

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Sonterra Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18514 Sonterra Place San Antonio, TX 78258	
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 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, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 8 residents (Resident #3, #4, and #14) reviewed for care plans. 1. The facility failed to ensure Resident #4's comprehensive care plan was updated to reflect that resident was no longer taking cephalexin. 2. The facility failed to ensure Resident #3's comprehensive care plan was updated with his current ADLs. 3. The facility failed to ensure Resident #14's comprehensive care plan included that she had contractures in her legs. These failures could place residents at risk for not having their needs and preferences met. The findings were: 1. Record review of Resident #4's face sheet reflected an [AGE] year-old female initially admitted on [DATE] and re-admitted [DATE]. Her diagnoses included: urinary tract infection. Record review of Resident #4's quarterly MDS assessment, dated 06/19/2026 revealed a BIMS score of 6 out of 15, which indicated a severe cognitive impairment. Record review of Resident #4's care plan, undated, reflected a focus [Resident #4] is at risk for infection r/t reoccurring UTI, revised 08/07/2025, with an intervention Cephalexin Oral Tablet 250 MG, dated 08/07/2025. Record review of Resident #4's order summary report, dated 07/07/2026, did not reflect an order for Cephalexin Oral Tablet 250 MG. During an interview on 07/08/2026 at 08:32 AM, Resident #4 revealed she received her medications on time and had no concerns with her care at this time. She revealed she was currently fine. 2. Record review of Resident #3's face sheet, dated 07/08/2026, reflected a [AGE] year-old male initially admitted on [DATE] and re-admitted [DATE]. His diagnoses included: cognitive communication deficit (condition when an individual struggles with the mental processes that support communication), unsteadiness on feet, lack of coordination, hemiplegia and hemiparesis following cerebral infarction (blood flow to part of the brain is blocked) affecting left dominant side (complete paralysis of one side of the body). Record review of Resident #3's (type not selected) MDS assessment, dated 06/18/2026 revealed a BIMS score of 12 out of 15, which indicated a moderate cognitive impairment. It further reflected Resident #3 required substantial/maximal assistance for toileting hygiene, substantial/maximal assistance for upper body dressing, and substantial/maximal assistance for putting on/taking off footwear. Record review of Resident #3's care plan, undated, reflected a focus [Resident #3] ADL Self Care Performance Deficit r/t CEREBRAL INFARCTION DUE TO THROMBOSIS OF UNSPECIFIED MIDDLE CEREBRAL ARTERY (type of cerebral infarction in which a blood clot has formed inside the middle cerebral artery), HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT DOMINANT SIDE, revised 06/08/2026, with intervention Toileting Hygiene: supervision or touching (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676158
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist, Upper Body Dressing: supervision, Putting on/taking off footwear: supervision., revised 06/09/2026. During an interview on 07/08/2026 at 12:41 PM, Resident #3 revealed he needed help with using the restroom and basic care and the facility was helping him with his needs. 3. Record review of Resident #14's face sheet, dated 07/07/2026, reflected a [AGE] year-old female initially admitted on [DATE] and re-admitted [DATE]. Her diagnoses included: urinary tract infection. Record review of Resident #14's admission MDS assessment, dated 06/10/2026 revealed a BIMS score of 15 out of 15, which indicated intact cognition. Record review of Resident #14's care plan, undated, did not reflect that Resident #14 had contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility) of the legs. During an interview and observation on 07/10/2026 at 08:40AM, Resident #14 was lying in bed under the covers (unable to assess her body that was covered). She revealed she was not in pain, and the facility managed her pain appropriately. She revealed she received her medications in a timely manner and had no complaints about her care at the facility. During an interview on 07/10/2026 at 12:27PM, CNA A and LVN B revealed Resident #14 had contractures of her legs, so they had to make sure she was comfortable. LVN B further revealed that because of Resident #14's contractures, Resident #14's pain medications had to be administered before they helped assist Resident #14 to minimize her pain. They revealed this should be care planned, but they did not have to refer to the care plan because they were given information about resident care verbally. LVN B revealed Resident #4 was on cephalixin multiple times, but she was recently taken off her antibiotic, date unknown. LVN B further revealed the nurses administered medication per doctor's orders and not per Resident #4's care plan. CNA A revealed Resident #3 needed maximal assist with upper body dressing, toileting, and putting on his shoes. CNA A revealed it was important for Resident #3 to get the assistance he needed because it would be neglectful behavior if the nursing staff was not giving residents the assistance they needed. During an interview on 07/10/2026 at 12:55 PM, LPN C revealed she was an MDS nurse and oversaw care plans being updated. She revealed Resident #14 had contractures, it was not in her care plan, and it should be updated in the care plan, so the staff knew how to turn her, reposition her, and give her appropriate care. LPN C revealed Resident #4 was not taking Cephalixin anymore per doctor's orders and it should be deleted from Resident #4's care plan. She revealed when Resident #4 was re-admitted, she was no longer taking Cephalixin. LPN C revealed Resident #3's ADLs were not updated to reflect how much assistance he needed for some of his ADLs. She revealed it was important to have his ADLs updated so the staff provided proper care. She revealed if proper care was not provided, then Resident #3 would not have his needs met. During an interview on 07/10/2026 at 01:39 PM, the DON revealed Resident #14's contractures should be care planned because it affected the care that the facility was giving the resident. The DON revealed if Resident #4's doctor's orders did not reflect Cephalixin, then it should not be reflected in her care plan because it would not accurately reflect her care. She further revealed Resident #3's ADLs should be updated to reflect the care that the facility was giving to the resident. She further revealed that the staff knew how to care for Resident #3 but the care plan should be updated to refer to If any new staff member was working or if anyone had questions about residents' care. During an interview on 07/10/2026 at 02:13PM, the ADM revealed his expectations for residents' care plans were that they should be updated to reflect resident care. Record review of the facility's policy Comprehensive Person-Centered Care Planning, last revised 4.2025, reflected It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. The facility failed to ensure the ice scoop was stored outside of the kitchen's ice machine.2. The facility failed to write a correct temperature for the reach-in refrigerator next to the food preparation areas for 07/01/2026 evening temperature.3. The facility failed to throw out cabbage that had black substance on 07/07/2026.4. The facility failed to keep a personal beverage away from storage of disposable plates.5. The facility failed to ensure Dietary Aide F was not wearing a necklace and small hoop earrings while preparing food for 07/08/2026 lunch. These failures could place residents at risk for food borne illness.The findings were: During an interview, record review, and kitchen observation on 07/07/2026 at 08:58 AM, there was an ice scoop hanging on a hook on the right-hand side of the interior of the ice machine. The CDM stated that this was okay because the ice machine was made with the hook inside for hanging the ice scoop. Record review of the Refrigerator Temperature Log for July 2026 for the reach-in refrigerator next to a food preparation area reflected 42 degrees Fahrenheit for 07/01/2026 evening temperature, signed by the CDM. The CDM revealed she wrote that temperature and did corrective action because 42 degrees was not a safe temperature for the refrigerator. She revealed that the plug had been out, unsure of how long, but the morning temperature for 07/01/2026 was at 34 degrees Fahrenheit so she did not have to throw the food out because the temperature went below 41 degrees Fahrenheit after corrective action was taken. She revealed she forgot to document the new temperature or the action taken on the refrigerator temperature log. She revealed it was important to document the new temperature that was within range, so the kitchen staff knew the refrigerator was staying at temperature, and the foods did not spoil. There was one cabbage with black substance on it stored in a cardboard box, on a shelf beneath a food preparation tabletop and about 6 inches above the floor. There was a personal beverage in front of a stack of disposable plates. The CDM revealed this beverage should not be in this area, and she threw away the disposable plates that were exposed to the personal beverage. During an interview and observation on 07/08/2026 at 11:26 AM, Dietary Aide F was wearing a chained necklace that was laying on top of her shirt and small hoop earrings while preparing food for 07/08/2026 lunch. The CDM revealed this was okay as long as the jewelry was not long. During an interview and observation on 07/09/2026 at 04:25 PM, Dishwasher D revealed he worked as a dietary aide, cook, or wherever he was needed in the kitchen. He revealed it was important to label food products with their discard dates to prevent sickness from bacteria or contamination. The CDM revealed she did not know what black substance was on the cabbage, but she threw it out so that no resident could get sick. During an interview on 07/10/2026 at 03:52 PM, Dietary Aide E revealed the kitchen staff was not allowed to store personal beverages in the kitchen or in the storage area because it could cause contamination. He revealed if a food had black substance on it, he would throw it out because the food may have mold or be bad. During an interview on 07/10/2026 at 02:13PM, the ADM revealed his expectation was for the kitchen to follow the best practice. Record review of the facility's policy Infection Control Policy/Procedure for Dietary Services reflected It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness . 1. Director of Food Service Responsibilities . B, Keep adequate records of temperature of refrigeration . G. Maintain storage of perishable foods at 41 degrees Fahrenheit or below3. Personnel, A. Employee Health, 1) Personnel will comply with all health policies, 4. Personal Hygiene . B. No long/drooping jewelry (sp)5. Food Storage . E. Fruits, vegetables, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dairy products, meat, and poultry must be stored at temperatures between 33 degrees to 45 degrees Fahrenheit .6. Proper Food Handling . X. Ice machines must be of a type that eliminates contamination during ice manufacture, storage and dispensing Record review of the FDA Food Code 2022, U.S. Department of H&HS, reflected, 2-303 Jewelry 2-303.11 Prohibition. Except for a plain ring such as a wedding band, while preparing FOOD, FOOD EMPLOYEES may not wear jewelry including medical information jewelry on their arms and hands. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 Guide 3-B .43. IN-use utensils; properly stored . Ice scoops may be stored handles up in an ice bin except for an ice machine.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for two (2) of two (2) residents (Resident #23 and Resident # 116) reviewed for hospice services. 1. The facility failed to maintain the current hospice plan of care to ensure Resident #23 received adequate end-of-life care. 2. The facility failed to maintain the current hospice plan of care to ensure Resident #116 received adequate end-of-life care. These failures could place residents at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: 1. Record review of Resident #23's Face Sheet, dated 07/09/2026, revealed Resident #23 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #23 was noted to be a 90-years-old male. Record review of Resident #23's Medical Diagnosis, undated and accessed 07/09/2026 at 10:19 a.m., revealed diagnoses included acute and chronic respiratory failure with hypoxia (a condition in which the lungs cannot adequately oxygenate the blood leading to low oxygen levels), tinea unguis (a fungal infection of the nails), and bronchiectasis (a persistent lung condition in which the airways become permanently widened, thickened, and damaged, impairing mucus clearance and leading to frequent infections). Record review of Resident #23's Quarterly MDS assessment, dated 04/30/2026, revealed Resident #23 had a BIMS of 07, which indicated severe cognitive impairment. He had an active diagnosis of respiratory failure. Record review of Resident #23's Care Plan Report, undated and accessed 07/09/2026 at 12:38 p.m., revealed Resident #23 had a focus of [Resident #23] has a terminal prognosis r/t bronchiectasis **Resident admitted to [Hospice N name and telephone number] under dx: Bronchiectasis, date initiated 12/17/2024, and created and revised on 12/23/2024. Record review of Resident #23's Order Summary Report, dated 07/09/2026 with active orders as of 07/09/2026, revealed the following order:- Admit to [Hospice N] Phone: [Hospice N phone number] Dx: Bronchiectasis No Lab, x-rays [a photographic image made by electromagnetic radiation to look at bones and joints] without hospice approval. Notify for ER send outs., noted as active with order date of 06/17/2025. No end date noted. Record review of Resident #23's physical hospice binder on 07/10/2025 at 10:55 a.m., revealed:- Out-Of-Hospital Do-Not Resuscitate order, signed 12/16/2024, - a binder checklist including 3071 Form, 3074 Form- For Current Cert, Plan of Care with Dates/Frequency, and DNR signed 06/18/2025 and 08/12/2025 with all four items checked off for each date, - a second binder checklist including 3071 Form, 3074 Form, Care Plan- From Hospice, Recert Forms, First 60 days- Recert, and 30 Days- Recert Cont with 3071 Form, Care Plan- From Hospice, and Recert Forms checked off and note 3074- updated (6/13/25) Texted Rep VA- per hospice 3074 to not be updated after admissions exp 8/12/25 with signature, - Form 3071 Texas Medicaid Hospice Program Individual Election/Cancellation/Update form, signed on 12/16/2024,- Form 3074 Texas Medicaid Hospice Program Physician Certification of Terminal Illness form, signed on 12/16/2024,- Hospice Plan of Care for certification period from 06/14/2025 to 08/12/2025,- Nursing Facility Record Documentation with ii. Certification/Plan of Care .2. Hospice care plan,- Communicating with [Hospice N] document, with regular business hours and phone numbers,- a second copy of Out-Of-Hospital Do-Not Resuscitate order, signed 12/16/2024,- Hospice Plan of Care for certification period from 03/16/2025 (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 06/13/2025,- Hospice Plan of Care for certification period from 12/16/2024 to 03/15/2025,- Hospice Certification of Terminal Illness [Hospice N] for certification period 12/16/2024-03/15/2025, - Patient Face Sheet [Hospice N], dated 12/16/2024,- Medication Profile [Hospice N], printed on 12/18/2024, - Chaplain Care Plan, printed on 12/18/2024, - Aide Care Plan, printed on 12/18/2024, - Interdisciplinary Team Care Plan, printed on 12/18/2024, - Medical Social Worker Care Plan, printed on 12/18/2024, and- Skilled Nursing Care Plan, printed on 12/18/2024. The binder did not include a plan of care for the current certification period. Record review of Resident #23's electronic medical record on 07/10/2026 at 12:22 p.m., revealed two (2) hospice visit notes (both dated as effective 06/10/2026) and two (2) hospice orders (one dated as effective 05/12/2026 and the second on 07/07/2026) uploaded to the record within the last three months. The documents did not include a hospice plan of care. During an observation and interview on 04/07/2026 at 10:50 a.m., Resident #23 was observed lying in bed. Resident #23 stated he had not had any concerns with communicating with his hospice team. During an interview on 07/10/2026 at 11:19 a.m., RN O stated she was Resident #23's hospice nurse. She stated she had only recently taken over as his nurse and did not usually provide hospice care to residents in nursing facilities. She stated she was unsure who was responsible for bringing the hospice's current care plan documentation. She stated she or the other members of the hospice team were possibly responsible. She stated she had not been contacted by the facility that the hospice plan of care was out of date. She stated she could bring a current hospice care plan document when she came to see Resident #23 later that day. During an observation and record review on 07/10/2026 at 02:20 p.m., RN O provided a current hospice care plan document. The document was dated 07/10/2026 with the benefit period noted to be from 06/09/2026 to 08/07/2026. Record review of facility Hospice Services Agreement, dated as agreement effective date and signed on 03/22/2017, for Hospice N, revealed:- 1. Definitions, 1.2. Clinical Record means an individual, comprehensive compilation of information established and maintained by Hospice for each patient receiving Services from Hospice. The Clinical Record contains (i) the initial and subsequent assessment; (ii) the Plan of Care; - 3. Coordination of Responsibilities .Hospice and Facility shall develop a process to exchange information between the IDG and Facility staff regarding development and updating of the POC and evaluation of care outcomes to ensure that each Hospice patient receives necessary and appropriate care and services. Each Party will designate one or more liaisons to facilitate cooperation and communication between the Parties to assure that individual and family needs are met .3.1. Development, Implementation and Modification of Plan of Care. When a Facility patient is admitted to the Hospice program, Hospice shall develop a POC. Hospice shall retain responsibility for directing the implementation of each POC. Hospice shall modify the POC at intervals required by federal and state regulation, taking into account changes in Hospice patient's condition and the effectiveness of pain management and symptom control. Facility and Hospice each shall designate a Registered Nurse responsible for coordinating the implementation of the POC for each Hospice patient.- 4. Provision of Hospice Services .4.1.3. For those Hospice patients receiving Hospice Inpatient Services from Facility as arranged by Hospice, Hospice shall provide Facility with a copy of each Hospice patient's POC and shall specify the Hospice Inpatient Services to be provided. 2. Record review of Resident #116's Face Sheet, dated 07/09/2026, revealed Resident #116 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #116 was noted to be a 78-years-old male. Record review of Resident #116's Medical Diagnosis, undated and accessed 07/09/2026 at 02:30 p.m., revealed diagnoses included encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke), acute bronchitis (inflammation of the bronchial tubes in the lungs), and Parkinson's disease (a disorder of (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the nervous system that affects movement, often including tremors) without dyskinesia (uncontrollable and involuntary movements). Record review of Resident #116's Quarterly MDS assessment, dated 05/25/2026, revealed Resident #116 had a BIMS of 11, which indicated moderate cognitive impairment. He had an active diagnosis of Parkinson's Disease. Record review of Resident #116's Care Plan Report, undated and accessed 07/09/2026 at 12:38 p.m., revealed Resident #116 had a focus of [Resident #116] is on hospice services r/t parkinsons [sic], date initiated, created, and revised 07/03/2026. Record review of Resident #116's Order Summary Report, dated 07/09/2026 with active orders as of 07/09/2026, revealed the following order:- Admit to [Hospice P] with DX of Parkinsons Disease ., noted as active with order date of 07/02/2026. No end date noted. Record review of Resident #116's physical hospice folder on 07/10/2025 at 10:55 a.m., revealed:- a document titled Facility and Hospice Delineation of Duties, dated 07/02/2026. The document included under Hospice Responsibilities, 3. The Hospice RN will coordinate and discuss changes in patient's POC with the Facility at least every 15 days. Under Facility Responsibilities, 1. The Facility will communicate with the Hospice: .b) clinical complications that suggest need to alter the POC; . - a document titled Palliative Care Form with the resident's diagnosis and areas marked where the attending physician should identify where the patient's response to the disease process or the end-of-life process may be unavoidable for the resident.- a document titled [Hospice P] INFORMATION FOR MEDICAL EXAMINER. - a document titled Facility Notification, signed 07/02/2026.- a sign-in sheet for [Hospice P] staff- an Out-Of-Hospital Do-Not Resuscitate order, signed 07/02/2026. - a Facility admission Contents document- a blank Volunteer Request Form. - a blank Medication Disposal form. - a blank Testimonial Authorization and Release form. - a blank Photograph Authorization and Release form.- a How does Immediate Advocacy help people with Medicare? document. The folder did not include a plan of care for the current certification period. Record review of Resident #116's electronic medical record on 07/10/2026 at 12:24 p.m., revealed two (2) hospice orders (one dated as effective 07/07/2026 and the second on 07/09/2026) and one [Hospice P] admission Orders (dated as effective 07/03/2026). The documents did not include a hospice plan of care. During an observation and resident representative interview on 04/08/2026 at 09:21 a.m., Resident #116 was observed sitting up in a wheelchair with his resident representative present. Resident #116's resident representative stated Resident #116 had just elected to be on hospice services. She denied having any concerns or problems with the facility communicating with the hospice. During an interview on 07/10/2026 at 11:19 a.m., RN Q stated she was Resident #116's hospice nurse. She stated she felt the facility had been very collaborative with the hospice team on his recent hospice admission. She stated Resident #116's family and his nurse were great at notifying her of any changes in Resident # 116's condition. She stated she was unsure if the facility had a copy of Resident #116's hospice care plan but stated the facility would typically have a copy. She stated she was unsure on who was responsible for providing the hospice care plan and did not know if it had been requested by the facility. Record review of facility Hospice Services Agreement, dated as agreement effective date 05/31/2019 and signed on 06/03/2019, for Hospice P, revealed:- 1. Definitions, 1.2. Clinical Record means an individual, comprehensive compilation of information established and maintained by Hospice for each patient receiving Services from Hospice. The Clinical Record contains (i) the initial and subsequent assessment; (ii) the Plan of Care; . - 3. Coordination of Responsibilities .Hospice and Facility shall develop a process to exchange information between the IDG and Facility staff regarding development and updating of the POC and evaluation of care outcomes to ensure that each Hospice patient receives necessary and appropriate care and services. Each Party will designate one or more liaisons to facilitate cooperation and communication between (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Parties to assure that individual and family needs are met .3.1. Development, Implementation and Modification of Plan of Care. When a Facility patient is admitted to the Hospice program, Hospice shall develop a POC. Hospice shall retain responsibility for directing the implementation of each POC. Hospice shall modify the POC at intervals required by federal and state regulation, taking into account changes in Hospice patient's condition and the effectiveness of pain management and symptom control. Facility and Hospice each shall designate a Registered Nurse responsible for coordinating the implementation of the POC for each Hospice patient.- 4. Provision of Hospice Services .4.1.3. For those Hospice patients receiving Hospice Inpatient Services from Facility as arranged by Hospice, Hospice shall provide Facility with a copy of each Hospice patient's POC and shall specify the Hospice Inpatient Services to be provided. During an interview on 04/10/2026 at 04:40 p.m., the DON stated she believed Staff R checked the hospice documentation regularly to ensure that the required documentation was present. She stated she did not believe there would have been an impact of not having a current hospice care plan for Resident # 23 and Resident #116 because the staff maintain communication with the hospice care teams for order and treatment updates. During an interview on 07/10/2026 at 03:30 p.m., Staff R stated she reviewed the hospice documentation quarterly and would contact the hospice companies for hospice visit notes and orders. She stated she had not ever requested or reviewed the hospice documentation for hospice care plans. She stated for Resident #116, she contacted Hospice P on 07/03/2026, but due to the holiday, the office staff were not available. She stated she had not yet recontacted them. During an interview on 04/10/2026 at 04:05 p.m., the ADM stated the facility staff had not reported any concerns with communicating with the hospice staff. He stated that due to the frequent visits of the hospice staff to the facility, the facility staff were able to stay updated to the hospices' current orders and plans of care. He stated he did not believe the residents would have been impacted by not having a current hospice plan of care due to the frequent and ease of communication between facility and hospice staff. Record review of facility policy End of Life Care; Hospice and/or Palliative Care, date revised 12/2023, revealed: Procedure .4. Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan. Collaboration with Hospice will include processes for orienting staff to facility policies and procedures which may include: resident's rights, documentation and record keeping requirements.		

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure at the time each resident is admitted, the facility had physician orders for the resident's immediate care for 1 of 8 residents (Resident #29) reviewed for new admissions. The facility failed to ensure Resident #29 had an order in place to provide catheter care for an indwelling urinary catheter. This failure could lead to residents not receiving necessary care. The findings included: Record review of Resident #29's face sheet, dated 07/07/2026, revealed that the resident was a [AGE] year-old male and initially admitted to the facility on [DATE] with diagnosis of reflex neuropathic bladder (when spinal cord damage blocks brain signals to the bladder affecting the sensation of bladder fullness and voluntary control). Record review of Resident #29's MDS assessment dated [DATE] revealed in section H0100 that Resident #29 has an indwelling catheter. Record review of Resident #29's physician orders revealed an order with a start date of 07/02/2026 for: Catheter Type 16Fr #30ml to closed urinary drainage system. Diagnosis for use: neurogenic bladder. No order was present for catheter care. Record review of Resident #29's baseline care plan, dated 07/02/2026 revealed Resident #29 has, an indwelling catheter: neurogenic bladder, with intervention, provide catheter care every shift and as needed. Interview on 07/07/2026 at 9:15a.m. with Resident #29 stated he has a urinary catheter and staff have been providing care for it. Observation on 07/08/2026 at 2:32p.m. revealed Resident #29 had an indwelling urinary catheter. Interview with DON on 07/09/2026 at 1:30p.m. DON stated Resident #29 has an indwelling urinary catheter and should be receiving catheter care every shift. DON stated the CNA staff is documenting incontinence care in the medical chart however, there was not an order. DON explained that urinary catheter orders are done upon admission and this order was missed for unknown reasons. DON stated the importance of having catheter care orders is to ensure care is provided while monitoring the catheter and preventing infection. Interview on 07/10/2026 at 9:25a.m. with MDS C nurse stated the interdisciplinary team reviews orders each day after their morning meeting and should have caught the missing order for catheter care for Resident #29 and she does not know why it was not caught. Interview on 7/10/2026 at 9:40a.m. with LVN H stated Resident #29 has an indwelling urinary catheter and she has witnessed Resident #29 receiving catheter care. LVN H stated it is a group effort to ensure physician orders are accurate and nursing staff is responsible for providing care. LVN H was not aware Resident #29 did not have an active order to provide catheter care. Interview on 07/10/2026 at 10:10a.m. with CNA J stated Resident #29 has a urinary catheter and she has been providing catheter care since his admission.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure the assessment accurately reflected the resident's status for two (2) of eight (8) residents (Resident #126 and Resident #64) reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #126 was coded on her Discharge Return Anticipated MDS assessment, dated 04/13/2026, for having received tube feeding while a resident and at discharge. 2. The facility failed to ensure Resident #64 was coded on her Quarterly MDS assessment, dated 05/11/2026, for having received a therapeutic diet while a resident. These failures could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #126's Face Sheet, dated 07/08/2026, revealed a [AGE] year-old female. She was admitted on [DATE] and discharged on 04/13/2026. Record review of Resident #126's Medical Diagnosis, undated and accessed 07/08/2026 at 01:52 p.m., revealed diagnoses included chronic obstructive pulmonary disease (a type of progressive lung disease), acute respiratory failure with hypoxia (a sudden condition when the lungs cannot deliver enough oxygen to the blood), and dysphagia (difficulty swallowing). Record review of Resident #126's Discharge Return Anticipated MDS Assessment, dated 04/13/2026, revealed the assessment reference and observation end date was 04/13/2026. The resident had a memory problem and was severely impaired for daily decision making. Under Section K - Swallowing/Nutritional Status of the MDS Assessment, Resident #126 was noted to have received a mechanically altered diet, defined as a diet that required a change in texture of foods or liquids, while a resident. She was not documented as having received feeding tube while a resident as a nutritional approach. LPN C was noted to have completed Section K on 04/15/2026. RN M was noted to have signed the assessment as complete on 04/27/2026. Record review of Resident #126's Order Summary Report, dated 07/08/2026 with active orders as of 04/13/2026, revealed the following orders:- REGULAR diet MECHANICAL SOFT- Ground texture, THIN LIQUIDS consistency, for diet, noted as active with order and start date of 04/09/2026. No end date noted.- Enteral Feed [any method of supplying nutrients through the gastrointestinal tract [mouth, stomach, and intestines] either by mouth, the use of liquid supplements, or the use of a feeding tube [a tube that supplies nutrients directly into the stomach or small intestine]] Order every shift CONTINUOUS TUBE FEEDING VIA:PEG [sic; a type of feeding tube] formula: ., noted as active with order and start date of 04/09/2026. No end date noted. - Enteral Feed Order every shift TYPE OF FEEDING TUBE: PEG DX: DYSPHAGIA, noted as active with order date of 04/08/2026 and start date of 04/09/2026. No end date noted. Attempted interview with Resident #126 and her resident representative on 07/10/2026 at 09:11 a.m. and 12:13 p.m. No return call was received. 2. Record review of Resident #64's Face Sheet, dated 07/09/2026, revealed a [AGE] year-old female. She was admitted on [DATE]. Record review of Resident #64's Medical Diagnosis, undated and accessed 07/09/2026 at 01:43 p.m., revealed diagnoses included dementia (a general term for impaired ability to remember, think, or make decisions), type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), and dysphagia. Record review of Resident #64's Quarterly MDS Assessment, dated 05/11/2026, revealed the assessment reference date and observation end date was 05/11/2026. The resident had a BIMS Summary Score of 14, indicating she was cognitively intact. Under Section K - Swallowing/Nutritional Status of the MDS Assessment, Resident #64 was noted to have received None of the above while a resident for nutritional approaches. Therapeutic diet was not selected. LPN L was noted to have completed Section K on 05/22/2026. RN M was noted to have (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signed the assessment as complete on 05/22/2026. Record review of Resident #64's Order Summary Report, dated 07/08/2026 with active orders as of 07/08/2026, revealed the following order:- LCS diet REGULAR texture, THIN LIQUIDS consistency, scoop dish with meals, noted as active with order and start date of 02/05/2024. No end date noted. During an observation and interview with Resident #64 on 07/07/2026 at 11:35 a.m., Resident #64 was observed lying in bed. She denied unintentional weight loss. She did not report receiving food inappropriate for her diet. During an interview on 07/10/2026 at 10:38 a.m., LPN C stated when completing Section K for nutritional approaches, she would review the resident's order listing report for active and discontinued orders. She stated if there was an error in how Resident #126 and Resident #64's nutritional approaches were coded; it would not have affected the residents' care but might impact the facility's reimbursement for that care. She stated for Resident #126 having not had been coded as received tube feeding on her discharge MDS, she would have to review the MDS Assessment. She stated for Resident #64, the LCS diet should be considered a therapeutic diet, but the missed coding of a therapeutic diet would not have impacted Resident #64's care. She stated LPN L, who completed Resident #64's MDS Assessment was a staff member from a different facility assisting with MDS Assessments and RN M, who signed both MDS Assessments as complete, worked offsite and reviewed the assessments. During an interview on 07/10/2026 at 10:53 p.m., LPN K stated she worked on MDS assessments and reviewed the two MDS Assessments discussed with LPN C, Resident #126's Discharge Return Not Anticipated MDS Assessment, dated 04/13/2026, and Resident #64's Quarterly MDS Assessment, dated 05/11/2026. She stated it appeared the nutritional approaches were missed. She stated she felt the missed coding could have an impact on the facility's reimbursement for the care provided and might impact the plan of care when it was next updated. She stated what was coded on the MDS would trigger care planning, and in that way, it could impact the resident's care. During an interview on 07/10/2026 at 11:01 a.m., LPN C stated she reviewed Resident #126's Discharge Return Not Anticipated MDS Assessment, dated 04/13/2026, and feeding tube should have been checked. During an interview on 07/10/2026 at 02:25 p.m., the DON stated she did not believe an error in coding Resident #126's feeding tube and Resident #64's therapeutic diet had impacted either resident's care. She stated the errors might have an impact on the facility's reimbursement and future care plan triggers. She stated the nursing staff were familiar with the residents' orders and care needs, and therefore the care the nursing staff provided would have been appropriate. The DON stated the facility's Comprehensive Person-Centered Care Planning policy was provided upon request for a policy to address MDS Accuracy. During an interview on 07/10/2026 at 03:15 p.m., LPN L stated she would review resident orders when completing Section K for nutritional approaches. She stated she did not recall completing Resident #64's Quarterly MDS Assessment but stated the LCS diet should have been coded as a therapeutic diet. She stated the order must have been missed when she reviewed the orders or she had an error when she completed the assessment. She stated she did not believe miscoding a therapeutic diet would have impacted Resident #64's care because the physician order would have been what the nurses and nutritional staff referred to for Resident #64's diet. Attempted interview on 07/10/2026 at 03:17 p.m. with RN M. Unable to contact via telephone and telephone did not allow a message to be recorded. During an interview on 07/10/2026 at 04:05 p.m., the ADM stated he did not believe an error in either residents' MDS Assessment for nutritional approaches would have impacted either resident's care but stated it might impact the facility's reimbursement for care. Record review of facility policy Comprehensive Person-Centered Care Planning, date revised 04/2025, revealed: PolicyIt is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment Procedure .4. The facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, .6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 8 Residents (Resident #133) whose care plan records were reviewed. The facility failed to ensure Resident #133's baseline care plan included the resident's indwelling urinary catheter. This deficient practice could contribute to residents not having their needs met based on their assessment. The findings included: Record review of Resident #133's face sheet, dated 07/07/2026, revealed that the resident was a 73-years-old male and admitted to the facility on [DATE] with diagnosis of retention of urine (the inability to completely empty the bladder). ^ Record review of Resident #133's 5-day MDS assessment revealed the assessment was in progress on 07/07/2026 because the resident was admitted to the facility on [DATE]. Record review of Resident #133's physician orders revealed an order with a start date of 07/03/2026 for: Catheter Type 16Fr #30ml to closed urinary drainage system. Diagnosis for use: retention. Record review of Resident #133's baseline care plan, dated 07/04/2026 revealed the resident did not have a baseline care plan for indwelling urinary catheter. ^ Observation on 07/08/2026 at 2:03p.m. revealed Resident #133 had an indwelling urinary catheter. Interview on 07/08/2026 at 2:05p.m. with Resident #133, stated he has a urinary catheter and staff have been providing care for it. Interview with DON on 07/09/2026 at 1:30pm. DON stated Resident #133 has an indwelling urinary catheter but it was not identified in the initial care plan. DON stated the MDS nurse along with the interdisciplinary team review new admissions daily and she is responsible for entering the initial care plan. DON stated the importance of accurate care plans is so the staff knows what kind of care the patient requires. Interview on 07/10/2026 at 9:25a.m. with MDS C nurse stated Resident #133's care plan did not reflect the indwelling urinary catheter. MDS C nurse stated the DON is responsible for completing the initial care plan and the team meets daily to discuss newly admitted residents and MDS nurse will personalize the care plan. MDS C nurse stated Resident #133's urinary catheter should have been included in the initial care plan and does not know why it was not. ^ Interview on 07/10/2026 at 9:40a.m. with LVN H stated Resident #133 has a urinary catheter and the importance of an accurate care plan is to ensure care and interventions are being followed. LVN H stated Resident #133 has been receiving catheter care and monitoring since he was admitted. Record review of the facility policy, titled Comprehensive Person-Centered Care Planning, dated 04/2025, revealed 1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care.		

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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 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 disease and infection for 1 of 3 residents (Resident #21) reviewed for infection control, in that: The facility failed to ensure signage was posted to alert staff that the resident was on Enhanced Barrier Precautions. The facility failed to ensure there was an active order for the use of Enhanced Barrier Precautions. This failure could place residents at risk of infection due to improper care practices. The findings included: Record review of Resident #21's face sheet, dated 07/09/2026, revealed that the resident was a [AGE] year-old female and initially admitted to the facility on [DATE] with diagnoses of Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood), generalized muscle weakness, and chronic pain syndrome. Record review of Resident #21's MDS assessment dated [DATE] revealed the resident has a BIMS score of 8 indicating moderately impaired cognition. Record review of Resident #21's skin assessment dated [DATE] indicated a new stage II pressure wound to resident's coccyx (tailbone). Record review of Resident #21's physician orders revealed: Tx to coccyx: cleanse with NS/ Wound cleanser, pat dry, apply medi-honey to wound bed, apply calcium alginate, cover with dry dressing one time a day every Mon, Wed, Fri for Stage 2 pressure injury. There was no order for Enhanced Barrier Precautions. Record review of Resident #21's care plan, dated 06/09/2026 revealed Resident #21 had, stage 2 pressure ulcer to coccyx r/t immobility, with intervention, Use Enhanced Barrier Precautions. Observation of wound care on 07/09/2026 at 9:00 a.m., revealed Resident #21 had an open wound to the coccyx area. Wound care nurse donned PPE when entering room to provide care. There was no signage outside or inside the resident's room indicating the need for PPE. Interview with LVN G on 7/9/26 at 12:00 p.m., stated EBP is put in place for residents with urinary catheters, peg tubes, wounds, or any openings into the body and are put in place to protect the resident and the staff from blood or bodily fluid exposures and consist of the staff donning PPE when providing care. LVN G stated Resident #21 has a pressure wound and should have an order for EBP, there should be a sign on the door. LVN G stated the ADON/Infection nurse is responsible for placing the signs. Interview with DON on 7/9/26 at 1:30 p.m., the DON stated Resident #21 had a stage 2 pressure wound and was made aware that there was not an order for EBP or a sign posted outside the resident's room. The DON stated EBP are necessary for any opening in the resident's body including IV's, catheters, and wounds. She stated the purpose of EBP is to prevent infection in the site. Interview on 07/10/2026 at 9:45 a.m., wound care LVN I stated Resident #21 developed a stage 2 pressure wound on 06/05/2026. LVN I stated EBP is a communication system to prevent infection and no one person is responsible for placing signs outside of resident rooms to indicate EBP is needed. LVN I stated she does not know why Resident #21 did not have an order for EBP or signage outside her room and the consequences could be possible infection to the resident. Interview on 7/10/2026 at 9:55 a.m., the Infection Preventionist ADON stated Resident #21 has an open pressure wound. The ADON stated all nurses have been educated to place EBP signs as needed and she runs audits to ensure EBP orders and signs are in place and does not know why the order and signage were missing. The ADON stated she learns of new wounds by obtaining a list from the wound care nurse. The ADON stated the purpose of EBP is to prevent infection. Record review of the facility policy, titled IPCP Standard and Transmission Based Precautions dated 10/2022, revealed 3. Enhanced Barrier Protection (EBP): expand the use of PPE and refer to the use of gown and gloves (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident -to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs.		