STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 3 of 9 residents (Resident #1, # 86 and #95) reviewed for pharmaceutical services.The facility failed to ensure Resident # 95 received Levothyroxine daily as prescribed by the physician.The facility failed to administer the correct dose of Metoprolol (an antihypertensive medication) as physician ordered to Resident #1 on 03/25/26. The facility failed to administer Clonidine (an antihypertensive medication) as physician ordered when Resident #86's systolic blood pressures were greater than 150 on 03/01/26, 03/02/26, 03/03/26, 03/04/26, 03/07/26, 03/17/26, 03/16/26, 03/17/26 and 03/20/26.These failures could place residents receiving medications at risk of inadequate therapeutic outcomes, reduced quality of life and hospitalization.Findings included:Record review of Resident #95's undated face sheet revealed he was a [AGE] year-old male who admitted on [DATE]. His diagnoses were hypothyroidism (low thyroid hormone levels), hypertension, heart disease, and protein calorie malnutrition.Record review of Resident #95's Initial MDS assessment dated [DATE] revealed a BIMS score 15 of 15 which indicated cognitively intact and he can understand and respond appropriately to questions. Record review of Resident #95's Physician Orders dated 03/22/2026 revealed Levothyroxine Sodium Oral Tablet 75MCG, give 1 tablet by mouth in the morning related to HYPOTHYROIDISM with a start date on 03/23/2026.Record review of Resident #95's eMAR dated 03/24/2026 revealed Resident #95 did not receive a check mark for medication received, but a number 9 which indicated a nurse's note has been attached to the eMAR by LVN L. Record review of Resident #95's Nurses Note dated 03/24/2026 at 5:02am revealed Levothyroxine Sodium Oral Tablet 75MCG- Give 1 tablet by mouth in the morning related to HYPOTHYROIDSIM Awaiting Pharmacy. Author: LVN L [e-SIGNED]During an interview with Resident #95 on 03/24/2026 at 10:17 a.m., he stated he had not received his Levothyroxine for the past two days due to staff reporting that the medication was unavailable and needed to be ordered . During an interview with LVN L on 03/25/2026 at 2:29 p.m., she stated that Levothyroxine for Resident #95 is scheduled to be administered daily between the hours of 4:00 a.m. and 6:00 a.m. On the morning of 03/24/2026, prior to medication administration, she realized the medication was not available. She reported she was unsure whether the medication was available in the e-kit due to the e kit computer rebooting and the screen remaining blank, which prevented her from logging in. LVN L stated she did not notify the physician of the missed dose but did notify the DON. She further stated the medication was reordered to arrive later that evening, resulting in the resident not receiving the medication on 03/24/2026. The failure to administer Levothyroxine as ordered placed the resident at risk for fluctuations in thyroid hormone levels, potentially affecting metabolic function.During an interview with the DON on 03/25/2026 at 4:47 p.m., she stated she asked LVN L why the e-kit was not utilized when the Levothyroxine was unavailable. The DON reported LVN L informed her that the e kit system was not functioning and the screen was completely shut down, preventing access. The DON confirmed the e kit system was down at that time and stated she reset the system. The DON (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she notified the nurse practitioner regarding Resident #95 and that LVN L was re educated on proper medication administration procedures, including the use of the e kit for commonly prescribed medications. The failure to administer the medication as ordered placed the resident at risk for not following physician orders and for impaired thyroid function, which could adversely affect metabolic regulation .During an interview with the Administrator on 03/25/2026 at 4:50 p.m., he stated the expectation for medication administration includes following the physician's orders and verifying the availability of medications in the e-kit prior to reordering. The Administrator stated that failure to follow physician orders and utilize available medications could place residents at risk for adverse outcomes.Record review of New E-kit Inventory List dated 03/25/2026 revealed 8 tablets available for Levothyroxine 75MCG.Record review of Resident #1's face sheet dated 03/25/26 revealed a [AGE] year-old admitted to the facility 03/03/26. Resident #1's diagnoses included Hemiplegia (one sided paralysis or severe loss of strength on one side), Hemiparesis (weakness to one side of body), pneumonitis (swelling and irritation of lung tissue) due to inhalation of other solids and liquids, malnutrition, Dementia (a general term for a group of symptoms that cause a loss of cognitive functioning), hypertension (elevated blood pressure) and atrial fibrillation (irregular heartbeat).Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe impaired cognition. Resident #1 had impairment to the upper extremity on one side of the body. He used a manual wheelchair for mobility. Resident #1 was dependent on staff assistance for oral hygiene, toileting, bathing, dressing, personal hygiene and transfers. He was always incontinent of bowel and bladder. He had a feeding tube to provide nutritional support.Record review of Resident #1's undated care plan revealed: Focus - Resident #1 had hypertension r/t stroke. Goal - Resident #1 will remain free from s/sx of hypertension through the review date, 06/16/26. Interventions included - give antihypertensive medication as ordered; obtain blood pressure readings; take blood pressure readings under the same conditions each time.Record review of Resident #1's active physician orders revealed an order for Metoprolol tartrate 25mg, give 0.5 tablet via G-tube, BID for HTN, hold if SBP < 110 or HR <60. The order date was 03/03/26. Observation on 03/25/26 at 7:30 AM, LVN B checked Resident #1's vital signs: blood pressure was 122/75 and pulse was 68. LVN B prepared medications including the bolus feeding formula for Resident #1. LVN B asked LVN E to retrieve Metoprolol from the medication room d/t Resident #1 did not have a supply in the medication cart. LVN B crushed each tablet separately and added 5ml water to each med cup to dissolve the medications. Resident #1 was easily woken up and when LVN B explained the procedure, Resident #1 said one word (an expletive). LVN B raised the HOB for Resident #1 to at least 30 degrees. LVN B performed hand sanitization, put on clean gown and gloves. LVN B unfastened the abdominal binder which was securing Resident #1's GT. LVN B attached the tip of the 60 ml syringe barrel (hollow cylindrical tube) to Resident #1's GT and poured 30ml of water into the barrel. The water infused via gravity. LVN B poured the first medication: Olanzapine 2.5mg into the barrel and followed with 5ml of water. The following medications were administered with 5ml to 10ml of water between each medication: Aspirin 81mg, Buspirone 10mg, Eliquis 5mg, folic acid 1mg, Multivitamin 1 tablet, Sacubitril-Valsartan 24-26mg, Valproic Acid solution 10ml and Metoprolol 25mg. LVN B poured 30ml of water after the last medication then poured the Isosource 1.5cal/ml, 250ml until all the formula was infused then flushed with 30ml of water. The medication pass was completed at 8:00 AM.Record review on 03/25/26 at 12:30 PM, during medication reconciliation of the medication pass, revealed LVN B administered Metoprolol 25mg to Resident #1 and not the physician ordered Metoprolol 25mg half a tablet.In an interview and observation on 3/25/26 at 12:45 PM, LVN B stated Metoprolol was given to Resident #1 for HTN. LVN B checked the eHR system and stated Resident #1 should have received half of the 25mg tablet of Metoprolol and was not aware the full 25mg of Metoprolol tablet was given. LVN B stated the risk of receiving a higher dose of Metoprolol than what the physician ordered was a drop in blood pressure. Resident #1 was sitting close to the nurse station in a wheelchair. Resident #1 was awake and in no distress. LVN B stated she would check Resident #1's blood pressure immediately (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then LVN B took Resident #1 down the hallway to his room.In an interview on 03/25/26 at 1:00 PM, the Unit Manager E stated the Metoprolol for Resident #1 was for HTN, to keep blood pressure within normal range and that if too much of the medicine was given the risk would be a drop in blood pressure. Unit Manager E stated when she retrieved the Metoprolol from the medication room for LVN B, she checked the order for Resident #1 and confirmed it was for half a tablet of Metoprolol 25mg. Unit Manager E stated she showed LVN B the medication which was still in the package and expected LVN B to follow the physician orders by splitting the tablet which was already scored. Unit Manager E stated she did not split the tablet herself because it was the responsibility of the administering nurse to do so. Unit Manager E stated going forward she would address the error with LVN B and review the rights of medication administration. Unit Manager E stated the five rights were: right route, right person, right dose, right time, right medication. Unit Manager E stated the expectation was for LVN B to look at what was written on the package and compare it to the MAR before administering.In an interview on 3/25/26 at 1:25 PM, the DON stated she was aware of the medication error by LVN B and that a medication error report and disciplinary action was completed. The DON stated the NP, who was in the building, was notified and Resident #1's RP was notified as well. The DON stated the plan was to check Resident #1's vital signs every hour. The DON stated the Metoprolol was usually in a blister pack from the pharmacy and when it was not in the medication cart LVN B asked for assistance. The DON stated LVN B told her she got distracted and was nervous. The DON stated the expectation was for LVN B to look exactly at the medication, the dose and then split the Metoprolol tablet. The DON stated that Metoprolol peaked 1 to 2 hours after administration. The DON stated the risk to Resident #1 would be low blood pressure and that was the reason why Resident #1 would be monitored for 24 hours. The DON stated that LVN B will never make the same mistake again. Record review of Resident #86's face sheet dated 03/25/26 revealed a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #86's diagnoses included ESRD (end stage renal disease), dependence on renal dialysis, diabetes and cirrhosis of the liver (abnormal liver function). Record review of Resident #86's quarterly MDS dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderately impaired cognition. Resident #86 was dependent on assistance for toileting, bathing, lower body dressing and personal hygiene. Resident #86 required supervision for eating, oral hygiene and upper body dressing. Resident #86 used a manual wheelchair for mobility. Record review of Resident #86's undated care plan revealed: Focus - Resident #86 had renal insufficiency r/t renal failure. Goal - Resident #86 will have no s/sx of complications r/t fluid deficit through the review date. Interventions included - Observe/document report to MD PRN the following s/sx: Edema; neck vein distention; difficulty breathing; increased heart rate; elevated blood pressure (hypertension). The responsible staff member listed was the Charge Nurse. Further review revealed there was no focus, goal or interventions addressing hypertension. Record review of Resident #86's active orders revealed an order for Amlodipine 10mg, give one tablet by mouth daily for HTN (hypertension), hold for SBP less than 110 or pulse less than 60. The order date was 02/12/26. Clonidine 0.1 mg by mouth PRN every 8 hours anytime the resident's systolic blood pressure is over 150. The order date was 02/27/26. Hydralazine HCL 25mg, give one tablet by mouth every 8 hours for HTN, hold for SBP <110. The order date was 02/08/26. Record review of resident #86's active MAR/TAR showed clonidine 0.1 mg was administered twice, once on March 6th 2026 and March 25th 2026. Record review of resident #86's recorded vital signs for the month of March 2026 revealed the following blood pressures which were unaddressed with PRN clonidine 0.1mg as per order: 03/01/26 at 3:27 PM = 152/6903/02/26 at 4:50 PM = 174/73 03/02/26 at 6:20 PM =155/8603/03/26 at 4:42 AM = 159/8903/03/26 at 7:31 AM = 159/68 03/03/26 at 11:10 PM = 156/7503/04/26 at 7:06 AM = 177/80 03/04/26 at 11:43 AM = 154/6903/07/26 at 2:12 AM = 168/74 03/13/26 at 8:14 AM = 151/7603/16/26 at 11:46 PM = 151/6503/17/26 at 7:00 AM = 156/5803/20/26 at 2:09 PM = 159/73 In an interview on March 26, 2026 at 9:50 am, MA A, stated that if a medication required a blood pressure reading prior to administration that MA A will take that blood pressure and that if it is out of range (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then MA A will report it to the nurse. MA A stated that if a PRN medication was needed then the nurse would make that determination and give it. In an interview on March 26, 2026 at 10:05 am, LVN A, stated that the medication aides generally take the residents' blood pressures, but that he will do it himself if they report to him that it is out of range. He said that if it's out of range when he checks it that he will recheck it in an hour. If it is still out of range at that point he will give a PRN medication and if that didn't correct the issue then he would call the physician. Specifically regarding Resident 86, LVN A stated that she is on dialysis and a lot of times her blood pressure is out of parameters so he keeps an eye on it. He said that when Resident 86?s blood pressure is high he rechecks it after an hour. LVN A said Resident 86 gets dialysis and scheduled medications for blood pressure so LVN A won't give PRN medication right then, but if it gets really high then LVN A will give it. In a telephone interview on March 26, 2026 at 11:31 am, MD C, stated that the order was not being followed if the PRN clonidine was not given when Resident #86's systolic blood pressure was over 150. He stated that the nurse should follow the order rather than make the decision if Resident #86 gets that medication or not. MD C said that he would review Resident #86's chart and may make Clonidine a scheduled medication in order to prevent a nurse from attempting to make that decision themselves . In an interview on March 26, 2026 at 12:50 pm, the DON, stated that the expectations for staff are to take the resident's blood pressure, follow up in an hour by rechecking the blood pressure, and then give the PRN clonidine 0.1 mg if the blood pressure was still over 150 systolic. She stated that a nurse should not neglect to give the PRN after a 1 hour recheck when the vital sign meets the required parameters for that medication. Record review of the facility's policy for Administering Medications revised December 2012 read.Policy StatementMedications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation3. Medications must be administered in accordance with the orders, including any required time frame.Record review of the facilities policy for Emergency Medications Revised April 2007 read.Policy StatementThe facility shall maintain a supply of medications typically used in emergencies.Policy Interpretation and ImplementationThe emergency medication kit will include medications and biologicals that are essential in providing emergency treatment.Record review of the facility policy for Administering Medications, revised December 2012, read in part: .Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation.3. Medications must be administered in accordance with the orders, including any required time frame.7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure all drugs and biologicals were stored securely for one of nine residents (Resident #86) and one of three medication carts (200 Hall nurse medication cart) reviewed for medication storage.The facility failed to keep resident medications stored securely. Two large white oblong tablets were found in Resident #86's possession with no nursing staff present.The facility failed to lock the 200 Hall nurse medication cart and secure an IV medication that was left on top of the cart prior to walking away. These failures could affect residents receiving medications placing them at risk of receiving the wrong medication, adverse side effects and drug diversion.Findings included:Record review of Resident #86's face sheet dated 03/25/26 revealed a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #86's diagnoses included ESRD (end stage renal disease), dependence on renal dialysis, diabetes and cirrhosis of the liver (abnormal liver function).Record review of Resident #86's quarterly MDS dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderately impaired cognition. Resident #86 was dependent on assistance for toileting, bathing, lower body dressing and personal hygiene. Resident #86 required supervision for eating, oral hygiene and upper body dressing. Resident #86 used a manual wheelchair for mobility. Active diagnoses included end stage renal disease and dependent on renal dialysis.Record review of Resident #86's undated care plan revealed: Focus - Resident #86 had renal insufficiency r/t renal failure. Goal - Resident #86 will have no s/sx of complications r/t fluid deficit through the review date. Interventions included - Resident/family/caregiver teaching to include the following: The importance of compliance with medications and dialysis treatment; Educate on the medications prescribed. Record review of Resident #86's active orders revealed an order for Sevelamer HCL oral tablet 800mg give 2 tablets by mouth with meals for CKD (chronic kidney disease). The order date was 02/02/26. Further review revealed there were no orders for self-administration of medications. In an interview on 3/25/26 at 6:30 AM, MA A stated Sevelamer was to be given with meals and would wait until Resident #86 received the breakfast tray at approximately 7:30 AM to administer the medication.In an observation and interview on 3/25/26 at 8:25AM, Resident #86 was in her room eating breakfast. On the tray were 2 large white oblong tablets in a clear 30ml medication cup. There were no nursing staff in the room. When asked what the pills were for and who gave them to her, Resident #86 did not reply. Resident #86 took each pill and swallowed them. The two tablets were marked with L025 and identified as Sevelamer 800mg tablets.In an interview on 3/25/26 at 8:55AM LVN A stated the 200 Hall medication aide was responsible for administering scheduled medications to Resident #86. LVN A stated he would watch a resident swallow a medication to ensure the medication was taken properly. LVN A stated it would be against policy and procedure to leave medications with a resident, and he would never do that. LVN A stated if Resident #86 refused the Sevelamer he expected to be notified by the medication aide so he could attempt to administer the medication himself. LVN A stated if nursing staff did not witness Resident #86 to consume the Sevelamer, the resident could throw away the medication, and the risk would be abnormal labs.In an interview on 3/25/26 at 9:45AM, MA A stated she watched Resident #86 swallow the Sevelamer tablets. MA A stated, Did she spit it out? MA A stated the Sevelamer was ordered to be given with meals and did not know why the tablets were on the breakfast tray.In an interview on 3/25/26 at 10:00AM, the DON stated she expected MA A to remain with Resident #86 until the medication was consumed. The DON stated medications should never be left alone with a resident but instead make sure they swallow the medication unless it is refused. The DON stated it was not ok for medications to be left out because another resident may come by and take medication that was not ordered for them.In an interview on 03/25/26 at 10:45AM, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using the Spanish interpreter telephone line, Resident #86, stated that she took her morning dose of Sevelamer. She stated that it was given to her before her meal came and that the staff watched her take it. After further questioning, she said that she took it with her meal and that staff were not in the room when she took it. In an observation on 03/26/26 at 10:07 AM, LVN A was preparing medications for administration when called by another staff to assist a resident. LVN A walked away from the 200-hall nurse medication cart, entered a resident's room, and closed the door. The medication cart was left unlocked with an IV medication on top of the cart. LVN A was in the resident's room with the door closed for privacy. There was no direct line of sight to the unsecured cart. Two residents walked past the cart during this time. The medication cart remained untouched during this time. LVN A returned to the med cart at 10:10 am. In an interview on 03/26/26 at 1:12 PM, LVN A stated that the procedure was to ensure medications are secure by locking the medication cart. LVN A stated that he remembered accidentally leaving the medication out but didn't realize that the medication cart was left unsecured as well. LVN A stated locking the cart was forgotten and knew the cart needed to be secure to prevent a resident from walking by and taking medication left there. LVN A stated that the most recent in-service on securing medication was earlier this month (March 2026). Record review of the facility policy for Administering Medications, revised December 2012, read in part: .Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation.3. Medications must be administered in accordance with the orders, including any required time frame.7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medications.16. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide.No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.Record review of the facility policy for Storage of Medications, revised on April 2007 read in part: .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe and sanitary manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident was fully informed in a language that he or she could understand of his or her total health status, including but not limited to, his or her medical condition for 2 (Resident #86 and #75) of 8 residents reviewed for resident rights.The facility failed to communicate effectively with Resident #86 whose primary language was Spanish, and Resident #75 whose primary language was Vietnamese.This failure could place residents who communicate in a foreign language at risk of unmet needs.Findings included:1.Record review of Resident #86's care plan revealed it did not include any plan for addressing her ability to communicate. In an interview on 3/24/26 at 9:40 a.m. via translation line, Resident #86 stated that she had some complaints about care and medications but was unable to communicate those needs to staff due to being Spanish speaking. In an interview on 3/24/26 at 10:45 a.m. via translation line, Resident #86 stated that she have issues getting her needs met due to a language barrier. Resident #86 stated that she understood and could speak a few sentences of English, but that she was Spanish speaking and that Spanish was her preferred language. Resident #86 stated that she quit asking for help with a lot of things (meal preferences, changing medication times, understanding diagnoses, and clothing were among examples given) and would either attempt to try and do it on their own or go without. During an observation on 3/25/26 at 3:45 p.m. of Resident #86 being changed and receiving care, CNA A and CNA B, assisted Resident #86 off the toilet, stood her up, got her cleaned, put on a new brief, and assisted her back into bed. During this time Resident #86 did not speak in English or at all to staff. CNA A and CNA B spoke only in English to Resident #86. Hand gestures were also made by CNA A and CNA B to Resident #86. Resident #86 made no hand gestures in return until getting back in bed at which point resident gestured to her phone. Staff handed the resident her phone, call light, and asked if resident needed anything else. Resident #86 shook her head no. After staff left the room Resident #86 asked surveyor via translation line to plug her phone in. In an interview on 3/25/26 at 3:47 p.m., CNA A stated that they're generally able to communicate with Resident #86 fairly well. CNA A stated that if she did not understand what Resident #86 is saying then they will grab a Spanish speaking staff member to help translate. In the event that Spanish speaking staff are unavailable, CNA A stated that they will use google or apple translate. CNA A stated that they were unaware if the facility has any translation line, but that if so, they have not heard of it. In an interview on 3/25/26 at 3:47 pm. CNA B stated that they're usually able to communicate with Resident #86. CNA B stated that sometimes to make communication with Resident #86 easier they will get Spanish speaking staff to help translate. In the event that a Spanish speaking staff was unavailable, CNA B stated that they use google translate. CNA B stated that they have not heard of the facility having a translation line and did not think that there was one. In an interview on 3/26/26 at 12:50 p.m., the DON stated that the facility does have a translation line and that the expectation was for her staff to use it with residents whose preferred language was not English. She stated that staff should not be using internet translation services or a family member, but the translation line in order to prevent misinterpretation via an internet service or a family member altering a resident's words. 2.Record review of Resident #75's face sheet dated 3/24/26 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included dementia, diabetes, and chronic respiratory failure.Record review of Resident #75's annual MDS assessment dated [DATE] revealed her race was Vietnamese and her preferred language was English. The assessment indicated she did not need an interpreter to communicate with a doctor or health care staff. She had clear speech, was able to understand others and made herself understood. Her BIMS score was 5 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care.Record review of Resident #75's care plan revealed she had a communication problem related dementia, revised on 4/18/25. The goal was to make basic needs known on a daily basis. (continued on next page)

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	676165	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions were to use communication techniques which enhance interaction: allow adequate time to respond, repeat as necessary, do not rush, request feedback, clarification from the resident, to ensure understanding, face when speaking and make eye contact, turn off tv/radio as needed to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs, and pictures. Date initiated 4/18/25. Resident #75 had impaired cognitive function/impaired thought processes. Interventions were to communicate with the resident/family/caregivers regarding resident's capabilities and needs. Communication: .the resident understands consistent, simple, directive sentences. Provide the resident with necessary cues. date initiated 4/30/24. The care plan did not include that the resident spoke Vietnamese. In an interview on 3/24/26 at 9:48 a.m. this Surveyor greeted Resident #75 and she did not respond. This Surveyor asked if she spoke English or Vietnamese and she said Vietnamese. Interview via the translation line using the Vietnamese language, Resident #75 said she needed medication because her throat had been hurting for over a week. She said she was unable to communicate her concern with the staff because she did not know English. She said whenever her family member visited the facility, she would communicate through her but if the family member was not here, she was unable to. Resident #75 said her throat hurt bad when she swallowed and asked the Surveyor to please let the staff know she needed medication.In an interview on 3/24/26 at 9:59 a.m. LVN J said she was unable to speak with Resident #75 because she did not speak English but spoke Vietnamese. She normally communicated through her family member, and said the resident was able to communicate her needs such as the need for water and ice. She said she checked on the resident this morning and she did not complain of any pain. This Surveyor informed LVN J that the resident communicated a need to the Surveyor and the nurse was asked to verify that need with Resident #75.In an observation and interview on 3/24/26 at 10:25 a.m. LVN J entered Resident #75's room and spoke to her in English. The resident motioned for a shower and said she was ok. LVN J ended the conversation with Resident #75 and exited the room. She said Resident #75 could say key words and could respond no to questions. She was unsure if the resident had a board for communication. This Surveyor told LVN J that the need Resident #75 shared with the Surveyor was still not made known. LVN J said the facility had a translation line and would ask someone for assistance.In an interview on 3/24/26 at 10:30 a.m. the Unit Manager said the translation line phone number used to be on the home page of the electronic chart but was no longer there. She said she did not know what happened to the number and would ask for assistance. She said other ways that staff communicated with Resident #75 was through the family. Resident #75 could point and say things in English. She had not seen a communication board for the resident. In an observation on 3/24/26 at 10:45 a.m. LVN J entered Resident #75's room and spoke with her via the translation line. LVN J said she was informed that the resident was coughing and had a really sore throat. She said the resident also complained of itchy throat and pain in shoulder. LVN J said she was not previously aware of these concerns.Record review of Resident #75's nursing note dated 3/24/26 at 11:10 a.m. and written by LVN J read in part, . Res c/o itching in throat that causes her to cough. Res alleges x 1 week. No redness noted to throat. No enlarged glands noted. No cough or cong noted at this time. Lungs CTA. Res also c/o pain to left shoulder. Res was provided Acetaminophen immediately after complaint. Res tol med well. Call placed to. NP to report res c/o. Pending new orders at this time.In an interview on 3/25/26 at 4:31 p.m. LVN D said Resident #75 could say words in English such as pee pee, number 2, and food. She said the resident also did a lot of pointing. To assess pain the nurse would observe for grimacing to the forehead and facial expressions. She said the resident was able to respond yes if asked if she was in pain. She said she was unaware of a translation line at the facility, had not used one with the resident and was unsure what language she spoke. She had not used communication boards with the resident. She said she could call Resident #75's family member for help with communication. She said she believed Resident #75 was cognitive in her language. It was important to communicate effectively (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the resident because that would benefit her and allow staff to take better care of her. In an interview on 3/25/26 at 4:33 p.m. CNA H said he communicated with Resident #75. He said she spoke 25% English and also communicated through her eyes, gestures, pointing, calling her family member or using the translation line. He said Resident #75 said words like number 2. He said she never complained of throat pain but had complained of pain to the side and butt. He said the resident would say hurt, hurt or medicine, medicine to communicate pain.In an interview on 3/25/26 at 4:52 p.m. the DON said the facility had translation service. She said Resident #75 was cognitive for the most part and was able to communicate basic needs such as the need to use the bathroom and pain. She has called the family member to translate. The family member had not reported a sore throat to the staff. The DON said there were also communication boards but did not believe Resident #75 had one. She said it was important to communicate effectively with the residents to ensure they were taken care of and their needs were met. In an interview on 3/25/26 at 4:53 p.m. the Administrator said staff used google translate and families to help translate. In an interview on 3/26/26 at 1:04 p.m. the MDS nurse said she was under the impression that Resident #75 understood English and that was why she coded it as her preferred language on the annual MDS. She said the resident spoke single words in English and her needs were met. She said she could update the MDS assessment.In an interview on 3/26/26 at 10:55 a.m. CNA W said Resident #75 spoke Vietnamese and he used hand signals to communicate with her. He said he was trained on using hand gestures to communicate with the resident and was going to ask about a chart with pictures but did not know where it was. He said she never communicated pain to him.Record review of the facility's Resident rights policy revised October 2009 read in part, .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: 1. Be informed about what rights and responsibilities he or she has;. 2. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the 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 1 of 8 (Resident #9) residents reviewed for comprehensive assessments. The facility failed to ensure Resident #9's care plan addressed the resident's history of UTI (urinary tract infection) and interventions for UTI.These failures could place residents at risk of not having their individually assessed needs determined, monitored and met.Findings included:Record review of Resident #9's face sheet dated 03/25/26 revealed an [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #9's diagnoses included Dementia (a general term for a group of symptoms that cause a loss of cognitive functioning), Hemiplegia (one-sided paralysis or severe loss of strength on one side), Hemiparesis (weakness to one side of body), stroke, urinary tract infection, atrial fibrillation (irregular heart beat), hypertension (elevated blood pressure) and depression.Record review of Resident #9's quarterly MDS dated [DATE] revealed a BIMS score of 9 out of 15 indicating moderately impaired cognition. Resident #9 had both UE and LE impairment to one side of the body. Resident #9 used a manual wheelchair for mobility. Resident #9 was always incontinent of bowel and bladder. Resident #9 was dependent on assistance for lower body dressing, toilet hygiene and bathing. Resident #9 required substantial assistance with bed mobility, transfers and personal hygiene. Resident #9 required moderate assistance with eating and oral hygiene. Section I - Active Diagnoses included urinary tract infection during last 30 days. Resident #9 was taking antibiotics and indication was noted for the medication.Record review of Resident #9's active physician orders revealed an order for Macrodantin oral capsule 50mg, give one capsule by mouth at bedtime for prophylactic (to prevent) UTI. The order was dated 08/18/25.Record review of Resident #9's March 2026 MAR/TAR revealed Macrodantin 50mg for prophylactic UTI was documented as administered daily at bedtime.Record review of Resident #9's undated care plan revealed the potential for UTI and the use of a prophylactic antibiotic to prevent a UTI was not addressed. In an interview on 03/26/26 at 10:11AM, the MDS Nurse stated the purpose of the care plan was to guide the care of the residents to ensure the plan was in the best interest of the residents and their care. MDS Nurse stated it was the responsibility of the unit managers and MDS Nurse to update the care plan. The MDS Nurse stated she did not know why Resident #9's history of UTI and the interventions for Macrodantin as prophylaxis for UTI was not included in the care plan. The MDS Nurse stated she was not an employee of the facility in August 2025, was new to the position and currently catching up, reviewing all resident's care plans. The MDS Nurse stated UTIs should be addressed in Resident #9's care plan as well as monitoring behaviors r/t UTIs and the nursing team should be using the care plan as a guide for the resident's benefit.In an interview on 03/26/26 at 11:30 AM, the DON stated Resident #9's UTI and antibiotic treatment should be part of the plan of care. The DON stated Resident #9 started on the Macrodantin in August 2025 and the person responsible was the MDS Nurse who should have made the additions in the care plan. The DON stated Resident #9's RP was insistent on the antibiotic because of recurrent UTIs. Record review of the facility's policy for Care Plans - Comprehensive, revised on December 2009 read in part: .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified problems.e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #1) of 2 residents reviewed for enteral nutrition.LVN B failed to check for Gtube (gastrostomy tube) placement prior to administration of medications as per Physician orders and facility policy.This failure could place residents who receive medications or feedings via Gtube at risk of aspiration, pain and hospitalization.Findings included:Record review of Resident #1's face sheet dated 03/25/26 revealed a [AGE] year-old admitted to the facility 03/03/26. Resident #1's diagnoses included Hemiplegia (one sided paralysis or severe loss of strength on one side), Hemiparesis (weakness to one side of body), pneumonitis (swelling and irritation of lung tissue) due to inhalation of other solids and liquids, malnutrition, Dementia (a general term for a group of symptoms that cause a loss of cognitive functioning), hypertension (elevated blood pressure) and atrial fibrillation (irregular heartbeat).Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe impaired cognition. Resident #1 had impairment to the upper extremity on one side of the body. He used a manual wheelchair for mobility. Resident #1 was dependent on staff assistance for oral hygiene, toileting, bathing, dressing, personal hygiene and transfers. He was always incontinent of bowel and bladder. He had a feeding tube to provide nutritional support.Record review of Resident #1's active physician orders revealed an order for GT (gastrostomy tube -a tube inserted through the abdomen giving direct access to the stomach for nutritional support): GT: bolus give one can of Isosource 1.5cal five times per day, flush with 30ml of water before and after each bolus; check GT placement prior to feeding and/or medication administration by aspiration of gastric contents every shift, order was dated 03/03/26. Resident #1 had the following medications ordered to be given via GT: Acetaminophen 500mg, 1 tablet every 6 hours PRN pain, Aspirin 81mg, daily, Atorvastatin Calcium 40mg at bedtime, buspirone 10mg TID, Eliquis 5mg daily, folic acid 1mg daily, Guaifenesin 5ml every 6 hours PRN, Levothyroxine 100mcg daily, Metoprolol 25mg BID, Multivitamin 1 tablet daily, Olanzapine 2.5mg BID, Sacubitril-Valsartan 24-26mg BID, Trazodone 50mg at bedtime and Valproic Acid solution 250mg/5ml, give 10ml BID.Record review of Resident #1's undated care plan revealed: Focus - Resident #1 required tube feeding d/t dysphagia (swallowing disorder). Goal - will remain free of side effects or complications related to tube feeding. Interventions included - check for tube placement and gastric content/residual volume per facility protocol and record. Hold if greater than 150 ml of aspirate (fluid withdrawn). Keep HOB elevated 30-45 degrees during and thirty minutes after tube feeding. Monitor/document/report to MD PRN: Aspirate - fever, SOB, tube dislodged, infection at tube site, distention, tenderness.Observation and interview on 03/25/26 at 8:00AM, LVN B prepared medications including the bolus feeding formula for Resident #1. LVN B crushed each tablet separately and added 5ml water to each med cup to dissolve the medications. Resident #1 was easily woken up and when LVN B explained the procedure, Resident #1 said one word (an expletive). LVN B raised the HOB for Resident #1 to at least 30 degrees. LVN B performed hand sanitization, put on clean gown and gloves. LVN B unfastened the abdominal binder securing Resident #1's GT. LVN B attached the tip of the 60 ml syringe barrel (hollow cylindrical tube) to Resident #1's GT and poured 30ml of water into the barrel. The water infused via gravity. LVN B poured the first medication: Olanzapine 2.5mg into the barrel and followed with 5ml of water. The following medications were administered with 5ml to 10ml of water between each medication: Aspirin 81mg, Buspirone 10mg, Eliquis 5mg, folic acid 1mg, Multivitamin 1 tablet, Sacubitril-Valsartan 24-26mg, Valproic Acid solution 10ml and Metoprolol 25mg. LVN B poured 30ml of water after the last medication then poured the Isosource 1.5cal/ml, 250ml until all the formula was infused then flushed with 30ml of water. LVN B (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the tip of the Gtube was supposed to be in the stomach. LVN B stated she would check for tube placement by drawing back on the syringe and that more than 100ml of residual would be too much, but said she was unsure of the amount of fluid to be worried about. LVN B stated she understood that the only time to pull back and check for residual would be when a resident received continuous feedings and not for bolus feedings. LVN B stated she was nervous. LVN B stated she would check the facility policy for when to check tube placement and that she would monitor Resident #1 for nausea and vomiting. Resident #1 was observed to cough a few times and LVN B stated the cough was not new for Resident #1 because he had a history of PNA. LVN B stated the risk of not checking for placement of the tube, would be the tube may not be in the stomach and may be in another space in the abdomen which would not be where it should be. LVN B checked the exit site of the Gtube and said there was nothing unusual. LVN B palpated Resident #1's abdomen and stated it was soft. Resident #1 was not in any distress. LVN B replaced the abdominal binder . LVN B stated that when she started working full time on 01/12/2026, she had in-service on medication administration and Gtube at the time.In an interview on 03/25/26 at 10:00 AM, the DON stated it was the facility policy to check proper GT placement by drawing back on the syringe to check for residual fluids. The DON stated she expected all nurses to check for placement before giving any medications or giving formula feedings. The DON stated the nurses received in-services regarding care of the GT during skills checks in December 2025 and that LVN B may not have been part of the training as LVN B returned to work full time starting January 2026 .Record review of the facility policy and procedure of Administering Medications through an Enteral Tube, revised on March 2015 read in part: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Preparation: 1. Verify that there is a physician's medication order for this procedure.Steps in the Procedure.18. Confirm placement of feeding tube per physician's order. By aspirating stomach contents, if no residual is aspirated check for bowel sounds, bloating, vomiting and pain. If no changes are noted proceed to administer medications/formula. 19. If you suspect improper tube positioning, do not administer feeding or medication and notify the Physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure bed rails were maintained and checked regularly to make sure they are installed correctly as rails may shift or loosen over time for 1 (Resident #14) of 10 residents reviewed for bed rails.The facility failed to ensure that Resident #14's bedrails were not loose.This failure could place residents at risk of injuries, entrapment or death. Findings included:Record review of Resident #14's face sheet dated 03/25/26 revealed a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #14's diagnoses included fracture of the left femur, sepsis (blood infection), Dementia (a general term for a group of symptoms that cause a loss of cognitive functioning), muscle weakness and depression.Record review of Resident #14's quarterly MDS dated [DATE] revealed a BIMS score of 6 out of 15 indicating severe impaired cognition. Resident #14 used a manual wheelchair for mobility. Resident #14 required supervision for transfers, bed mobility and personal hygiene. Resident #14 required moderate assistance with bathing and dressing. He was frequently incontinent of bowel and bladder. Resident #14 had a fall with a major injury since admission/re-entry. Further review revealed Section P - Restraints and Alarms: Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body was coded as bedrail not used in bed.Record review of Resident #14's March 2026 MAR/TAR revealed: Bed rails - may have 1/4 bilateral bedrails to assist with mobility and self-positioning while in bed r/t weakness and mobility by the patient and family's desire to keep resident as independent as possible, was checked every shift daily at 6:00AM -6:00 PM shift and at 6:00 PM - 6:00 AM shift.Record review of Resident #14's bedrail evaluation effective 04/28/25 included: the resident was currently utilizing the bedrails; the resident was not able to physically release the bed rails; the resident was able to get in/out of bed without assistance and the resident had a history of falls. Record review of Resident #14's Informed Consent for Use of Bed Rails revealed a verbal consent was completed with the RP on 07/10/25 and the recommendations were for 1/4 partial rails for the left and right to be always used when Resident #14 was in bed.In an observation and interview on 03/24/26 at 1:15 PM, Resident #14 was alert, lying in bed. The bed had bedrails attached to the bedframe on both sides of the bed. The bed was in low position and there were fall mats on the floor placed on both sides of the bed. Resident #14 was observed using both rails to self-turn in bed. Both bedrails were loose and the bedrail to Resident #14's right side was wobblier than the rail to the left as noted when the resident grabbed hold of the rail to turn. Resident #14 stated the bedrail was loose. Resident #14 stated he had fallen before but not out of bed. In an interview on 03/24/26 at 1:50PM, CNA F stated the bedrails on Resident #14's bed were loose and that was a safety hazard because the resident could fall or fall under the rail and get hurt. CNA F stated the loose bedrails were reported to Maintenance via the electronic workorder request sometime between 3/16/26 and 3/21/26 but was unsure of the exact date.In an interview on 03/24/26 at 1:55PM, LVN G stated she was assigned to Resident #14 and that it was the nursing department's responsibility to check bedrails. LVN G stated Resident #14 had bedrails d/t the high risk of falls. LVN G stated if the bedrails were not secure the resident could slip and get caught in between the rails.In an interview and observation on 3/24/26 that began at 1:55PM, Maintenance stated there was a workorder to check bedrails for two resident rooms and that he learned about the loose bedrail for Resident #14 on Thursday 3/19/26 but did not get the work order. Maintenance did not explain why the bedrail was not tightened at that time. The cell phone Maintenance had, showed the 2 resident rooms but not Resident #14's room. Then Maintenance stated he just received the work order for Resident #14's bed on 3/24/26 at 2:04 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM. The cell phone Maintenance had confirmed the request for the bedrail workorder for Resident #14 was received on 3/24/26 at 2:04PM. Maintenance stated the bedrails would get loose from being used or handled and would tighten them when a notification was received or if he was verbally notified. Observed Maintenance tighten bedrails for Resident #14.In an interview on 03/24/26 at 4:05 PM, the DON stated it was the responsibility of the nursing staff to always make workorder notifications through the electronic system used to notify Maintenance. The DON stated during Ambassador rounds every day would be another opportunity for staff to check bedrails. The DON stated bedrails can become loose from wear and tear. The DON stated the risk of loose bedrails would be injury to residents and that all bedrails were a potential for injury. The DON stated moving forward, in-services on bedrails had been started.Record review of logs for Ambassador Room Rounds dated 3/19/26 to 3/24/26 revealed there were no issues with Resident #14, or the environment of the resident's room. The log checklist did not include bedrails. Record review of the facility's Owner's Manual for the Long-Term Care Bed, revised 04/01/2018 read in part: .Quarterly inspection.inspect bed and rotating assist bars/rails bolts, if loose tighten and if missing replace.Record review of the facility policy for Proper Use of Side Rails, revised on December 2007 read in part: The purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms.10. The resident will be checked periodically for safety relative to side rail use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety reviewed for 1 of 5 (Dietary Manager) kitchen staff members. The facility failed to ensure food service staff wore appropriate hair nets while in the kitchen and food was being prepared.This failure had the potential to contaminate food and affect residents' health and safety.Findings included:During an observation and interview on 03/24/2026 at 8:11 am the Dietary Manager was cleaning the kitchen floors without wearing a hairnet. The Dietary Manager stated she had just returned from bringing the water hose inside to clean the floors. She stated she knew she should have word a hairnet due to the risk of hair contaminating food.During an interview with the Administrator on 03/25/2026 at 8:30am The Administrator stated that staff are expected to wear hairnets immediately upon entering the kitchen. The Administrator stated that failure to wear hairnets poses a risk for food contamination. Record review of the facilities policy for Staff Hygienic Dress Code Policy Statement undated, read.Policy StatementThis policy mandates that all employees adhere to an approved dress code tailored for their specific job functions to ensure safety, hygiene, and professionalism.Dress Code GuidelinesHair and Facial Hair: Staff must keep hair tied back or off shoulders and secured under a hair net or cap. Facial hair should also be neatly restrained to prevent contamination.