and made 2 grilled cheese sandwiches. Once the grilled cheese sandwiches were done, Dietary [NAME] G put them to the side and never temped them. At 11:39 a.m. the Dietary Manager was observed washing her hands, she then went to where the serving trays were, picked up some trash on the counters, picked up the lid to the trashcan to throw the trash away and went back to the trays and touched them with her unwashed hands. An interview with Dietary [NAME] G on 05/12/2026 at 1:06 p.m. revealed she realized she had forgotten to wash her hands between glove changes during food service. Dietary [NAME] G stated glove changes should have been done as much as possible and when changing tasks. Dietary [NAME] G stated she was supposed to wash her hands after every glove change. Dietary [NAME] G stated it was not okay to use a paper towel instead of sanitizing wipes to clean the thermometer after each temp but reiterated the facility had not received their shipment of sanitizing wipes. Dietary [NAME] G stated using paper towels had not properly sanitized the thermometer and could have caused cross contamination of bacteria. Dietary [NAME] G stated she should not have held the paper towel under her arm against her clothing because it could cause cross contamination and illness for residents. Dietary [NAME] G stated the expectation for temperatures of food was all foods should have been temped. Dietary [NAME] G stated she had not temped the grilled cheese and should have. Dietary (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] G stated if food was not cooked to the right temperature it could have made residents sick and the only way to know if food was at the right temperature was to actually take the temperature of the food. An interview with the Dietary Manager on 05/12/2026 at 1:11 p.m. revealed the expectation for glove changes with kitchen staff was every time staff took gloves off, they needed to wash their hands with soap and water. The Dietary Manager stated her touching the trashcan lid and food trays was unsanitary and could have caused cross contamination. The Dietary Manager stated Dietary [NAME] G should not have used paper towels to wipe the thermometer between temps and she should have used the sanitizing wipes. The Dietary Manager stated the facility had a whole box of sanitizing wipes and they were stored in her office. The Dietary Manager stated she was unsure of the reason Dietary [NAME] G stated they had not had any wipes. The Dietary Manager stated the risk to the residents of not properly sanitizing the thermometer after every food temp was cross contamination. The Dietary Manager stated the risk of using a paper towel that was touching the cook's clothing to wipe the thermometer would have been bacteria from the cook's clothing could have gotten in the food. The Dietary Manager stated all foods made in the kitchen should have been temped and any alternatives items offered to the residents outside of the daily menu should have been temped as well to include the grilled cheeses. The Dietary Manager stated the risk of not temping all food was illness from undercooked food or food could have been too cold or too hot. The Dietary Manager stated hair nets should have covered the whole head and stated she fixed her net later. The Dietary Manager stated the risk to the residents of kitchen staff not wearing hair nets in the kitchen could have been hair in the food served to them. An interview with the Administrator on 05/14/2026 at 12:05 p.m. revealed all dietary staff should wear hair nets and it should have been covering all their hair not just portions. The Administrator stated the risk to the residents of staff not wearing hair nets correctly would have been hair falling in their food. The Administrator stated every time dietary staff changed their gloves, they should wash their hands between each glove change and the risk to the resident of improper hand hygiene in the kitchen was cross contamination. The Administrator stated all food served in the kitchen should have been temped before serving and the risk to the resident of not temping all food was the residents could have received food at an unsafe temp and food could not have been fully cooked. The Administrator stated dietary staff should not have used paper towels that touched any part of the cook's clothing to clean the thermometer, sanitizing wipes should have been used between each food temperature. The Administrator stated the risk to the resident of not appropriately sanitizing the thermometer was cross contamination. Review of the facility's Nutrition Policies and Procedures - Safe Food Temperatures revised 10/15/25 reflected .6. Hold hot foods at 135F or higher during meal service (on the tray line). Hold cold foods at 40F or lower during meal service (on the tray line). Review of the facility's Infection Prevention and Control Policies and Procedures - Hand Hygiene/Handwashing revised 9/2011 reflected .Hand hygiene/hand washing is done: before: .B. before eating or handling food.After:.H. after removal of medical/surgical or utility gloves. Review of the facility's Nutrition Policies and Procedures - Dress code revised 10/15/25 reflected .Dietary staff involved in food production adheres to the department dress code that includes: .6. Appropriate hair restraints (hair covers or nets, beard restraints) while involved in food production activities.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six of eight residents (Resident #100, Resident #37, Resident #20, Resident #34, Resident #5 and Resident #13) reviewed for infection control. 1. The facility failed to ensure LVN B performed hand hygiene after obtaining a FSBS for Resident #100 and Resident # 37 on 05/12/26 and failed to allow the glucometer the full 2 minutes of contact time to ensure adequate disinfection prior to using on Resident #37 on 05/12/26. 2. The facility failed to ensure RN A performed hand hygiene after sanitizing the glucometer, after glove removal after obtaining FSBS on Resident #20, and before retrieving Resident # 20's insulin pen on 05/12/26. 3. The facility failed to ensure CNA C and CNA D performed hand hygiene during incontinence care for Resident #34 on 05/13/26. 4. The facility failed to ensure CNA F and CNA E utilized Enhanced Barrier Precautions during incontinence and catheter care and failed to perform hand hygiene during incontinence care for Resident # 5 on 05/14/26. 5. The facility failed to ensure RN H wore appropriate PPE when performing supra-pubic catheter care for Resident #13 who was on Enhanced Barrier Precautions on 05/13/26. These failures could place residents at risk for infection and cross contamination. 1. Record review of Resident #100's, Face sheet, dated 05/14/26, reflected an [AGE] year-old female with an admission date of 11/09/24. Resident #100 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy). Record review of Resident #37's, Face sheet, dated 05/14/26, reflected a [AGE] year-old female with an admission date of 05/02/26. Resident #37 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy). During an observation on 05/12/26 at 11:18 a.m. LVN B was at the medication cart in front of Resident #100's room. LVN B put on gloves without performing hand hygiene, placed a glucometer, lancets, a few test strips and alcohol wipes on a tray and entered Resident #100's room to check her blood sugar. LVN B pricked the resident's finger and obtained a blood sugar reading of 168. LVN B returned to the medication cart, placed the tray containing the glucometer, used test strip and lancet on top of the medication cart. She removed her gloves and without performing hand hygiene opened the medication cart and retrieved the Resident's oral medication, Nateglinide (used to control blood sugar) 120 mg and popped one pill into a medication cup. LVN B re-entered the Resident's room and administered the medication. LVN B then left the room and without performing hand hygiene pushed the cart to Resident #37's room. LVN B then put on gloves, disposed of the used lancet and test strips and removed a germicidal wipe with a kill time of 2 minutes and wiped down the glucometer and the tray. LVN B then changed her gloves without performing hand hygiene she placed the glucometer on a tray, with some lancets, test strips and alcohol wipes and entered Resident #37's room without waiting the full 2 minutes to disinfect the glucometer. LVN B pricked the resident's finger and obtained a fingerstick blood sugar with a reading of 153. LVN B then returned to the medication cart, removed her gloves and without performing hand hygiene checked the computer and retrieved the resident's insulin pen and dialed in 4 units. LVN B put on new gloves without performing hand hygiene and entered the resident's room and administered the insulin. During an interview on 05/12/26 at 11:28 a.m. LVN B stated she was supposed to perform hand hygiene every time she changed her gloves and stated she realized she had failed to do that. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she knew she was supposed to disinfect the glucometer between each resident use, but stated she was not sure what the contact time was for the germicidal wipe she had used. LVN B retrieved the germicidal wipe and verified the contact time for disinfecting was 2 minutes. She stated she had not waited for the full amount of time needed to ensure the glucometer was properly disinfected. She stated the risk of these failures was the spread of infections and blood borne pathogens. 2. Record review of Resident #20's, Face sheet, dated 05/14/26, reflected a [AGE] year-old male with an admission date of 03/24/26. Resident #20 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy). During an observation on 05/12/26 at 11:30 a.m. RN A was at the medication cart in front of Resident #20's room. RN A put on gloves and retrieved a germicidal wipe and sanitized the glucometer and placed it on a tray with test strips, lancets and alcohol wipes. RN A then removed her gloves and put on new gloves without performing hand hygiene and entered Resident #20's room to obtain a fingerstick blood sugar. The blood sugar reading was 112. RN A returned to the medication cart, removed her gloves and without performing hand hygiene she checked the computer for the resident's insulin orders. She stated the MD had also just ordered another medication to assist with blood sugar control and she would have to go to the medication room to retrieve the Liraglutide (used to improve blood sugar) pen. RN A returned to the medication cart, and without performing hand hygiene, pulled the resident's Humalog (lispro insulin) pen and attached needles to both the Humalog pen and the Liraglutide pen. She then dialed in 12 units on the Humalog pen and 0.6 mg on the Liraglutide pen. RN A then sanitized her hands, put on gloves and entered Resident #20's room and administered both injections. RN A returned to the medication cart, removed her gloves and performed hand hygiene. During an interview on 05/12/2026 at 11:40 a.m. with RN A she stated she should have performed hand hygiene after sanitizing the glucometer and immediately after she had obtained the fingerstick blood sugar and after she had returned to the medication cart. She stated she just forgot. She stated the risk was the spread of infections. 3. Record review of Resident #34's, Face sheet, dated 05/14/26, reflected a [AGE] year-old female with an admission date of 03/25/24. Resident #34 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) and congestive heart failure (heart is too weak and stiff to pump). During an observation on 05/13/26 at 1:20 p.m. CNA C and CNA D entered Resident #34's room to provide incontinence care. Both staff performed hand hygiene and put on gloves and unfastened the residents' brief. CNA D raised up the resident's belly folds, wiped under her belly folds, and then wiped front to back changing the wipes with each wipe. Both staff then rolled resident onto her side. CNA C then wiped front to back, cleaning a small amount of bowel movement. CNA C then placed a clean brief under the resident without changing gloves or performing hand hygiene. CNA D then assisted with rolling resident back onto her back without first changing her gloves and performing hand hygiene. Both staff adjusted the brief, the sheets, repositioned her in bed all while still wearing dirty gloves. After completion of care both staff removed gloves and performed hand hygiene. During an interview on 05/13/26 at 1:35 p.m. CNAs D and C stated they were to do hand hygiene before care and after. After thinking for a bit, they both stated they should have done hand hygiene when they went from dirty to clean. CNA C stated this was her 2nd day and was training with CNA D. CNA D stated the facility did classroom training with them on incontinent care and stated she had gone to the training. She stated not doing hand hygiene properly could spread infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #5's, Face sheet, dated 05/14/26, reflected an [AGE] year-old female with an admission date of 03/25/24. Resident #5 had a diagnosis which included fracture of the left femur (thigh bone) and congestive heart failure (heart is too weak and stiff to pump). During an observation on 05/14/26 at 10:00 a.m. revealed an Enhanced Barrier Precautions sign posted on Resident #5's door. CNA E and CNA F were observed entering Resident #5's room to provide catheter and incontinence care. Both staff washed their hands. CNA F opened Resident #5's top chest of drawers to retrieve gloves and wipes. Isolation gowns were observed in the drawer next to the gloves and wipes. CNA F retrieved gloves and put on 2 pairs of gloves, one on top of the other, and handed CNA E gloves. Neither staff put on a gown. Both staff repositioned the resident in the bed and then CNA F unfastened the resident's brief and provided peri care and catheter care, wiping down each groin and down the middle changing wipes with each stroke. CNA F then cleaned down the catheter tubing away from the resident's body. CNA F then removed the first pair of gloves and assisted to roll resident onto her side, revealing she had a small bowel movement. CNA E then wiped the resident's anal area from front to back, changed her gloves and put on clean gloves without performing hand hygiene and placed the clean brief under the resident and both staff rolled the resident back onto her back and fastened the brief. Both staff then removed their gloves but did not perform hand hygiene, and repositioned the resident, covered her up and attached the call light. Both staff then washed their hands in the resident's bathroom sink. During an interview on 05/14/26 at 10:10 a.m. CNA E and CNA F stated they knew Resident #5 was on enhanced barrier precautions, but stated they just forgot to put the gown on. They stated they were supposed to do hand hygiene before and after and then stated they should have used hand sanitizer between glove changes. They stated the risk of not performing hand hygiene correctly was the spread of infection. 5. Record review of Resident #13's admission MDS assessment dated [DATE] reflected Resident #13 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included hypertension (elevated blood pressure), Benign Prostatic Hyperplasia (a common, noncancerous enlargement of the prostate gland that affects many men over 50). Record review of Resident #13's Care Plan dated 03/26/26, reflected the following: Focus: [Resident #13] a requires an indwelling urinary catheter related to obstructive uropathy (blockage or obstruction in the urinary tract). Goal: Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma During an observation on 05/13/26 at 10:31 a.m., There was signage on Resident #13 which indicated he was on Enhanced Barrier Precautions. RN H entered Resident#13's room to perform suprapubic catheter (a thin, flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine) care. RN H washed her hands, and put on gloves but no gown. RN H uncovered Resident#13, exposed the SPC catheter exit site, and removed the old dressing. RN H changed her gloves but did not perform hand hygiene. She cleaned the catheter exit site with gauze soaked with normal saline, changed her gloves again, but did not perform hand hygiene, and applied a clean split gauze dressing on the site. RN H then covered Resident#13, disposed of the trash, removed her gloves, washed her hands, and exited the room. During an interview on 02/10/26 at 10:47 a.m., RN H stated she did not put the gown on, because she forgot. RN H stated that residents' Suprapubic catheter care was a form of high contact which required Resident #13 to be on Enhanced Barrier Precautions and required the use of a gown and (continued on next page)

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	676155	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Courtyards at Pasadena	4048 Red Bluff Road Pasadena, TX 77503

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves during care. She said the risk of not wearing appropriate PPE was increased risk of infection and possible cross contamination among the residents. During an Interview with the DON on 05/14/26 at 07:25 a.m., he stated any resident that required Enhanced Barrier Precautions had signage on the resident's door, and for any high contact activity which included transfer, peri care, and any medical device care, the staff had to wear gown and gloves. He stated he and the unit managers were responsible for training staff in infection control. The DON further stated training for Enhanced Barrier Precautions was done on hire, on monthly staff meeting, and as needed. The DON stated they used Enhanced Barrier precautions to prevent infection to high-risk residents. During a follow-up interview with the DON on 05/14/26 at 11:50 a.m. he stated the staff had been trained on the proper sanitizing of glucometers and when to perform hand hygiene during glucose monitoring. He stated the staff were to use the EPA approved Sani-wipes to clean the glucometers and ensure they were to wait the required contact time to ensure the glucometer was disinfected. He stated staff were to always perform hand hygiene after any procedure, before moving to the next procedure. He stated the risk of not following the proper procedures was cross contamination and potential for the spread of blood borne pathogens. He stated staff were to change their gloves and perform hand hygiene after they performed incontinence care and before applying the clean brief and always before going from dirty to clean. He stated by not following proper hand hygiene it placed residents at risk of urinary tract infections. He stated they had just completed staff training on infection control and enhanced barrier precautions on 04/30/26. He stated he and the unit managers will continue to train and make rounds to ensure the staff were following the correct procedures. Review of the facility policy titled Infection prevention and control policies and procedures, dated 03/15/2023 revealed Subject: Transmission-Based/standard Precautions, and enhanced barrier precaution .1. Enhanced Barrier Precautions (EBP) – Expand the use of PPE (Gown and gloves) during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. B. Enhanced-Based Precautions are implemented during the following high-contact resident care: . 7) Device care or use: Central line, urinary catheter, feeding tube. Record review of the facility's policy titled, Disinfection of Patient/Resident Care Equipment: Blood Glucose Meters, dated May 2023, reflected, .Blood glucose meters and point of care testing devices are at high risk of becoming contaminated with bloodborne pathogens.The facility uses a two-step cleaning and disinfecting procedure between every patient/resident use.Use an EPA disinfectant wipe.to remove any visible contaminants, soil or other debris.Use a second EPA wipe disinfectant wipe to disinfect the device surfaces, ensuring adequate contact time.Contact time is the total time needed for the disinfectant solution to remain wet on the surface to achieve disinfection of all the stated efficacy kill claims. The contact time requirements can be located on the product label. Record review of the facility's policy titled, Hand Hygiene/Hand Washing, dated September 2011, reflected, .Hand Hygiene/hand washing is done: .Before Patient/resident contact.After.contact with soiled or contaminated articles, such as articles that are contaminated with body fluids.After patient/resident contact.After removal of medical/surgical or utility gloves.

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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 that included measurable objectives and time frames to meet residents' medical, nursing, mental and psychosocial needs, for 1 (Resident #129) of 8 residents reviewed for comprehensive care plans. The facility failed to develop and implement a comprehensive person-centered care plan to address Resident #129's oxygen therapy. This failure could affect residents by placing them at risk for not receiving necessary care and services. Record review of Resident #129's Quarterly MDS assessment, dated 04/23/26 reflected a [AGE] year-old female with an original admission date of 11/22/23 and readmission date of 05/08/26. Pertinent diagnoses included hypertension (elevated blood pressure), diabetes mellitus type 2 (high blood sugar), Non-Alzheimer's Dementia (a group of brain disorders causing cognitive, behavioral, and language decline, often affecting individuals under 65), and Non-Traumatic Brain Dysfunction (damage to the brain caused by internal factors rather than external physical force). Resident#129 had a BIMS of 12 indicating moderate cognitive impairment. Section O-C1 reflected resident did require oxygen while residing at the facility. Record review of Resident #129's care plan dated 04/09/26 did not reveal oxygen therapy as a care area and/or problem. Record review of Resident #129's Order Summary Report dated 06/30/25, reflected O2 (oxygen) at 4 liters per minute via nasal cannula. EQUIPMENT Oxygen: Change O2 tubing/nasal cannula/mask/humidification system weekly. Once A Day on Thursday. Observation of Resident #129 in her room on 05/12/26 at 10:12 a.m. revealed resident was asleep and had oxygen on via nasal cannula. The concentrator (a medical device that pulls in ambient air, filters out nitrogen, and delivers purified oxygen (typically 90%-95% pure)) was set at 4 liters per minute. The nasal cannula tubing was not dated, the solution bottle on the concentrator was dated 04/28/26. In an interview on 05/14/26 at 07:15 a.m. with the MDS Nurse stated he was responsible for the care plans, initiation and update. He stated the charge nurses too had the responsibility to update the care plans any time there was a new order or change in resident's condition. He stated the care plans updates were done quarterly during the IDT meeting. When asked how this missing care plan could potentially affect resident care, he stated staff would not know how to care for the resident. Interview on 05/14/26 at 07:20 a.m. ADON L stated she was going in the last three months through the residents' care plans and updating, and she did not get to Resident#129's care plan yet. She stated she would like for Resident#129's oxygen therapy to have been care planned as ordered and those were her expectations, so all the direct care staff for the resident would know how to handle the oxygen therapy care. Interview on 05/14/26 at 07:25 a.m. with DON stated the expectation was to complete an audit of the residents' care plans by the MDS nurse, and the charge nurses, to make sure they were up to date. He stated residents' oxygen therapy should be care planned according to the doctor's orders. The DON stated the risk to residents the staff would not know the oxygen therapy was on if not care planned. Review of facility policy titled Care plan process, person-centered care, dated 05/05/2023, revealed, The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centeredcare of the resident that meet professional standards of quality care.6. The Interdisciplinary Team (IDT) will review for effectiveness and revise the person-centered care plan after each assessment. This includes both the comprehensive and quarterly assessments.

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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 provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #86) of 8 residents reviewed for ADLs. The facility failed to ensure Resident #86 had her fingernails cleaned and trimmed on 05/12/26. These failures could place residents who were dependent on staff for ADL care at risk for infections, and a decreased quality of life.Record review of Resident #86's quarterly MDS assessment, dated 04/08/26, reflected a [AGE] year-old female with an admission date of 09/22/25, and readmission on [DATE]. Resident #86 had active diagnoses which included hypertension (elevated blood pressure), type 2 diabetes mellitus (elevated blood sugar), cerebral vascular accident (stroke) hemiplegia (partial paralysis on one side of the body), and heart failure. Resident#86 had a BIMS score of 14/15 indicating intact cognition. Further review revealed she required partial/moderate assistance for personal hygiene. Staff assessment listed her as moderately cognitively impaired. Record review of Resident #86's care plan revised on 04/22/26 reflected, ADLS function status/rehabilitation potential .[Resident #86] .partial/moderate assistance .Interventions .encourage and provide positive feedback for any effort . Observation and interview on 05/12/26 at 10:19 AM revealed Resident#86 was lying in bed quietly, she had long nails on both hands, they were approximately 0.4 cm in length extending from the tip of her fingers. The nails were discolored tan and the underside, and the nail beds had dark brown colored residue. Resident #86 stated she wanted her fingernails trimmed and cleaned. In an observation and interview on 05/12/26 at 1:54 PM, CNA I looked at Resident#86's fingernails and stated, they needed to be trimmed and cleaned. She stated that Nurses and CNAs were responsible for cleaning and trimming residents' fingernails. She stated that for residents with diabetes, Nurses were responsible for trimming fingernails as needed. CNA I stated the risks of long, dirty fingernails included increased risk of infection and decreased quality of life. In an interview on 05/14/26 at 07:20 AM. ADON L stated nail care on all the residents should be done during the shower days, and as needed. She stated CNAs were responsible unless the residents were diabetic, and then the nurses were responsible. She stated the risk would be potential for infection and skin integrity problems. During an interview on 05/14/26 at 07:25 AM, the DON stated CNAs were responsible for checking on residents and providing appropriate care and grooming every shift and as needed. He stated the nurses in charge for the Halls were also responsible for checking on residents to ensure their needs were met. The DON stated not providing appropriate care, and grooming placed residents at risk of infection, skin breakdown, and dignity issues. Record review of the facility's policy titled, Activities of daily living, optimal function with revise dated May 5, 2023, reflected, The Facility provides care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene.

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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 residents who needed respiratory care were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 4 (Resident #129) residents reviewed for respiratory care. The facility failed to ensure Resident #129's oxygen tubing was dated, and the humidifier bottle changed weekly per MD order on 05/12/26. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care.Record review of Resident #129's Quarterly MDS assessment, dated 04/23/26 reflected a [AGE] year-old female with an original admission date of 11/22/23 and readmission date of 05/08/26. Pertinent diagnoses included hypertension (elevated blood pressure), diabetes mellitus type 2 (high blood sugar), Non-Alzheimer's Dementia (a group of brain disorders causing cognitive, behavioral, and language decline, often affecting individuals under 65), and Non-Traumatic Brain Dysfunction (damage to the brain caused by internal factors rather than external physical force). Resident#129 had a BIMS of 12 indicating moderate cognitive impairment. Section O-C1 reflected resident did require oxygen while residing at the facility. Record review of Resident #129's care plan dated 04/09/26 reflected the oxygen therapy for the Resident had not been care planned. Record review of Resident #129's Order Summary Report dated 06/30/25, reflected O2 (oxygen) at 4 liters per minute via nasal cannula. EQUIPMENT Oxygen: Change O2 tubing/nasal cannula/mask/humidification system weekly. Once A Day on Thursday. Observation of Resident #129 in her room on 05/12/26 at 10:12 a.m. revealed resident was asleep and had oxygen on via nasal cannula. The concentrator was set at 4 liters per minute. The nasal cannula tubing was not dated, the solution bottle (for an oxygen concentrator is a humidifier bottle (or bubbler) used to add moisture to the oxygen, preventing your nose and throat from drying out) on the concentrator was dated 04/28/26. In an observation and interview on 05/12/26 at 1:08 p.m. LVN K looked at Resident #129's oxygen tubing and stated it was not dated, and looked at the bottle solution on the concentrator, and stated she would change the bottle to a new one, because that one had a 04/28/26 date on it. LVN K stated it was the responsibility of the nurses to check the oxygen tubing every shift and make sure they were up to date, and it was the responsibility of the night shift nurses to change the tubing and the concentrator solution bottle weekly. She stated not changing the concentrator's tubing and solution bottle as ordered could cause development of infection, and the solution may not be effective and cause dry nose and throat for the resident. In an interview with the DON on 05/14/26 at 07:25 a.m. the DON stated, his expectations were for the nurses to change the oxygen therapy tubing weekly and as needed, label with the date, and for the solution bottle to be changed weekly and if it became emptied during the week period and also dated. He stated the risk to residents not getting oxygen therapy properly, could be drying of the nasal cavity, and a source of infection if it stayed longer than one week. Record review of facility policy titled Respiratory policies and procedures revised April 01, 2022 reflected Subject: Oxygen Therapy general policy.15. Label tubing and humidifier with date, time, and RC practitioner initials.