STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676168	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd Highland Village, TX 75077

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident had a right to confidentiality of his or her personal and medical records for six (Residents #9, #11, #12, #25, #36, and #40) of eighteen residents reviewed for privacy and confidentiality.The facility failed to ensure LVN C secured Residents #9, #11, #12, #25, #36, and #40's medical information before leaving his nurse's cart on [DATE]. This failure could place the residents at risk of not having their private and medical information exposed to unauthorized individuals.Findings included:Resident #9Record review of Resident #9's Face Sheet, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with tachycardia (fast heart rate) and intracranial hemorrhage (bleeding inside the skull).Record review of Resident #9's advance directive on [DATE] reflected that the resident was a full code (life-saving measures would be provide if the heart stops).Record review of Resident #9's Comprehensive Care Plan, dated [DATE], reflected that the resident wished to be a full code and one of the interventions was that the request for CPR (Cardiopulmonary Resuscitation: an emergency life-saving procedure) to be initiated would be followed.Resident #11Record review of Resident #11's Face Sheet, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with upper respiratory disease and fracture (broken bone) of left fibula.Record review of Resident #11's advance directive on [DATE] reflected that the resident was a DNR (Do Not Resuscitate: refuse CPR if the heart or breathing stops).Record review of Resident #11's Comprehensive MDS Assessment, dated [DATE], reflected the resident had moderate impairment in cognition with a BIMS score of 11.Record review of Resident #11's Comprehensive Care Plan, dated [DATE], reflected the resident had an order for Do Not Resuscitate and one of the interventions was in the absence of b/p, pulse, and respiration, CPR would not be initiated.Record review of Resident #11's Progress Notes, dated [DATE], reflected Answered . had chest x-ray done .Resident #12Record review of Resident #12's Face Sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with atrial fibrillation (an irregular, rapid heartbeat).Record review of Resident #12's advance directive on [DATE] reflected that the resident was a full code.Record review of Resident #12's Comprehensive MDS Assessment, dated [DATE], reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 13. Record review of Resident #12's Comprehensive Care Plan, dated [DATE], reflected that the resident was on full code and one of the interventions was that the request for CPR to be initiated would be followed.Resident #25Record review of Resident #25's Face Sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with fracture to left humerus.Record review of Resident #25's advance directive on [DATE] reflected that the resident was a full code.Record review of Resident #25's Comprehensive MDS Assessment, dated [DATE], reflected the resident was cognitively intact with a BIMS score of 15. Record review of Resident #25's Comprehensive Care Plan, dated [DATE], reflected that the resident was on full code and one of the interventions was that the request for CPR to be initiated would be followed.Resident #36Record review of Resident #36's Face Sheet, dated [DATE], reflected a [AGE] year-old male (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE]. The resident was diagnosed with atrial fibrillation.Record review of Resident #36's advance directive on [DATE] reflected that the resident was a DNR.Record review of Resident #36's Comprehensive MDS Assessment, dated [DATE], reflected the resident was cognitively intact with a BIMS score of 14. Record review of Resident #36's Comprehensive Care Plan, dated [DATE], reflected the resident had an order for Do Not Resuscitate and one of the interventions was in the absence of b/p, pulse, and respiration, CPR would not be initiated.Resident #40Record review of Resident #40's Face Sheet, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with atrial fibrillation.Record review of Resident #40's advance directive on [DATE] reflected that the resident was a DNR.Record review of Resident #40's Comprehensive MDS Assessment, dated [DATE], reflected the resident was cognitively intact with a BIMS score of 15. Record review of Resident #40's Comprehensive Care Plan, dated [DATE], reflected the resident had an order for Do Not Resuscitate and one of the interventions was in the absence of b/p, pulse, and respiration, CPR would not be initiated.An observation on [DATE] at 11:41 AM, revealed a piece of paper was on top of the cart that was parked in front of the nurses' station and the cart was facing the hallway. On the piece of paper were some of Residents #9, #11, #12, #25, #36, and #40's medical information. The piece of paper revealed that Residents #9, #12, and #25 were a full code and Residents #11, #36, and #40 were a DNR. The piece of paper also showed that Resident #11 needed a chest X-ray and Resident #40 was on oral ABT. During an observation and interview on [DATE] at 11:25 AM, revealed LVN A saw the piece of paper on top of the cart that showed medical information for some of the residents. She flipped the paper and stated the paper should have been turned upside down because medical information would be a HIPAA violation if exposed to unauthorized individuals. LVN A said she would let LVN C know that he needed to make sure no information was exposed.In an interview on [DATE] at 11:27 AM, LVN C stated he left his cart because he attended to someone. He said he thought he covered the paper, which was their shift report, but did not make sure it was fully covered. He said he was in a hurry and just turned away from his cart. He said he would be mindful the next time he would leave his cart because the information written on the piece of paper was medical information and was confidential.In an interview on [DATE] at 6:41 AM, the ADON stated the medical information of any resident should not be left unattended because it was confidential and could be a HIPAA violation. She said, before leaving the cart, the staff should have secured it somewhere so unauthorized individuals would not see them. She said the expectation was for the staff to secure or flip any paper that had medical information in it. She said it would be better if they would lock it inside their carts because somebody might flip it and read it. She said the expectation was for the staff to be mindful every time they leave their carts to secure any paper with medical information. She said the DON already started an in-service about privacy and confidentiality.In an interview on [DATE] at 7:40 AM, the DON stated if what was written on the piece of paper was medical information of the residents, then it should not be left unattended because unauthorized individuals might see it. She said medical information about a resident should be protected and not be visible for everybody to see because that was confidential information. She said the health information of a resident could not be shared without the permission of the resident or the resident's responsible party. She said if the confidential information was exposed, non-nursing staff, other residents, and visitors would be able to see it. She said all staff, including her, was expected to provide confidentiality of all the residents' personal and medical information. The DON stated she already started an in-service about confidentiality of medical records.In an interview on [DATE] at 8:36 AM, the Administrator stated the expectation was for the staff to have turned the paper upside down before leaving the cart because what was written on the paper was supposed to be confidential because it was medical information. He said he would coordinate with the DON regarding closely monitoring the staff regarding confidentiality of medical records.Record review of the facility's policy entitled, Confidentiality of Information and Personal Privacy 2001 MED-PASS, Inc., revised [DATE] reflected Policy Statement: Our facility will protect (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and safeguard resident confidentiality and personal privacy . Policy Interpretation and Implementation . 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records . 4. Access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 8 of 20 resident rooms (room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, and #8) observed for cleanliness. The facility failed to ensure Rooms #1, #2, #3, #4, #5, #6, #7, and #8 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 01/06/26 at 10:58 AM, in room [ROOM NUMBER] reflected the bathroom floor had grayish dirt stains on the floor under the sink and grayish and brownish stains around the toilet area. An observation on 01/06/26 at 11:01 AM, of room [ROOM NUMBER] reflected the bathroom floor had grayish dirt stains on the floor under the sink and thick black dirt stains around the toilet area. An observation on 01/06/26 at 11:05 AM, of room [ROOM NUMBER] reflected the bathroom floor had grayish dirt stains on the floor under the sink and thick black dirt stains around the toilet area. The air conditioning unit had dirt in the vents. An observation on 01/06/26 at 11:13 AM, of room [ROOM NUMBER] reflected the bathroom floor had grayish and brown dirt stains on the floor, especially around the toilet area. In an interview on 1/06/26 at 11:14 AM, the resident in room [ROOM NUMBER] stated they mopped the bathroom floor, but she had to scrub the floor around the toilet area because it grossed her out. An observation on 01/06/26 at 11:20 AM, of room [ROOM NUMBER] reflected the bathroom floor had grayish dirt stains on the floor around the toilet area. An observation on 01/06/26 at 11:23 AM, of room [ROOM NUMBER] reflected the bathroom floor had brown and grayish dirt stains on the floor around the toilet area. An observation on 01/06/26 at 11:36 AM, of room [ROOM NUMBER] reflected the bathroom floor had grayish dirt stains on the floor around the toilet area. An observation on 01/06/26 at 11:39 AM, of room [ROOM NUMBER] reflected the bathroom floor had grayish dirt stains on the floor around the toilet area. In an interview on 1/08/26 at 12:02 PM, Housekeeper M stated he had been at the facility for about 4 months, and he was assigned to clean the 200 Hall. He stated they were trained to clean the room from the back of the room to the front of the room. He stated they were to clean the bathrooms and the air condition units in the rooms. He stated they were to clean the resident rooms daily. He was shown photos of the concerns observed in Rooms #1, #2, #3, #4, #5, #6, #7, and #8, and he stated he tried to clean the stains in the bathroom floors but they had never attempted to deep clean the floors. He stated the bathroom floors being in the condition observed was not appealing to the residents who resided in the rooms. In an interview on 1/08/26 at 12:11 PM, Housekeeping Supervisor stated she had been at the facility since July 2025. She stated they trained staff to clean the facility by doing 1 on 1 training and showing them a video of how to properly clean the rooms. She was shown pictures of the concerns observed in Rooms #1, #2, #3, #4, #5, #6, #7, and #8 and she stated the bathroom floors needed to be scrubbed with a machine, and all the areas were fixable. She stated the concerns observed did not have a good impact on the residents. In an interview on 1/08/26 at 12:15 PM, the Administrator stated he was told by his Housekeeping Supervisor of the concerns observed in the resident rooms, He was shown pictures of concerns observed in Rooms #1, #2, #3, #4, #5, #6, #7, and #8, especially the bathroom floors. He stated he would work with Housekeeping to deep clean the floors. He stated the impact these concerns had on the resident was it did not present a homelike environment for them. Review of the facility's policy on Housekeeping Cleaning & Disinfecting (2021) revealed Purpose: To keep facilities clean and odor free, while providing the residents, their families, and staff with the safest environment possible and projecting a positive image.

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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	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 assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for two (Resident #3 and Resident #15) of eighteen residents and one (LVN A) of three LVNs reviewed for pharmaceutical services.1. The facility failed to ensure LVN C did not leave Resident #3's medications inside the resident's room for the resident to administer unattended on 01/06/2026. 2. The facility failed to ensure Resident #15 was not self-administering her eye drops without an assessment on 01/06/2026.3. The facility failed to ensure LVN A did not put her personal beverage on top of the nurse's cart while passing medications on 01/06/2026.4. The facility failed to ensure that there was no expired medications inside the medication room on 01/07/2026.These failures could place residents at risk of not receiving medications as ordered, taking medications without a proper assessment, potential overdose, adverse effects, cross contamination, not receiving the medication's full therapeutic benefits, and potential interference with medication preparation.Findings include: 1. Record review of Resident #6's Face Sheet, dated 01/06/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason), anxiety (intense or excessive fear or worry), and depression (persistent feeling of sadness or loss of interest). Record review of Resident #3's Comprehensive MDS Assessment, dated 12/18/2025, reflected the resident had moderate impairment in cognition with a BIMS 07. The Comprehensive MDS Assessment indicated the resident had dementia, anxiety, and depression.Record review of Resident #3's Comprehensive Care Plan, dated 12/18/2025, reflected that the resident was taking an antidepressant and one of the interventions was to give medications as ordered. The Comprehensive Care Plan did not indicate that the resident could self-administer her medications.Record review of Resident #3's Physician's Order, dated 01/03/2026, reflected PreserVision AREDS 2 Oral Capsule (Multiple Vitamins w/ Minerals) Give 1 capsule orally two times a day for Supplement. Record review of Resident #3's Physician's Order, dated 10/06/2025, reflected Apixaban Oral Tablet 2.5 MG (Apixaban) Give 1 tablet orally two times a day for Stroke prevention.Record review of Resident #3's Physician's Order, dated 01/02/2025, reflected Ferrous Sulfate Oral Tablet 325 MG (Ferrous Sulfate) Give 1 tablet orally in the morning for Supplement.Record review of Resident #3's Physician's Order, dated 01/04/2025, reflected Levocetirizine Dihydrochloride Oral Tablet 5 MG (Levocetirizine Dihydrochloride) Give 1 tablet by mouth two times a day for Seasonal Allergies.Record review of Resident #3's Clinical Assessment Notes on 01/06/2026 reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications.During an observation and interview on 01/06/2026 at 09:43 AM, revealed Resident #3 was in her bed, awake. It was observed that a small plastic cup, with four pills inside, was on top of the resident's overbed table. According to the resident, her nurse left the medications with her and she would take them after she was finished with his breakfast. The resident said it was not the first time that her medications were left with her. She said there was more than four pills, she already took some of them. She said she was not sure what the remaining pills was in the small cup. In an interview on 01/06/2026 at 10:12 AM, LVN C stated he left Resident #3's morning pills with her because the resident insisted. He said the resident was oriented to person, place, time, and event and could decide for herself. In an interview on 01/07/2026 at 8:12 AM, LVN C stated he should not have left Resident #3's medications and should have stayed with the resident until the resident had taken all the medications. He said the pills should not be left with the residents because the residents might not take them, throw them, or choke while taking them and no one would know. He said the resident was a nurse before but was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosed dementia.2. Record review of Resident #15's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia. Record review of Resident #15's Comprehensive MDS Assessment, dated 10/30/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated the resident had dementia.Record review of Resident #15's Comprehensive Care Plan, dated 11/12/2025, reflected that the resident had dementia and one of the interventions was to administer medications as ordered.Record review of Resident #15's Physician's Order on 01/06/2025 reflected the resident did not have an order for eye drops. During an observation and interview on 01/06/2026 at 9:27 AM, revealed Resident #15 was in her bed, awake. It was observed that three vials were on top of the resident's side table. According to the resident, the vials were eyedrops that she used every morning because her eyes were itchy and dry every morning. She said she was the one putting it in her eyes every morning. She said the staff knew about her eyedrops.In an interview on 06/01/2026 at 9:43 AM, LVN B stated she did not notice the vials on the Resident #15's side table. She said, sometimes family members were the ones bringing the medications. She said, for the resident's safety, there should be no medications inside the rooms because the nurses were the ones giving the medications and doing the treatments as well. She said the residents had no reason to have medications inside the room. She said the resident was oriented and cognitive but unless she had an assessment indicating that she could self-medicate, there should be no medications inside her room. She said she would talk to the resident and the resident's family member about the medications inside the room. She would also see if the resident needed eye drops so she could request an order for the eye drops.3. During an observation and interview on 01/06/2026 at 9:08 AM, revealed a personal tumbler was on top of the nurse's car parked at the nurse's station. LVN A stated it was her cart and the tumbler was hers. She took the tumbler and put it inside the nurse's station. She said she could not have her personal tumblers on the cart when passing medications or doing treatments because it could cause cross contamination. She said it could create clutter on the medication cart and might accidentally be mixed with the medications she was preparing.4. Record review of Resident #10's Face Sheet, dated 01/07/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with Parkinson's disease (movement disorder) and pain.Record review of Resident #10's Quarterly MDS Assessment, dated 12/04/2025, reflected the resident had a moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment indicated that the resident had Parkinson's disease and pain.Record review of Resident #10's Comprehensive Care Plan, dated 12/04/2025, reflected the resident had Parkinson's disease and pain and the interventions were to administer medications as ordered.Record review of Resident #10's Physician Order, dated 12/27/2025, reflected Gabapentin Oral Tablet 600 MG (Gabapentin) Give 1 tablet by mouth three times a day related to PAIN.Record review of Resident #10's Physician Order, dated 12/27/2025, reflected Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 3 tablet by mouth three times a day related to PARKINSON'S DISEASE WITHOUTDYSKINESIA (involuntary muscle movements), WITHOUT MENTION OF FLUCTUATIONS.An observation on 01/07/2026 at 1:38 PM, revealed during medication cart inspection, it was observed that three bottles of medications inside Nurse's Cart #1 was expired. The bottles, one for gabapentin and two for carbidopa, had a use by date of 12/10/2025. The medications belonged to Resident #10.During an observation and interview on 01/07/2026 at 1:39 PM, revealed LVN B saw the three bottles and said the medications was expired as indicated by the bottle. She said she did not notice that the medications was expired. She said she did not know who put the medications inside the cart. She said she did not use them when she passed her morning medications because Resident #10 had blister packs for the said medications. She said the ADON checked the cart monthly, so she was not sure why there was expired medications in the cart. She said she was also responsible in checking any expired medications during her shift. She said expired medications should not be inside the cart so that staff administering the medication would not mistakenly use them. She (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the effectiveness of expired medications could be lesser or could cause adverse reactions depending on the medications.In an interview on 01/08/2026 at 6:41 AM, the ADON stated staff should not leave any medications with the residents for the residents to take unsupervised. She said the staff administering the medications should stay with the resident until the resident was done with the medications. She said the resident might not take them or someone else might, like another resident or a visitor. She said the resident might aspirate or choke while taking the medications and nobody would know. She said the same rationale applied for the eyedrops. She said the resident should not be applying it by herself. She said the residents could not take medications by themselves except if they were assessed that they could self-administer. She said no personal beverages should be on the medication carts because aside from being a clutter that might contribute to medication error, staff might bring some microorganism from their home to the medication cart. She said she was responsible in auditing the carts to check for any expired medications. She said she did how the three expired medications was missed. She said aside from her, the staff passing the medications should also check the expiration date of the medications inside the carts so they would be disposed. She said expired medications lose their effectiveness and would not address the medical needs of the residents. She said the DON already started an in-service about not leaving the medications with the residents, no expired medication inside the carts, and no personal beverages in the carts.In an interview on 01/08/2026 at 7:40 AM, the DON stated staff should never leave the medications at the bedside for the resident to take later. She said the staff must ensure the resident took his medications before leaving the room. She said so much could go wrong like the resident could hoard or hide the pills to avoid taking them, could overdose on hoarded pills, and could choke without anybody to help the resident. She said the eyedrops should not be applied by the resident by herself. She said there was a breakroom where the staff could put their personal belongings as well as their drinks. She said aside from the risk of cross contamination, some residents might take it and drink its content. She said its content might also spill on the medications the staff were preparing. The DON said there should be no expired medications inside the carts. She said the carts were audited regularly so she was not sure why there was expired medications inside the cart. She said the effects of expired medications could range from reduced effectiveness to unfavorable side effects. She said the expectation was that no residents were administering their medications without proper assessment. The DON said she already started an in-service about medication administration.In an interview on 04/17/2026 at 8:36 AM, the Administrator stated the expectation was for the staff would not leave medications with the residents unattended because of the risk of the resident not taking them or the pills not taken on time. He said if personal beverages should not be on top of the cart, the staff should not put them there. He said another expectation was that expired medications should be disposed of so they would not be used for the residents. He said the staff should check for the expiration dates before administering the medications to prevent any reaction it might cause. He said he would coordinate with the clinicians on how to go forward to prevent untoward outcomes of leaving the medications with a resident.Record review of the facility's policy, Medication Administration Procedures Pharmacy Policy & Procedure Manual 2003, undated reflected 1. All medications are administered by licensed medical or nursing personnel.Record review of the facility's policy entitled, Medication Labeling and Storage MED-PASS revised February 2023 reflected Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys . Policy Interpretation and Implementation . Medication Storage . 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals . instructions regarding returning or destroying these items.Policy for not leaving personal beverages requested on 01/08/2026 at 9:39 AM but was not provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #8 and Resident #26) of eighteen residents, for two (LVN C and LVN B) of three LVNs, for two (CNA D and CNA E) of six CNAs reviewed for infection control. 1. The facility failed to ensure LVN C would not walk the hallway with a glove to one hand after coming out of Resident #11's room on 01/06/2026. 2. The facility failed to ensure LVN B wore a gown when connecting Resident #8's IV on 01/06/2026. 3. The facility failed to ensure LVN B wore a gown while emptying Resident #8's catheter bag on 01/06/2026. 4. The facility failed to ensure CNA D and CNA E did not use the gloves inside their pockets during Resident #26's incontinent care on 01/07/2026.These failures could place residents at risk of cross-contamination and development of infections.Findings include:1. Record review of Resident #11's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with depression. Record review of Resident #11's Comprehensive MDS Assessment, dated 11/27/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 11. The Comprehensive MDS Assessment indicated the resident had depression.Record review of Resident #11's Comprehensive Care Plan, dated 11/10/2025, reflected that the resident required antidepressant medication and one of the interventions was to monitor any signs and symptoms of depression.An observation on 01/06/2026 at 11:14 AM, revealed LVN C exited Resident #11's room with his left hand holding a disposable cup and with his right hand with glove on. LVN C went to the sink at the nurse's station and washed the disposable cup.In an interview on 01/06/2026 at 11:19 AM, LVN C stated he was just getting Resident #11 some water. He said he should have disposed of his gloves first before going out of the resident's room to get her some water. He said, even though he did not touch the resident, the rule of the thumb was to dispose of the gloves before leaving the room to prevent spread of infection. He said the resident did not have any infection, but he still should have taken off his glove before going to the nurse's station.2. Record review of Resident #8's Face Sheet, dated 01/06/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with urine retention. Record review of Resident #8's Comprehensive MDS Assessment, dated 12/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had urine retention.Record review of Resident #8's Comprehensive Care Plan, dated 11/10/2025, reflected the resident had UTI and one of the interventions was to administer antibiotic as ordered.Record review of Resident #8's Physician Order, dated 01/06/2025, reflected Imipenem 1-gram IVPB every 8 hours X days every 8 hours for 7 Days.Record review of Resident #8's Physician Order, dated 04/28/2025, reflected ENHANCED BARRIER PRECAUTIONS AS NEEDED.An observation on 01/06/2026 at 2:06 PM, revealed LVN B was about to connect Resident #8's antibiotics via IV. She washed her hands and put on a pair of gloves. She took the resident's antibiotics and the IV set from the top of her cart, placed them on the resident's overbed table, and closed the resident's door. She connected the IV set to the antibiotics and primed it. After priming the IV, she flushed the PICC line, and then connected the IV. She did not wear a gown while she was connecting the IV. It was observed that there was a sign outside the resident's room that PPE was required because the resident was on enhanced barrier precautions because she had a central line.3. Record review of Resident #8's Face Sheet, dated 01/06/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with urine retention. Record review of Resident #8's Comprehensive MDS Assessment, dated 12/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd Highland Village, TX 75077

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	flow in the catheter bag).Record review of Resident #8's Comprehensive Care Plan, dated 11/10/2025, reflected the resident had an indwelling catheter and one of the interventions was catheter care every shift.Record review of Resident #8's Physician Order, dated 04/28/2025, reflected Foley (device used to help drain urine from bladder) catheter every shift.Record review of Resident #8's Physician Order, dated 04/28/2025, reflected ENHANCED BARRIER PRECAUTIONS AS NEEDED.An observation on 01/06/2026 at 11:56 AM, revealed that Resident #8's catheter bag was full. The resident asked LVN B if she could empty it. LVN B put on a pair of gloves, went to the bathroom to get a basin, and then emptied the resident's catheter bag. She did not wear a gown when she emptied the resident's catheter bag. It was observed that there was a sign outside the resident's room that PPE was required because the resident was on enhanced barrier precautions because she had a catheter.In an interview on 01/06/2026 at 2:29 PM, LVN B stated Resident #8 was on EBP because the resident had an IV and a catheter. She said when a resident was on EBP, it meant that a gown was required when doing a treatment. She said she did not know why she forgot to wear a gown when she administered the resident's antibiotics via IV and when she emptied the resident's catheter bag. She said the gown was needed basically to prevent transmission of microorganisms from staff to resident, from resident to staff, and from staff to another resident. She said she would wear a gown the next time she would care for residents with an IV and a catheter.4. Record review of Resident #26's Face Sheet, dated 01/08/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with retention of urine and kidney failure.Record review of Resident #26's Comprehensive MDS Assessment, dated 10/16/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated that the resident was incontinent for bowel and bladder.Record review of Resident #26's Comprehensive Care Plan, dated 11/12/2025, reflected the resident had incontinence and one of the interventions was to provide pericare after each incontinent care.An observation on 01/07/2026 at 9:54 AM, revealed that CNA D and CNA E was about to do Resident #26's incontinent care. Both CNAs washed their hands before putting on their gloves. It was observed that both CNAs had gloves inside their pockets. During the process of incontinent care, both CNAs used the gloves in their pockets when they changed their gloves. It was observed that a box of gloves was on top of the resident's bedside table, both CNAs only took gloves from the box of gloves when they were out gloves from their pockets.In an interview on 01/07/2026 at 10:18 AM, CNA D stated she put some gloves in her pockets, and she was not sure if her pocket was clean. She said she guessed her pocket was not clean because she would put her keys and cell phone in her pocket. She said she would not put gloves inside her pocket again and would just get them from the box to make sure she was using clean gloves.In an interview on 01/07/2026 at 10:21 AM, CNA E stated she would put gloves in her pockets for easy access. She said it did not dawn on her that her pockets might have dirt in them or was soiled making the gloves she used for incontinent care dirty.In an interview on 01/08/2026 at 6:41 AM, the ADON stated staff should not walk in the hallway with gloves on coming out of a resident's room. She said it did not matter if the staff touched the resident or not or that the resident did not have any infection at all but gloves should be disposed of inside the room before coming out of the room. She said if the staff needed to go back to the residents' room, then the staff needed to put on a new pair of gloves. She said if a resident had IV and had a catheter, then the staff should wear a gown because the resident was on EBP. She said gloves should not be in the pockets because the pockets were dirty rendering the gloves dirty when used. She said the issues discussed contributed to cross contamination and probable infection. She said the expectation was for the staff to be mindful of what they were doing to protect the residents. She said the DON already started an in-service about infection control.In an interview on 01/08/2026 at 7:40 AM, the DON stated gloves should be disposed of before leaving a resident's room. She said gloves in the hallways could contribute to spread of infection. She said if a resident was on EBP, then the staff doing care or treatment should wear a gown every time they had contact with the resident. She said residents with g-tube, catheter, tracheostomy, or an IV were on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBP and required PPE to prevent the spread of infection from one resident to another. She said there might be no policy that would say not to put the gloves in the pockets but the best practice was not to put gloves inside the pockets to make sure the gloves being used were clean. She said she already started an in-service about infection control.In an interview on 04/17/2026 at 8:36 AM, the Administrator stated that the expectation was for the staff to be mindful to dispose the gloves before coming out of a resident's room, to wear gowns in addition to the gloves if the residents were on EBP, and not to use dirty gloves. He said the concerns discussed would all contribute to the development and spread of infection. He said the DON already started an in-service about infection control but would closely coordinate with the DON if the staff were following the policy and procedure for infection control. Policy and procedure for Enhanced Barrier protection was requested via email to the Administrator on 01/07/2026 at 9:16 AM and on 01/08/2026 at 9:39 AM 09/19/202 but was not provided prior to exit.Record review of the facility's policy Fundamentals of Infection Control Precautions Infection Control Policy & Procedure Manual 2010 revised October 21, 2022 reflected A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility . Gloving . Gloves are worn for three important reasons . 1. To provide protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucous membranes, and nonintact skin . 5. Gowns and protective apparel . Gowns are also worn . they are removed before the personnel leave the resident's environment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for three (Resident #7, Resident #15, and Resident #27) of eighteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #7, Resident #15, and Resident #27's rooms was in a position that was accessible to the resident on 01/06/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #7 Record review of Resident #7's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with ataxic gait (a person walking with uncoordinated movements) and difficulty in walking.Record review of Resident #7's Quarterly MDS Assessment, dated 12/05/2025, reflected the resident had a severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS score of 04. The Quarterly MDS Assessment indicated the resident was dependent for transfer, toileting hygiene, shower, dressing, and personal hygiene.Record review of Resident #7's Comprehensive Care Plan, dated 12/16/2025, reflected the resident was at risk for falls and one of the interventions was to be sure the resident's call light was within reach.Observation and interview on 01/06/2026 at 9:23 AM, revealed Resident #7 was in her bed, awake. It was observed that the resident's call light was on the floor at the head of the bed. When asked where her call light was, the resident said her call light was nowhere to be found. Observation and interview on 01/06/2026 at 9:45 AM, CNA F stated call lights should always be within reach of the residents because that was how they called the staff if they needed something. She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. She went inside Resident's #7's room and saw the call light on the floor. She pulled the call light from the floor and put it where the resident could reach it. She said, maybe, the call light fell when the resident was repositioned. She said the staff who repositioned her should have made sure the call light was with the resident before leaving the resident's room. Resident #15 Record review of Resident #15's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with muscle weakness and difficulty in walking.Record review of Resident #15's Quarterly MDS Assessment, dated 10/30/2025, reflected the resident had a moderate (resident may need additional support and monitoring) impairment in cognition with a BIMS score of 10. The Quarterly MDS Assessment indicated the resident needed supervision for shower and dressing. Record review of Resident #15's Comprehensive Care Plan, dated 02/27/2025, reflected the resident had limited physical mobility and one of the goals was that the resident would be free from complications including falls.Observation and interview on 01/06/2026 at 9:27 AM revealed Resident #15 was in her bed, awake. It was observed that the resident's call light was on the floor and was on the resident's roommate's side. When asked where her call light was, the resident just shrugged her shoulders.Observation and interview on 01/06/2026 at 9:43 AM, CNA F stated call lights were important for the residents because the residents used them to call the staff when they needed something or needed assistance. She said the residents might fall trying to get the call light or trying to do some activities that needed assistance. She went inside Resident #15's room and saw the call light on the floor. She said she did not notice the call light was on the floor when she did her morning round. Resident #27Record review of Resident #27's Face Sheet, dated 01/06/2026, reflected an [AGE] year-old female admitted on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).Record review of Resident #27's Quarterly MDS Assessment, dated 01/05/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 01. The Quarterly MDS Assessment indicated the resident was (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dependent for shower, dressing, personal hygiene, toileting, and transfer. Record review of Resident #27's Comprehensive Care Plan, dated 01/06/2025, reflected the resident was a high risk for falls and one of the interventions was to be sure the resident's call light was within reach.Observation and interview on 01/06/2026 at 9:20 AM, revealed Resident #27 was in her bed, awake. It was observed that the resident's call light was on the floor at the head of the bed. When asked where her call light was, the resident looked at her side and said Oh, it might be hanging or was on the floor. The resident said she could get up and pull her call light.Observation and interview on 01/06/2026 at 9:47 AM, LVN B stated call lights were important for the residents because the residents used them to call the staff when they needed something or needed assistance. She went inside Resident #27's room and saw the call light on the floor. She picked-up the call light and placed it where the resident could reach it. She said she did not notice the call light was on the floor when she administered the resident's medication. She said she should have made sure the call light was with the resident before leaving the room, because even though the resident could stand up and walk. She said the resident might be having a heart attack or shortness of breath and could not get up to pick-up the call light. In an interview on 01/08/2026 at 6:41 AM, the ADON stated the call lights should always be with the residents or within reach of the residents. She said the staff should make sure that the call lights were with the residents before they left the room. She said the call lights were for all residents, regardless they were dependent or independent. She said independent residents might be dizzy or was not feeling well and could not call the staff because their call lights were not with them. She said everybody was responsible in making sure the call lights were with the residents. She said the expectation was for the staff to make sure that all the call lights were within reach of the residents. She said she the DON already initiated an in-service regarding the call light. In an interview on 01/08/2026 at 7:40 AM, the DON stated call lights were inside the residents' rooms so they can call the staff for assistance, a glass of water, pain medication, or because they needed to be changed. The DON said if the call lights were not within reach, their needs would not be met. The DON said the call lights were for all residents and all the staff were responsible for the call lights. The DON said the expectation was for the staff to scan the residents' room when they did their rounds and ensure the call lights were within reach of the residents before they leave the room. The DON said she already started an in-service about call light placement and would continually educate the staff about the importance of call lights for the residents. In an interview on 04/17/2026 at 8:36 AM, the Administrator stated call lights should be within the reach of the residents at all times. He said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. The Administrator said the residents might fall trying to get up to get what they needed. He said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. He said he would collaborate with the DON and the ADON about the issue regarding call lights.Record review of facility's policy Answering the Call Light 2018 MED-PASS, Inc. revised September 2022 reflected Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs . General Guidelines . 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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 observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth 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 6 residents (Resident #37) reviewed for care plan revisions. The facility failed to ensure Resident #37's care plan reflected the use of her BiPAP device. This failure could place residents at risk of their needs not being met.Findings include:Record review of Resident #37's Face Sheet, dated 01/08/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #37 had acute respiratory failure with hypoxia (low oxygen intake). Record review of Resident #37's Quarterly MDS Assessment, dated 12/02/25, reflected Resident #37 had a severe cognitive impairment response. The Quarterly MDS Assessment reflected the resident had an active diagnosis of respiratory failure. Record review of Resident #37's Physician Orders, dated 01/07/26, reflected BiPAP on at night per home settings at bedtime for sleep apnea. Record review #37's Comprehensive Care Plan, dated 11/17/25, reflected no plan of care for the resident's use of the BiPAP device. In an interview on 01/07/26 at 1:10 PM, the MDS nurse stated Resident #37 should have been care planned for the BIPAP device because it is important to her care. She stated it was the MDS nurse's responsibility to ensure the resident's use of the device was care planned. She stated she was responsible for care planning the resident's long term care and the DON and ADON were responsible for care planning acute care. In an interview on 01/07/26 at 1:55 PM, the DON and ADON stated they thought there was a care plan for Resident #37's BiPAP device. The DON stated it was everyone's responsibility to ensure the resident's care plans were updated with the appropriate plan of care for the resident to ensure they received the right care. They both stated the resident's use of the device should have been care planned. Record review of facility's policy, Comprehensive Care Planning, undated, reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for one of five residents (Resident #36) reviewed for accident prevention. The facility failed to ensure Residents #36's bed was lowered to the lowest position possible while he was lying in the bed. This failure could result in the resident falling from his bed and sustaining an injury. Findings include: Record review of Resident #36's Face Sheet, dated 01/07/26, reflected he was a [AGE] year-old male admitted to the facility on [DATE] and he had a moderate cognitive impairment response. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #36's Quarterly MDS assessment, dated 10/24/25, reflected he had a BIMS score of 00 (severe cognitive impairment). For ADL care, it reflected the resident required extensive assistance and an active diagnosis of muscle weakness and muscle weakness and difficulty walking. Record review of Resident #36's Comprehensive Care Plan, dated 11/17/25, reflected the resident was a fall risk, with recent falls occurring on 12/29/25 (with injury) and 11/26/25 (no injury). Intervention included the resident's bed being in the lowest position possible. In an observation on 01/07/26 at 9:07 AM, Resident #36 was observed lying in his bed sleeping and his bed was not placed in the lowest position possible. In an interview and observation on 01/07/26 at 9:09 AM, LVN C stated Resident #36 was a fall risk and one of the interventions was for his bed to be at the lowest position. LVN C and Surveyor observed the resident's bed not in the lowest position possible and LVN C lowered the bed. He stated the bed should be in the lowest position in case the resident had a fall. He stated the resident had just finished breakfast, but no food was observed on the resident's bedside table. He stated it was his and the CNA's responsibility to lower the bed once the resident had finished his meal. In an interview on 01/07/26 at 1:00 PM, CNA E stated Resident #36 was a fall risk and his bed was to be in the lowest position possible and fall mats placed on both sides of the bed. She was told by the surveyor of Resident #36 being observed lying in bed, and it was not in the lowest position possible. She stated the resident needed his bed in a low position to assist in preventing the resident from injury if he fell out of bed. In an interview on 01/07/26 at 1:55 PM, the DON and ADON were told by the Surveyor of Resident #36's bed being observed not in the lowest position possible while he was lying in his bed. The DON stated the resident had a history of changing the height of his bed, The DON was told the resident was sleeping in his bed and the CNA admitted to not lowering his bed after he had finished eating breakfast. They stated the resident had recent falls and his bed should be in the lowest position possible, so if he fell out of the bed, there was less chance of injury. Record review of the policy Falls and Fall Risk, Managing (03/2018) reflected Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved.

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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 provide appropriate treatment and services to prevent complications of enteral feeding for two (Resident #13 and Resident #39) of two residents reviewed for feeding tube (a way of providing nutrition directly to the stomach) management.1. The facility failed to ensure LVN A checked Resident #13's g-tube (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) placement and residual before administering medication on 01/07/2026. 2. The facility failed to ensure Resident #39 had orders to flush the g-tube before, during, and after medication administration on 01/07/2026.These failures could place residents with g-tubes at risk for tube displacement, clogging, aspiration, and discomfort.Findings included:1. Record review of Resident #13's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing).Record review of Resident #13's Comprehensive MDS Assessment, dated 11/14/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had a feeding tube.Record review of Resident #13's Quarterly Care Plan, dated 11/30/2025, reflected the resident required tube feeding and one of the interventions was to check for tube placement.Record review of Resident #13's Physician Order, dated 10/04/2023, reflected Check placement of G-Tube prior to medication administration every shift.An observation on 01/07/2026 at 9:03 AM, revealed LVN A was about to give Resident #13's medication via g-tube. She sanitized her hands, put the medications in a small plastic cup one by one, crushed them, returned the crushed medications to the small plastic cup, and dissolved them. She put the cups of crushed medications in a tray along with 60 cc of water and another 120 cc of water. She then went inside the resident's room and placed the tray on top of the resident's overbed table. She took a 60 ml piston syringe from the resident's cabinet and placed it on the overbed table. She put on a gown and a pair of gloves, raised the bed, elevated the head of the bed, turned off the machine, and disconnected the g-tube from the formula. After disconnecting the g-tube, she pulled the plunger out of the syringe, attached the syringe to the g-tube, and flushed the g-tube. After flushing the g-tube, she poured the dissolved medications one by one and flushed in between medications. She did not check for placement of the resident's g-tube before flushing and administering the medication. After she was done administering the medications, she flushed the g-tube, detached the syringe, connected the g-tube to the formula, and cleaned the table and the syringe.In an interview on 01/07/2026 at 9:19 AM, LVN A stated she forgot to check the placement before flushing the g-tube. She said the placement should be checked to make sure that the g-tube was not dislodged. She said the dislodged g-tube could cause aspiration. 2. Record review of Resident #39's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (presence of surgical opening in the stomach to support nutrition).Record review of Resident #39's Comprehensive MDS Assessment, dated 12/29/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident had a feeding tube.Record review of Resident #39's Quarterly Care Plan, dated 01/02/2026, reflected the resident had a feeding tube and one of the goals was the peg tube (a flexible feeding tube inserted directly to the stomach) would be patent throughout facility stay.Record review of Resident #39's Physician Order on 01/07/2026 reflected no orders to check for residuals, check for tube placement, and to flush before, during, and after medication administration.An observation on 01/07/2026 at 10:19 AM, revealed LVN B was about to administer Resident #39's medication via g-tube. She flushed the resident's g-tube with 30 ml of water and proceeded to administer the medications one-by-one, flushing in between medications with 5 ml water. After she was done administering the medications, she flushed the g-tube with 30 ml (continued on next page)

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	676168	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd Highland Village, TX 75077

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of water.Observation and interview on 01/07/2026 at 10:29 AM, LVN B stated g-tubes should be flushed before and after medication administration to maintain its patency, to make sure all the medications went through, and nothing was left in the tube. She said placement and residual should also be checked to see if the tube was not dislodged and that the resident's stomach had no problem with absorption. When asked if the resident had an order for flushing the g-tube, checking for placement, and checking for the residual. LVN B checked her computer for the order and said there was no orders for flushing the g-tube, checking for placement, and checking for the residual. She said she knew what to do but there should be an order for flushing the g-tube, checking for placement, and checking for the residual. She said this should have been caught earlier by whoever was administering the resident's medications, so an order was put in place. She said she was partly at fault because she did not check if the resident had appropriate orders. She said there should be an order for everything done for the resident to ensure continuity of care. She said she would just finish what she was doing and then would transcribe the orders.In an interview on 01/08/2026 at 6:41 AM, the ADON stated the g-tube placement should be checked before giving the medications. She said g-tube placement should be checked to ensure the g-tube was in the right place and would not cause aspiration. She said even though the residents were on continuous feeding, the placement should still be checked. She said there should be orders for everything done for the residents. She said even though the nurses knew what to do, there should be an order in the resident's profile. She said the resident had been in the facility for almost two weeks and nobody noticed that there was no order pertaining to the flushing, checking for placement, and checking for residual. She said it was an oversight for those administering the resident's medication. She said it was also an oversight on her part because she was supposed to check the orders as well. She said the expectation was for the staff to check for g-tube placement and to check if appropriate orders were in place. She said the DON already started an in-service about enteral feeding.In an interview on 01/08/2026 at 7:40 AM, the DON stated the placement of the g-tube should be checked before flushing it and before medication administration to ensure the medications and the fluid would enter the stomach and not the lungs. She said even though the staff did the right procedure and knew that the g-tube needed flushing before and after administering medications via g-tube, there should still be an order for flushing before and after and how much should be used for flushing. She said, new nurses might not be familiar with how to administer medications via g-tube and end up not flushing the g-tube before and after, and then they would wonder why the g-tube was clogged. She said the expectation was for the nurses to check for g-tube placement and check if the orders for g-tubes were complete. She said she already started an in-service about g-tube and physician order as soon as she learned about the issue.In an interview on 04/17/2026 at 8:36 AM, the Administrator stated the expectation was for the staff to check the g-tube placement as per order and there were appropriate orders for the g-tube. He said the DON already started an in-service about g-tube and physician orders but would closely coordinate with the DON to monitor the adherence of the staff to the policies.Record review of the facility's policy Administering Medications through an Enteral Tube 2001 MED-PASS, Inc., revised November 2018 reflected Purpose: 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 . 6. Verify placement of feeding tube.Record review of the facility's policy Medication and Treatment Orders 2001 MED-PASS, Inc., revised July 2016 reflected Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and Implementation . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . 3. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer parenteral fluids consistent with professional standards of practice and in accordance to physician orders for one (Resident #8) of eight residents reviewed for parenteral (delivery of medications through injection)/IV (intravenous: administering fluids or medications directly into a vein) fluids. The facility failed to ensure Resident #8 had orders to flush the IV before medication administration, to monitor for infiltration (fluid leaks from a vein to the surrounding tissues) and infections, and when to change the IV site dressing.This failure could place residents receiving IV medications at risk for injury, infections, IV infiltration, clogging, pain, which may result in required replacement of IV.Findings included:Record review of Resident #8's Face Sheet, dated 01/06/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with urine retention. Record review of Resident #8's Comprehensive MDS Assessment, dated 12/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had urine retention.Record review of Resident #8's Comprehensive Care Plan, dated 11/10/2025, reflected the resident had a UTI and one of the interventions was to administer antibiotic as ordered.Review of Resident #8's Physician Order, dated 01/06/2025, reflected Imipenem (medication used for bacterial infection) 1-gram IVPB every 8 hours X days every 8 hours for 7 Days.An observation on 01/07/2026 at 2:06 PM, revealed LVN B was about to connect Resident #8's antibiotics via IV. She washed her hands and put on a pair of gloves. She prepared the antibiotics and connected it to the resident's PICC line. Before, connecting the antibiotics, LVN B flushed the PICC line.During an observation and interview on 01/07/2026 at 2:29 PM, LVN B stated before connecting the IV, the PICC line should be flushed to ensure the line was patent and would not get clogged. She said the dressing should be changed every seven days. When asked if the resident had orders for flushing and dressing changes, LVN B checked the resident's profile and said there were no orders for flushing and dressing changes and there should be an order.In an interview on 01/08/2026 at 6:41 AM, the ADON stated there should be an order on the Resident #8's chart about flushing the PICC line before connecting the IV bag with antibiotics. She said there should also be orders on when to change the dressing and what to assess, like check for signs and symptoms of infections. She said LVN B told her about the issue and they already entered the appropriate orders pertaining to the resident's IV on the resident's physician orders. She said, for example, there was no order when to change the dressing, the staff would not be able to change the dressing because it would not be on the resident's eTAR.In an interview on 01/08/2026 at 7:23 AM, LVN G stated he was the one that put in Resident #8's order for the antibiotics. He said aside from the order for the antibiotics, he did not put any order to flush the IV every shift or before medication administration, and when to change the dressing. He said the orders should be in place to ensure continuity of IV care. He said there was standard orders pertaining to IVs but those orders should still be in the resident's profile.In an interview on 01/08/2026 at 7:40 AM, the DON stated there should be orders to flush the PICC line, when to change the dressing, and what to assess. She said everything done for the resident should have orders. She said the nurses might know what to do but there should be orders so the staff would be in synched with the residents' care. She said she already started an in-service.In an interview on 04/17/2026 at 8:36 AM, the Administrator stated the expectation was orders would be in place to make sure the staff were doing the care correctly. He said the DON already started an in-service.Record review of the facility's policy Peripheral and Midline IV Catheter Flushing and Locking 2001 MED-PASS, Inc., revised March 2022 reflected Purpose: The purposes of this procedure are to maintain catheter patency and function.Record review of the facility's policy Medication and Treatment Orders 2001 MED-PASS, Inc., revised July 2016 reflected Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing . Policy Interpretation and (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementation . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state . 3. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of four residents (Resident #37) reviewed for respiratory care. The facility failed to ensure Resident #37's BiPAP mask and nebulizer machine (breathing treatment device) was properly stored in a bag when not in use on 01/06/26. This failure could place the resident at risk for respiratory infection and not having his respiratory needs met.Findings included: Record review of Resident #37's Face Sheet, dated 01/08/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #37 had acute respiratory failure with hypoxia (low oxygen intake). Record review of Resident #37's Quarterly MDS Assessment, dated 12/02/25, reflected Resident #37 had a severe cognitive impairment response. The Quarterly MDS Assessment reflected the resident had an active diagnosis of respiratory failure. Record review of Resident #37's Physician Orders, dated 01/07/26, reflected BiPAP on at night per home settings at bedtime for sleep apnea and Albuterol Sulfate inhalation solution, 2 puff inhale orally every 4 hours for shortness of breath. In an observation on 01/06/26 at 11:05 AM, Resident #37's BiPAP mask was observed sitting on top of a stand unbagged and a nebulizer machine was sitting on a nightstand unbagged. In an interview and observation on 1/06/26 at 11:07 AM, LVN A was shown Resident #37's BiPAP mask and breathing treatment device unbagged and she stated they should both be bagged to avoid any bacteria from getting on them. She stated it was the nurse's responsibility to ensure the items were bagged when not in use. In an interview on 01/08/26 at 11:10 AM, the DON and ADON stated they were told by LVN A about Resident #37's BiPAP mask and breathing treatment device not being bagged. The DON stated the nurse stated she had bagged the items previously, but the resident may have unbagged them. They stated it was the nurse's responsibility to ensure both devices were bagged when not in use to avoid the resident getting an infection. Review of the facility's policy Oxygen Administration, 10/2010, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.2. Review the resident's care plan to assess any special needs of the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for four (Residents #2, #10, #15, #25) of eighteen residents and one (Nurse's Cart #1) of three nurses' carts reviewed for medication storage. 1. The facility failed to ensure that Resident #2's nystatin powder, antifungal powder, and zinc oxide were not on top of the resident's side table on 01/06/2026.2. The facility failed to ensure that a skin barrier was not left on top of Resident #25's overbed table on 01/07/2026.These failures could place the residents at risk of accidental overdose, misuse of medications, not receiving the medication's full therapeutic benefits, and possible adverse reactions.Findings include: 1. Record review of Resident #2's Face Sheet, dated 01/06/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with neoplasm (abnormal growth of tissue in the body) of the breast. Record review of Resident #2's Comprehensive MDS Assessment, dated 12/23/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident had neoplasm of the breast.Record review of Resident #2's Comprehensive Care Plan, dated 11/13/2025, reflected that the resident had potentials for alteration of skin integrity related to fungal or yeast infections under the breasts and one of the interventions was to apply medications as ordered. Record review of Resident #2's Physician's Order, dated 09/21/2025, reflected Nystatin Cream 100000 UNIT/GM Apply to under bilateral breast topically every 8 hours as needed for Skin Irritation.During an observation and interview on 01/06/2026 at 9:13 AM, revealed Resident #2 was in her bed, awake. Containers of nystatin powder, antifungal powder, and zinc oxide were on top of the resident's side table. The resident the medications on top of the side table were hers. In an interview on 01/06/2026 at 11:23 AM, LVN C stated the nystatin powder, antifungal powder, and zinc oxide should not be inside Resident #2's room. He said it should be inside the nurses' carts because the nurses were supposed to be the ones administering the nystatin and the fungal powder and the CNAs were supposed to apply the zinc oxide. He said he did not know who left the nystatin powder, antifungal powder, and zinc oxide inside the resident's room and said he did not notice them when he gave the resident's morning medications. He said the resident might use it more than the recommended and could result in skin redness or dryness. He said confused residents might consume them as well that could result to upset stomach and nausea. LVN C said he would go to the resident's room and would get the medications.2. Record review of Resident #25's Face Sheet, dated 01/06/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with fracture to left humerus.Record review of Resident #25's Comprehensive MDS Assessment, dated 12/29/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder.Record review of Resident #25's Comprehensive Care Plan, dated 01/06/2025, reflected that the resident was incontinent and one of the interventions was to apply skin barrier after incontinent care.During an observation and interview on 01/07/2026 at 6:50 AM, revealed that a tube of skin barrier was on Resident #25's overbed table. Resident #25 said the staff would use it every time they changed her. She said she was not sure who left the skin barrier on her table.During an observation and interview on 01/07/2026 at 7:02 AM, revealed LVN C took the tube of skin barrier from Resident #25's overbed table. He said he took the tube of skin barrier because it should not be inside the room. He said the resident might have mistook it as toothpaste or might mistakenly consumed it. He said the skin barrier should be in the cart.In an interview on 01/08/2026 at 6:41 AM, the ADON stated medicated creams and medicated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	powders. She said the nystatin powder, antifungal powder, and zinc oxide should not be inside the residents' rooms and should be in the carts and should be secured so the residents, especially the confused resident, would not get a hold of them. She said residents with poor eyesight could mistakenly thought that zinc oxide was sauce and put on their food. She said the DON already started an in-service about medication storage.In an interview on 01/08/2026 at 7:11 AM, CNA E stated zinc oxides should not be inside the resident's rooms or somewhere they could access them. She said the zinc oxides should be in the cart and just ask for it when needed. She said the zinc oxide could be placed in a small cup so that the tube would stay in the cart. She said they should not be left inside the room where the resident or other residents could reach it and accidentally put it in their mouth. She said she was not sure what could happen, but she was sure zinc oxides was not for consumption. In an interview on 01/08/2026 at 7:40 AM, the DON stated medications should not be stored inside the resident's room. She said nystatin powder, antifungal powder, and zinc oxide should be inside the carts to secure them. She said the residents might use them inappropriately that could result in adverse reactions. She said zinc oxide was applied topically and could be harmful when ingested. She said the same rationale applied to the medicated powders. She said she already started an in-service about medication storage.In an interview on 04/17/2026 at 8:36 AM, the Administrator stated the expectation was for the staff to make sure there was no medications inside the resident's rooms because the residents might consume the medications or use them inappropriately. He said another expectation was that expired medications should be disposed of so they would not be used for the residents. He said the DON already started an in-service about medication storage but closely coordinated with the DON so the issue would not happen again.Record review of the facility's policy entitled, Medication Labeling and Storage MED-PASS revised February 2023 reflected Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys . Policy Interpretation and Implementation . Medication Storage . 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals . instructions regarding returning or destroying these items.