STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a private meeting space for residents' monthly Resident Council Meeting for 10 of 10 confidential residents reviewed for Resident Council.The facility failed to provide a private space for residents who attended monthly Resident Council Meetings.This failure could place residents at risk of not being able to voice their concerns amongst each other due to a lack of privacy.Findings included:During an interview on 04/20/26 at 10:46 a.m., the Activities Director stated the confidential group meeting on 04/21/26 with the residents of Resident Council and the State Surveyor would be held at 2:00 p.m. in the facility's Activities Room located at the end of the 200 Hall. The Activities Director stated since her employment at the facility, the residents monthly Resident Council Meetings were held in the Activities Room.During an observation on 04/20/26 at 1:38 p.m. of the Activities Room at the end of 200 Hall revealed the space was an open area and did not include any door (s) that separated the area from the 200 Hall for privacy. The Activities Room was adjacent to the 200 Hall, which included 15 resident rooms. The Activities Room area shared common walls with two occupied resident rooms on the 200 Hall. The Activities Room had one interior/exterior side door that led to the facility's designated Smoking Area for the residents in the facility who were smokers. During the observation, several residents and staff members were observed entering and exiting the interior/exterior side door of the Activities Room. Observation revealed a partition barrier with a grey curtain on wheels.During an interview on 04/20/26 at 10:46 a.m., the Activities Director stated she was employed for three months. She stated during the monthly Resident Council Meetings, she would place the partition barrier with a grey curtain on wheels between the 200 Hall and the Activities Room. She stated that the partition barrier with a grey curtain on wheels had a sign that stated, Resident Council Meeting in Progress. She stated the monthly Resident Council Meetings were held in the Activities Room, but no staff members or residents had entered the Activities Room via the 200 Hall because of the posted sign on the partition barrier. She stated no staff members or residents had entered the Activities Room via the interior/exterior side door and interrupted the monthly Resident Council Meetings. She stated that she would have to think about a place to have the monthly Resident Council Meetings and suggested the Employee Break Room. She stated that the Employee Break Room would not work because the Employee Time Clock for Employees was in there. The Activities Director stated there was a risk for residents not to have privacy when there was not a door in the area where the monthly Resident Council Meetings were held. She stated without any doors in the area where the monthly Resident Council Meetings, there was potential for the discussions to be overheard by staff, residents or anyone on the 200 Hall. The Activities Director stated that if the discussions in the monthly Resident Council Meetings were overheard by someone, it could cause harm such as retaliation to a resident because what they discussed was not confidential.During an interview on 04/20/26 at 11:27 a.m., the Activities Director stated the confidential group meeting on 04/21/26 with the residents of Resident Council and the State Surveyor would be held in the Private Dining Room on the 100 Hall for privacy.A confidential group meeting was held at an undisclosed date and time in the Private Dining room [ROOM NUMBER] Hall. In the confidential group meeting, 10 (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents that regularly attended the facility's monthly Resident Council Meetings stated that their monthly Resident Meetings were held in the Activities Room, which was adjacent to the 200 Hall. The residents described the Activities Room area as being a room connected to the 200 Hall. The residents stated that the Activities Room had one interior/exterior side door that led to the facility's designated Smoking Area and parking lot. The residents stated the large opening that led to the 200 Hall did not provide any privacy for the residents to discuss what they needed to discuss about the facility operations, including their concerns regarding the staff and the care they received by the staff and there was no privacy. The residents stated they had never had any Resident Council Meetings in the area where the Resident Council Meeting was being held on 04/21/26. The residents stated during some of their previous monthly Resident Council Meetings, they were disrupted by staff during their meetings and would prefer that staff and residents did not enter the Activities Room during their meetings, which occurred on several occasions. The residents stated they would prefer to have their monthly Resident Council Meetings in a location that had doors to ensure privacy and would not allow staff or residents to overhear what was being discussed in their meetings to prevent retaliation from staff and other residents. The residents stated the Private Dining Room provided privacy and would prefer to have their monthly Resident Council Meetings in the same area where the confidential group was held on 04/21/26.During an interview on 04/21/26 at 2:56 p.m., CNA A revealed she was employed at the facility for one year. CNA A stated she was unaware the facility needed to have a private area that allowed residents who attended the monthly Resident Council Meetings with privacy, which included doors to ensure privacy for the residents during their meetings. CNA A stated that residents had not told her anything about wanting to have more privacy during the monthly Resident Council Meetings. CNA A stated that the monthly Resident Council Meetings were held when she was not on duty. CNA A stated the risk of not having a secure area for the residents during their monthly Resident Council was the residents did not have privacy due to there not being doors between the 200 Hall. She stated residents may not feel comfortable expressing themselves during their monthly Resident Council Meetings if what they discussed was overheard by anyone who was not attending the meetings. She stated the doors would provide privacy and some protection for the residents to have discussions amongst themselves. She stated the members of the Resident Council have the right to have privacy during their monthly Resident Council Meetings. CNA A stated if a resident(s) mentioned their concerns during one of their monthly Resident Council Meetings and the discussions were overheard and involved another resident or staff member, there was a potential for harm to the residents in the meeting to face being retaliated against and may cause arguing and disagreements with the person that overheard what was being discussed in the meetings.During an interview on 04/21/26 at 3:17 p.m., CNA B revealed she was employed for one year. CNA B stated she was unaware the facility needed to have a private area that allowed residents who attended the monthly Resident Council Meetings with privacy, which included doors to ensure privacy for the residents during their meetings. CNA A stated residents had not told her anything about wanting to have more privacy during the monthly Resident Council Meetings. CNA B stated that there was a risk to residents that attended the monthly Resident Council Meetings to have everything they mentioned in the meeting being overheard by someone who did not attend the meeting. CNA B stated that harm could be caused to a resident, if their discussions were overheard, which could cause retaliation and an unsafe environment for the staff and residents.During an interview on 04/21/26 at 4:05 p.m., the Administrator stated that the facility did not have a policy on Resident Council and Resident Council Meetings.Record review of the facility's undated policy, Notice of Resident Rights and Responsibilities, did not provide any information relating to Resident Council and Resident Council Meetings.Record review of the facility's, List of Smokers reflected there were 8 residents in the facility who were Smokers.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a person-centered, comprehensive care plan for each resident that included measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs for 6 (Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, Resident #8) of 6 residents reviewed for care plans.1 The facility failed to revise the person-centered care plan for six (Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, Resident #8) of six residents addressed their interventions for Full Code or DNR on their Advanced Directives. 2. The facility failed to include the Advanced Directives for one (Resident #8) of one resident on the resident's Care Plan.These failures could affect residents at the facility by placing them at risk of not receiving the appropriate services, care and treatments needed to maintain their optimal health.Findings included:Record review of Resident #12's admission face sheet dated 04/22/26 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: encephalopathy (any disease, damage, or malfunction of the brain that causes an altered mental state, such as confusion, memory loss, or reduced consciousness0, dementia (memory loss), schizoaffective disorder and multiple sclerosis (a chronic disease of the central nervous system (brain, spinal cord, and optic nerves), and acute kidney failure. Resident #12's Advance Directive was listed as DNR-DO NOT RESUSCITATE.Record review of Resident #12's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 3 indicated severe cognitive impairment.Record review of Resident #12's Care Plan printed 04/20/2026 reflected, Focus: Resident has initiated Advanced Directives.Date Initiated: 03/13/2025Revision on: 03/13/2025Goal: Advanced Directive preferences will be honored through review date.Date Initiated: 03/13/2025Target Date: 05/13/2026Interventions/Tasks: Provide advanced directive education and support in directive completion.Date Initiated: 03/13/2025 Review advanced directives and preferences quarterly and PRN with resident / RP.Date Initiated: 03/13/2025 Update contact information with Power of Attorney/ Legally Authorized Representative information.Date Initiated: 03/13/2025 Update resident's chart to reflect elected code status, staff must be aware of code status election.Date Initiated: 03/13/2025Record review of Resident #12's Order Summary printed 04/22/26 reflected an active verbal order on 03/29/26 for DNR-DO NOT RESUSCITATE.Record review of Resident #12's OOH DNR was signed by Resident #12 on -1/25/2018.Record review of Resident #43's admission face sheet dated 04/20/26, reflected a [AGE] year-old female admitted to the facility on [DATE] with active diagnoses that included: dementia with anxiety, COPD (chronic pulmonary disease - a progressive, incurable lung disease that obstructs airflow, causing chronic breathing difficulties), chronic bronchitis and Type 2 diabetes. Resident #43's Advance Directive was Full Code (use AED - automated External Defibrillator) with CPR during sudden cardiac arrest.Record review of Resident #43's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 indicated moderate cognitive impairment.Record review of Resident #43's Care Plan printed 04/20/2026 reflected, Focus: Resident has been educated about an Advanced Directive.Date Initiated: 02/29/2024Revision on: 11/25/2024Goal:Code Status election will be honored through review dateDate Initiated: 02/29/2024Revision on: 11/17/2025Target Date: 06/19/2026Interventions/Tasks: Provide advanced directive education and support in directive completion.Date Initiated: 11/25/2024 Review advanced directives and preferences quarterly and PRN with resident / RP.Date Initiated: 11/25/2024 Review code status quarterly and PRN with resident / RPDate Initiated: 02/29/2024 Update contact information with Power of Attorney/ Legally Authorized Representative information.Date Initiated: 11/25/2024 Update resident's chart to reflect elected code status, staff must be aware of code status election.Date Initiated: 02/29/2024Record review of Resident #43's Order Summary printed 04/20/26 reflected an active verbal order on 01/08/24 for FULL CODE: USE (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AED (Automated External Defibrillator) WITH CPR DURING SUDDEN CARDIAC ARREST.Record review of Resident #9's admission face sheet dated 04/23/26 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: Type 2 diabetes, stroke, chronic kidney disease and chronic kidney disease. Resident #9's Advance Directive was listed as CPR/Full Code.Record review of Resident #9's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 indicated moderate cognitive impairment.Record review of Resident #9's Care Plan printed 04/23/2026 reflected, Focus: Resident has been educated about an Advanced Directive.Date Initiated: 04/09/2024Goal:Code Status election will be honored through review date.Date Initiated: 04/09/2024Revision on: 01/29/2025Target Date: 04/15/2026Interventions/Tasks: Review code status quarterly and PRN with resident / RP.Date Initiated: 04/09/2024 Update resident's chart to reflect elected code status, staff must be aware of code status election.Date Initiated: 04/09/2024Record review of Resident #9's Order Summary printed 04/23/26 reflected an active phone order on 05/09/24 for CPR/FULL CODE.Record review of Resident #4's admission face sheet dated 04/20/26 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with active diagnoses that included: dementia with anxiety, COPD (chronic pulmonary disease - a progressive, incurable lung disease that obstructs airflow, causing chronic breathing difficulties), chronic bronchitis and Type 2 diabetes. Resident #4's Advance Directive was Full Code (use AED - automated External Defibrillator) with CPR during sudden cardiac arrest.Record review of Resident #4's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 indicated moderate cognitive impairment.Record review of Resident #4's Care Plan printed 04/20/2025 reflected, Focus: Resident has been educated about an Advanced Directive.Date Initiated: 02/29/2024Revision on: 11/25/2024Goal:Code Status election will be honored through review dateDate Initiated: 02/29/2024Revision on: 11/17/2025Target Date: 06/19/2026Interventions/Tasks: Provide advanced directive education and support in directive completion.Date Initiated: 11/25/2024 Review advanced directives and preferences quarterly and PRN with resident / RP.Date Initiated: 11/25/2024 Review code status quarterly and PRN with resident / RPDate Initiated: 02/29/2024 Update contact information with Power of Attorney/ Legally Authorized Representative information.Date Initiated: 11/25/2024 Update resident's chart to reflect elected code status, staff must be aware of code status election.Date Initiated: 02/29/2024Record review of Resident #4's Order Summary printed 04/20/26 reflected an active verbal order on 01/08/24 for FULL CODE: USE AED (Automated External Defibrillator) WITH CPR DURING SUDDEN CARDIAC ARREST.Record review of Resident #59's admission face sheet dated 04/23/26 reflected she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: anoxic brain damage (brain injury caused by a total lack of oxygen reaching the brain, leading to cell death within minutes), epilepsy (chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain), and quadriplegia (paralysis causing partial or total loss of motor and/or sensory function in all four limbs (arms and legs) and the torso, resulting from a cervical spinal cord injury or brain injury), and anemia in chronic kidney disease. Resident #59's Advance Directive was Full Code (use AED - automated External Defibrillator) with CPR during sudden cardiac arrest.Record review of Resident #59's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 12 indicated moderate cognitive impairment.Record review of Resident #59's Care Plan printed 04/23/2025 reflected, Focus: Resident has been educated about an Advanced Directive.Date Initiated: 05/20/2024Revision on: 11/25/2024Goal: Code Status election will be honored through review date.Date Initiated: 05/20/2024Revision on: 05/21/2025 Advanced Directive preferences will be honored through review date.Date Initiated: 11/25/2024Revision on: 05/21/2025Interventions/Tasks: Provide advanced directive education and support in directive completion.Date Initiated: 05/20/2024 Review advanced directives and preferences quarterly and PRN with resident / RP.Date Initiated: 05/20/2024 Review code status quarterly and PRN with resident / RPDate Initiated: 05/20/2024 Update resident's chart (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to reflect elected code status, staff must be aware of code status election.Date Initiated: 05/20/2024. Record review of Resident #59's Order Summary printed 04/23/26 reflected an active verbal order on 03/08/25 for FULL CODE: USE AED (Automated External Defibrillator) WITH CPR DURING SUDDEN CARDIAC ARREST. Record review of Resident #8's admission face sheet dated 04/23/26 reflected she was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted [DATE] with active diagnoses that included: postprocedural hypothyroidism (an underactive thyroid condition resulting from thyroid removal surgery), schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia (psychosis) and mood disorders (mania or depression), and Type 2 diabetes. Resident #8's Advance Directive was Full Code (use AED - automated External Defibrillator) with CPR during sudden cardiac arrest.Record review of Resident #8's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 13 indicated intact cognition.Record review of Resident #8's Care Plan printed 04/20/2026 reflected, no Advanced Directives.Record review of Resident #8's Care Plan printed 04/23/2026 was updated and reflected, Focus: Resident has elected Full Code statusDate Initiated: 04/22/2026Revision on: 04/22/2026Goal: Advanced Directive preferences will be honored through review date.Date Initiated: 04/22/2026Target Date: 08/04/2026Interventions/Tasks: Initiate full code measures in case of cardiac arrest, to include CPR and AED use.Date Initiated: 04/22/2026 Provide advanced directive education and support in directive completion.Date Initiated: 04/22/2026 Review advanced directives and preferences quarterly and PRN with resident / RP.Date Initiated: 04/22/2026 Review code status quarterly and PRN with resident / RP.Date Initiated: 04/22/2026 Update resident's chart to reflect elected code status, staff must be aware of code status election.Date Initiated: 04/22/2026Record review of Resident #8's Order Summary printed 04/23/26 reflected an active phone order on 01/29/26 for FULL CODE: USE AED (Automated External Defibrillator) WITH CPR DURING SUDDEN CARDIAC ARREST.During an interview with the MDS Coordinator on 04/22/26 at 11:10 AM, she stated that she had been employed at the facility for 1 1/2 years. She stated she recently became the MDS Coordinator at the facility in December 2025. The MDS Coordinator stated she was unaware that the Care Plans for Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, Resident #8 addressed their interventions for Full Code or DNR on their Advanced Directives. The MDS Coordinator stated she was unaware that the Care Plan for Resident #8 did not include the Advanced Directives. The MDS Coordinator stated that the residents Advanced Directives should reflect if they requested Full Code or DNR. She stated that she had been on Leave from work and during her Leave of Absence from work, the facility's MDS Resource was given the role of the MDS Coordinator for the facility. The MDS Coordinator stated that she was responsible for inputting information such as the Advanced Directives with special instructions for Full Code or DNR in each resident's EHR. The MDS Coordinator was asked to verify in the facility's EHR if Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, and Resident #8's Advanced Directives included the special instructions per the resident's request of Full Code or DNR, and she confirmed that all 6 resident's Advanced Directives included their requests of being Full Code or DNR. The MDS Coordinator stated the Advanced Directive should have been included in Resident #8's Care Plan upon her admission to the facility. She stated that according to the MDS Training she had taken, the Advanced Directives should be included on each Care Plan. She stated that she would get with the MDS Resource and resident's Care Plans for the residents in the facility. She stated that the risk to a resident is if there was an Emergency, no know would know if the resident requested Full Code or DNR. She stated that the harm caused by the Advanced Directives not being inputted correctly in a resident's Care Plan was there could be a delay in care and treatment to fit the resident's needs.During an interview with the Social Worker on 04/22/26 at 11:35 AM, she stated that she had been employed at the facility for 3 months. She stated that she was unaware that the Care Plans for 6 residents (Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, Resident #8) did not include the special directions of Full Code and DNR. The Social Worker stated that she was unaware that Resident #8 did not have any (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Advanced Directives on her Care Plan. She stated that the Care Plans she has seen for residents included Advanced Directives but was unsure if the Advanced Directions included Full Code or DNR. She stated that a resident's Care Plan should include if they requested to be Full Code or DNR during an emergency. The Social Worker stated that the Nursing Staff inputted the Advanced Directive information on the resident's Care Plan. She stated that the risk of a resident Care Plan not including Full Code or DNR status would be if a resident were a Full Code and the staff did not perform CPR, that would be unethical and the resident could not survive and could have survived per their request of being Full Code. She stated that the risk of a resident Care Plan not including DNR and the resident was given CPR in an emergency, that would be unethical and the resident would be resuscitated instead of their request of being DNR. The Social Worker stated that psychological harm could be caused to a resident if their wishes were not respected due to their Care Plans being incorrect.During an interview with the DON on 04/22/26 at 12:24 PM, she stated that she had been employed at the facility for 3 years. She stated that she was unaware that the Care Plans for 6 residents (Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, Resident #8) did not include the special directions of Full Code and DNR. The DON stated that she was unaware that Resident #8 did not have any Advanced Directives on her Care Plan. The DON stated that the Nursing Staff were not responsible for inputting the Advanced Directives information on resident's Care Plans. She stated that the Social Worker was responsible for inputting the Advanced Directives information on resident's Care Plans. The DON stated during an emergency the Nursing Staff review the resident's Order Summary to find out if the resident has a Physician's Order for Full Code or DNR. She stated that the Care Profile for residents stated if the resident was DNR or Full Code. She stated the Face Sheet, Order Summary are the 2 documents sent with the resident if they are sent out of the facility to the hospital. The DON stated that there was no risk or harm caused to residents if their Advanced Directives did not include DNR or Full Code.During an interview with CNA A on 04/23/26 at 2:40 PM, stated she had been employed at the facility for 1 year. She stated that she was unaware that the Care Plan for 6 residents (Resident #12, Resident #9, Resident #43, Resident #4, Resident #59, Resident #8) did not include the special directions of Full Code and DNR. CNA A stated that she was unaware that Resident #8 did not have any Advanced Directives on her Care Plan. CNA A stated each resident's Care Plan should include Advanced Directives with special instructions of Full Code and DNR. She stated that harm could be caused to residents if an emergency incident occurred and there were not any special instructions on the resident's Advanced Directives in their Care Plan that stated Full Code or CPR. She stated that the staff or emergency personnel would not know whether or not to perform CPR on a resident depending on their Physicians Orders.Record review of the facility's undated policy, Advanced Directives and Associated Documentation - Resident Rights, reflected, POLICY:It is the policy of this facility that a resident's choice about advanced directives will be recognized and respected. Further, it is the policy of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advanced directive. The facility recognizes and respects the resident's right to choose their treatment and make decisions about care to be received at the end of their life. It is the policy of this facility to implement the resident decisions and directives that are in compliantcompliance with State and/or Federal Law and the policies of this facility. The resident will not be discriminated against for a decision to implement or not implement Advance Directives. Definitions: Advance care planning: Process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. Advance directive: A written instruction that relates to the provision of health care when the individual is incapacitated, such as a Living Will, Durable Power of Attorney for Health Care or the Natural Death Act. These documents allow the individual to identify choices related to their medical treatment or designate someone to make treatment choices for them should they lose decision (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	making capacity for themselves Agent: The individual (Attorney-in-fact) designated by a person (Principal) pursuant to a Durable Power of Attorney for Health Care to act on his or her behalf in health matters in the event that the person loses decision-making capacity Conservator: The person appointed by a court with the legal power and duty of taking care of and managing the property and/or personal affairs of another person who is considered incapable of administering his/her own affairs Health care decision-making: Refers to consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat a resident' physical or mental condition. Health care decision-making capacity: Refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choice. A person is presumed to have a capacity to make health care decisions unless the attending physician determines that the person is incapacitated or a court rules that the person is incompetent. Life Sustaining Treatment/Procedures: Any medical intervention including artificially administered food and fluids that would prolong the dying process or to artificially prolong life in a permanent vegetative state of irreversible coma. Surrogate Decision maker: - An individual who participates in health care decision making on behalf of an incapacitated person. This individual may be formally appointed (by the Durable Power of Attorney for Health Care or by a court in a conservatorship or guardianship proceeding) or, in the absence of a formal appointment, may be recognized by virtue of a relationship with the person (person's next of kin or close friend)The facility has defined advanced directives to include preferences regarding treatment options; the following list reflects examples of such advance directives (and is intended to be illustrative, not exhaustive): Living Will -A document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis; Do Not Resuscitate - Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health-care proxy, or representative (sponsor) have directed that no cardiopulmonary resuscitation (CPR) is to be attempted; Do Not Hospitalize - Indicates that the resident is not to be hospitalized , even if he/she has a medical condition that would usually require hospitalization; Organ Donation - Indicates that the resident wishes his/her organs to be available for transplantation upon his/her death; Autopsy Request - indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) has requested an autopsy performed upon the death of the resident.NOTE: The person making the request must still be contacted for permission prior to performance of the procedure. Feeding Restrictions - Indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) does not wish for the resident to be fed by artificial means (e.g., tube, intravenous nutrition, etc.) if he/she is not able to be nourished by oral means; Medication Restrictions - Indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) does not wish for the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy, etc.); and Other Treatmen1t Restrictions - Indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) does not wish for the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusions, tracheotomy, respiratory incubation, etc. Procedure:1. Prior to, upon, or immediately after admission, a facility staff member shall:a. Provide the resident/family or responsible agent written information, in a manner easily understood by the resident or resident representative, regarding the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directivesb. Document in the resident health record that, at the time of admission, the resident and/or resident representative have been provided with written information regarding advance directives.c. Inquire whether they have completed an Advance Directive. 2. If the resident is incapacitated at the time of admission and is unable to receive information or indicate whether they have executed an advance directive, the facility may give advance directive information to the resident's representative in accordance with existing State law.a. Identify the primary decision-maker.b. If the resident becomes able to receive information at a later point during their admission, the facility will follow its policy relative to the provision of advance directive information to extent permitted by the resident's condition.c. (continued on next page)

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	676188	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	developed by the IDT which includes, but is not limited to the following professionals:A. Attending PhysicianB. Registered Nurse responsible for the residentC.Dietary Supervisor/DietitianD. Social Services staff member responsible for the residentE. Activity staff member responsible for the residentF. Rehabilitation Specialist physical, occupational, and/or speech therapists as indicatedG. Director of Nursing Services (as applicable)H. Nursing assistants responsible for resident careI. Others as necessary or indicated3. To the extent possible, the resident, the resident's family and/or responsible party should participate in the development of the care plan.4. Every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party5. When the resident has no family or responsible party, and is unable to make his/her own health care decisions, the IDT will act as surrogate decision makers6. Scheduling and preparation of the care plan meeting calendar is completed by the MDS Coordinator7. The MDS Coordinator, Social Services or designee staff will notify the resident, family and/or responsible party, and other interested parties designated by the resident, of the date and time of the care plan conference prior to the meeting.8.Initial care plan/ Interim care plan - initial care plan is started within 24-hours of admission to provide an overview of the resident's care needs. Initial plan of care can be started in PCC /POC and/or through the use of resident care guidelines, shift to shift report.9.The resident's plan of care - focus, goals, and interventions - are communicated and implemented by the members of the health care continuum accordingly.10.The resident's plan of care is reviewed and revised on an ongoing basis, quarterly at a minimum and/or as needed with changes in condition.Findings included:Record review of Resident #12's admission face sheet dated 04/22/26 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with active diagnoses that included: encephalopathy (any disease, damage, or malfunction of the brain that causes an altered mental state, such as confusion, memory loss, or reduced consciousness0, dementia (memory loss), schizoaffective disorder and multiple sclerosis (a chronic disease of the central nervous system (brain, spinal cord, and optic nerves), and acute kidney failure. Resident #12's Advance Directive was listed as DNR-DO NOT RESUSCITATE.Record review of Resident #12's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 3 indicated severe cognitive impairment.Record review of Resident #12's Care Plan printed 04/20/2026 reflected, Focus: Resident has initiated Advanced Directives.Date Initiated: 03/13/2025Revision on: 03/13/2025Goal: Advanced Directive preferences will be honored through review date.Date Initiated: 03/13/2025Target Date: 05/13/2026Interventions/Tasks: Provide advanced directive education and support in directive completion.Date Initiated: 03/13/2025 Review advanced directives and preferences quarterly and PRN with resident / RP.Date Initiated: 03/13/2025 Update contact information with Power of Attorney/ Legally Authorized Representative information.Date Initiated: 03/13/2025 Update resident's chart to reflect elected code status, staff must be aware of code status election.Date Initiated: 03/13/2025Record review of Resident #12's Order Summary printed 04/22/26 reflected an active verbal order on 03/29/26 for DNR-DO NOT RESUSCITATE.Record review of Resident #12's OOH DNR was signed by Resident #12 on -1/25/2018.Record review of Resident #43's admission face sheet dated 04/20/26, reflected a [AGE] year-old female admitted to the facility on [DATE] with active diagnoses that included: dementia with anxiety, COPD (chronic pulmonary disease - a progressive, incurable lung disease [TRUNCATED]

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	676188	A. Building B. Wing	04/23/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety.1. The facility failed to ensure food in the facility's dry storage and freezer areas were labeled and dated according to guidelines.2. The facility failed to seal open items in plastic bags in the dry storage pantry, refrigerator, and freezer areas.3. The facility failed to ensure that expired items in the dry storage pantry and freezer areas were removed.4. The facility failed to ensure that dented cans were removed in the dry pantry area and were separated from the other canned food.These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other food-borne illnesses.Findings Included:An Observation of the kitchen during the brief initial tour of the kitchen on 04/20/26 at 5:06 AM, revealed the following:Dry Pantry area:* 1 box of 6 variety packages of Nutritional Powder Drink Mix with an expiration date of 06/18/24.* 4 boxes of 32 oz. powdered cane sugar with an expiration date of 02/16/25.* 1 box of 6 buttermilk pancake mix with an expiration date of 03/06/25.* 1 box of 11 cans of 14.5 oz. diced sweet red peppers with an expiration date of 11/04/25.* 2 bottles of Nepro with Carb Steady Therapeutic Nutrition Drink with an expiration date of 04/01/26.* 1 bottle of Thick and Easy Thickened Dairy Beverage with an expiration date of 02/04/26.* 1 box of 4 bottles of 8 fl. oz. Glucose Control with an expiration date of 10/27/25.* 1 box of 5 lb. buttermilk pancake mix was labeled 4-3 and did not include the year of expiration.* 1 box of 6 lb. chocolate cake mix was labeled 4-3 and did not include the year of expiration.* 1 box of 2 packages of elbow macaroni were labeled 4-3 and did not include the year of expiration.* 1 box of 6 lb. packages of yellow cake mix were not labeled with an expiration date,* 1 container of 80 fl. oz. hamburger pickles were not labeled with an expiration date.* 1 gallon container of sweet n sour sauce was undated and was unsealed and exposed to air.* 1 package of tortillas was undated and was unsealed and exposed to air.* 1 box of 5 lb. boxes of 16 oz. baking soda was unsealed and exposed to air.* 1 bag of 10 lb. enriched macaroni was in a zip loc bag and was unsealed and exposed to air.* 1 bag of 16 oz. Potato Chips were in a plastic Ziploc bag and were unsealed and exposed to air.* 1 package of 22.97 oz. refried pinto beans were in a plastic Ziploc bag and were unsealed and exposed to air.* 2 boxes of 36 oz. grain and wild rice were unsealed and exposed to air.* 1 clear plastic container of labeled, corn meal was unsealed and exposed to air.* 1 package of elbow macaroni was unsealed and exposed to air.* 1 plastic container of labeled sugar was unsealed and exposed to air.* 3 dented cans of 5 oz. Chunk Light Tuna.* 1 box of 5 dented cans of 4 lb. 62 oz. Light Tuna.* 2 dented cans of 14 oz. jellied cranberry sauce.* 1 dented can of 22.6 oz. Cream of Mushroom Soup.* 1 dented can of 62 oz. mushroom pieces and stems.* 1 dented can of 6 lb. 14 oz. black beans.Refrigerator area:* 1 metal pan with 8 bowls of custard in white bowls were unsealed and exposed to air.* 1 metal pan with 1 custard in a clear bowl was unsealed and exposed to air.Freezer area:* 1 plastic Ziploc bag labeled, turkey was unsealed and exposed to air.* 1 metal pan labeled, Hamburger was unsealed and exposed to air. There was a pool of liquified blood observed inside of the metal pan.* 1 white plastic container labeled, margarine was empty and had black particles at the bottom and was filled with water.* 1 white plastic container labeled, shredded cheese had 2 packages of shredded cheese that were unsealed and exposed to air.* 1 white plastic container labeled, shredded cheese had an empty plastic Ziploc bag and there were 10 lunch meat slices located on top of the Ziploc bag which were unsealed and exposed to air.* 1 clear container labeled, gravy was unsealed and exposed to air.* 1 plastic Ziploc bag labeled, turkey included 12 pieces of meat and the meat was white in appearance with green spots.* 1 black plastic bag of bacon was unsealed in an unsealed box and exposed to air.* 1 box of Classic Corndogs were unsealed in an unsealed box and exposed to air.* 1 box of pancakes were unsealed in an unsealed box and exposed to air.* 1 box of beef patties were (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired and unsealed items in the dry storage, and refrigerator areas on 04/20/26. Dietary Aide I stated she was unaware that dented cans were observed in the facility's dry storage area on 04/20/26. Dietary Aide I stated that the Dietary Manager informed the kitchen staff about the state surveyors findings during the initial brief tour of the kitchen on 04/20/26. She stated all the staff were responsible for labeling and storing the items on the shelf and checking the expiration dates on everything in the dry storage, refrigerator, and freezer areas in the facility's kitchen. Dietary Aide I stated dented cans were to be immediately removed from the shelf with the other dented cans and placed in the designated area marked Dented Cans, which was in the Dietary Managers Office. Dietary Aide I stated that all kitchen staff received previous education and training on food storage utilizing the FIFO method. Dietary Aide I stated if she observed food that was expired and/or unsealed, and not labeled in the dry pantry, refrigerator, and/or freezer areas, she would immediately trash the item(s), then immediately notify the Dietary Manager of her findings. Dietary Aide I stated that prior to 04/20/26, the Dietary Manager provided several In-Service training courses for all kitchen staff on food storage, handling, and preparation. She stated all the staff were responsible for labeling and storing the items on the shelf and checking the expiration dates on everything in the dry storage, refrigerator, and freezer areas in the facility's kitchen. Dietary Aide I stated dented cans were to be immediately removed from the shelf with the other dented cans and placed in the designated area marked Dented Cans. Dietary Aide I stated that all kitchen staff received previous education and training on food storage utilizing the FIFO method. She stated if she observed any food item (s) that was expired and/or unsealed, and not labeled in the facility's dry pantry, refrigerator, and/or freezer, she would immediately trash the item (s), then immediately notify the Dietary Manager of her findings. Dietary Aide I stated if someone ingested food from the facility's kitchen dry pantry, refrigerator and freezer areas that were unsealed or expired, or from dented cans they were at risk of food-borne illness from cross-contamination and could become sick. She stated that any ingestion of food that had been unsealed or expired, or from dented cans can cause a person to have stomach issues including stomach aches, diarrhea and vomiting.During an interview with Dietary Aide J on 04/21/26 at 12:05 PM, she stated that she had been employed at the facility for 2 years. She stated that she was unaware that there were expired and unsealed items in the dry storage, refrigerator, and freezer areas on 04/20/26. Dietary Aide J stated she was unaware that dented cans were observed in the facility's dry storage area on 04/20/26. Dietary Aide J stated that the Dietary Manager informed the kitchen staff about the state surveyors findings during the initial brief tour of the kitchen on 04/20/26. She stated that all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She stated that she had taken in-service trainings on food preparation and storage and her last in-service training was about a few weeks ago. She stated prior to 04/20/26, all kitchen staff were In-Serviced by the Dietary Manager to use the First In, First Out Method, which meant that kitchen staff should label the food with the dates they store them, and when staff are restocking the shelves, they are to put the older foods in front or on top so they can be used first. She stated that if a staff member in the kitchen sees any item(s) that are expired, the staff member was to immediately throw the item away in the trash and notify the Dietary Manager what item(s) were thrown away. She stated that everything in the dry storage, freezer and refrigerator should be labeled and dated. Dietary Aide J stated that dented cans should not be placed on the shelves with the other dented cans and need to be immediately removed from the shelf if found and placed in the designated area labeled Dented Cans in the Dietary Managers office and notify the Dietary Manager. She stated that She stated that all staff were responsible for ensuring that the food items in the facility's kitchen were sealed and not exposed to air including the dry storage, refrigerator and freezer areas. Dietary Aide J stated that if food item(s) were found to be unsealed and exposed to air, she would immediately throw the item away and notify the Dietary Manager. She stated if someone ingested any food item(s) that had been cross-contaminated, there was a risk that someone could have severe stomach issues and diarrhea. She stated that with food in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the dry pantry, refrigerator and freezer areas being unsealed and expired items or from dented cans can cause anyone who ingests the food to have an airborne illness and become sick which can cause them harm.Record review of facility's policy, Infection Control - Dietary Services, revised 05/2007 reflected, POLICY:It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness.PROCEDURES:1.Director of Food Service ResponsibilitiesA. Provide safe food services for residents and employees.3. Personnel.B. Education1. Basic orientation and annual in-service education will include.food handling sanitation.5.Food StorageA. Upon arrival, all food will be inspected for damage.G. Old stock is rotated and used first.6. Proper Food Handling.B. Foods coming from broken packages or swollen cans or food with abnormal appearance or odor will not be served.K. Leftovers must be dated, labeled, covered and stored.in a refrigerator, not at room temperature.8. Dietary Housekeeping.G. Storage facilities for raw and cooked food must be cleaned and sanitized on a fixed schedule.Record review of the facility's undated policy titled, Food Storage reflected, POLICY:It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner.PROCEDURES:1.Food storage areas shall be clean at all times.2.The dietary manager, or his/her designee, will check refrigerators and freezers at least daily.Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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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 2 of 6 residents (Resident #65 and #89) reviewed for infection control. The facility failed to ensure CNA C wore appropriate PPE and completed hand hygiene while providing incontinent care to Resident #65.The facility failed to ensure CNA E wore the appropriate PPE while transferring and providing incontinent care to Resident #89.The facility failed to ensure CNA F wore the appropriate PPE and completed hand hygiene while transferring and providing incontinent care to Resident #89.The facility failed to ensure that hand hygiene was completed by staff when providing care to Resident #89, who was on enhanced barrier precautions per facility policy, and that LVN H, the infection control preventionist understood the facility's policy on hand hygiene. This failure could place residents at risk of being infected by staff in contact with other residents with infections.Findings included:Review of Resident 65's Quarterly MDS assessment dated [DATE] revealed a [AGE] year-old male, admitted to the facility 05/06/25. Admitting diagnoses included hypertension (high blood pressure), muscle weakness, muscle waiting (thinning of muscles), lack of coordination, gastrostomy status (individual has a surgically placed gastrostomy tube (medical device inserted through the abdominal wall directly into the stomach to provide nutrition, fluids, and medication) and cognitive communication deficit. Resident #65 was always incontinent with bowels and bladder and required maximum assistance with toileting. Review of Resident #65's care plan revised on 08/28/26 reflected, Resident #65 had bowel and bladder incontinence related to dementia, and impaired mobility. Goal, will remain free from skin breakdown and intervention, check as required for incontinence. Observation on 04/20/2026 at 5:25 AM, revealed CNA C providing incontinent care to Resident #65. CNA C completed hand hygiene and double gloved and did not put on a gown. CNA C cleaned the resident, the resident had a moderate amount of bowel movement. Without changing gloves or any form of hand hygiene, CNA C proceeded and applied the clean brief and then she took off a pair of gloves and remained with one pair. CNA C then positioned Resident #65 and turned on the feeding pump. The posting on the door indicated the staff were required to put on a gown and gloves while taking care of the resident. In an interview on 04/20/2026 at 6:08 AM, CNA C stated she had not been informed to use the gown while taking care of residents with a G-tube. CNA C stated she had taken care of other residents who had a G-tube and she did not wear a gown. CNA C stated according to her training after being hired she was not supposed to clean her hands in-between care, and she was only expected to clean her hands before and after care. CNA C stated she had been educated on infection control upon hire about two weeks ago. CNA C stated infection control was to be maintained to prevent the spread of infection. Review of Resident 89's admission MDS assessment dated [DATE], reflected an [AGE] year-old female, initial admission to the facility on [DATE] and re-admitted on [DATE]. Admitting diagnoses included anorexia (eating disorder), heart failure (inability of the blood to send enough blood), dysphagia (difficult swallowing) and malnutrition (lack of proper nutrition). Resident #89 required moderate assistance with activities of daily living. Review of Resident #89's care plan dated 04/20/26 reflected Resident #89 had nutritional problem related to malnutrition and she had a with G-tube. There was no information in the care plan regarding EBP. Observations on 04/21/2026 at 10:58 AM, revealed CNA E and CNA F assisting Resident # 89 with transfer and incontinent care. The staff gloved but they did not have a gown on. During care CNA F did not complete hand hygiene after cleaning the resident who was soiled with urine and used the same gloves to apply the clean brief. With the same gloves CNA F assisted Resident #89 to get dressed and transferred the resident from the bed to the chair. In an interview on 04/21/2026, at 11:15 AM CNA F stated she was supposed to change gloves and complete hand hygiene after cleaning (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident, but she forgot. She stated regarding PPE use she was not aware she was supposed to put on a gown and gloves, and she had checked with LVN G, and LVN G confirmed with her that she did not require PPE while taking care of Resident #89 because the resident was not in any precaution. CNA C stated she was to maintain infection control to prevent cross contamination and prevent the spread of infections. In an interview on 04/21/2026 at 1:34 PM, CNA E she stated she was in-serviced on infection completed on 04/20/2026 on precautions signs on the door, if there was a posting on the door the staff was to mask and gown up. CNA E stated she did not see the posting until after caring for the resident. CNA E stated Resident #89 had a G-tub, but she had not seen the G-tube being used. CNA E stated she was to maintain infection control to prevent the spread of infections. In an interview on 04/21/2026 at 1:57 PM, LVN G stated she was not aware of the residents who were to be on EBP. She stated staff were to use gowns for the residents who were in isolation but not the ones with the G-tube. LVN G stated Resident #89 had a G-tube and staff did not need to gown when taking care of the resident, the staff were required to put on gloves. LVN G stated she had been in-serviced on infection control about 4 weeks ago. She stated the staff were to maintain infection control to prevent the spread of infection. In an interview on 04/21/26 at 2:05 PM, LVN H (Infection Preventionist) stated the staff in the facility had been in-serviced on infection control. She said staff were expected to wear a gown and gloves while taking care of residents who were on EBP. She said it was posted on the door for the residents who EBP and reminded the staff what to wear. LVN H stated both CNA's and LVN's were to wear gowns and gloves when taking care of residents who were on EBP. LVN H stated if staff completed incontinent care, and the resident was soiled with urine, staff were not required to complete hand hygiene after changing gloves. LVN H said staff were to change gloves up to three times when providing care to the residents and then complete hand hygiene. LVN H stated when completing wound care, she was not required to complete hand hygiene after changing gloves three times, after the third time then she would complete hand hygiene. LVN H stated she was not aware what the infection control policy indicated regarding hand hygiene. LVN H stated staff were to maintain infection control to prevent the spread of infection and cross contamination. In an interview on 04/22/2026 at 10:27 AM, the DON stated residents who had any skin openings were placed on EBP and staff were expected to wear a gown and gloves while taking care of those residents. She said each resident on EBP had a posting on the door and PPE in the room. She said regarding hand hygiene, staff were to complete hand hygiene every time they changed gloves. She said staff were to complete hand hygiene after cleaning the resident, before applying clean brief or touching any of the residents' belongings. The DON stated the staff were to maintain infection control to prevent cross contamination and spread of infection. The DON stated nursing staff had been in-serviced on infection control. Review of the facility policy revised 04/12 and titled Hand Washing reflected, It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff.Review of the facility policy revised 10.22 and titled Infection Prevention and Control Program reflected, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program Facility did not provide a policy on EBP on request and by exit.

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	676188	A. Building B. Wing	04/23/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide maintenance services necessary to maintain a safe, sanitary, orderly, and comfortable Dining Room for 10 of 10 confidential residents reviewed for safe, clean, and homelike environment.1.The facility failed to ensure the one chandelier in the Dining Room was clean and not dusty on 04/20/26, 04/21/26, and 04/22/26.2.The facility failed to ensure the one chandelier in the Dining Room had an operating bulb on 04/20/26, 04/21/26, and 04/22/26.3.The facility failed to ensure the four ceiling fans in the Dining Room were clean and not dusty on 04/20/26, 04/21/26, and 04/22/26.4.The facility failed to ensure that seven lights in the Dining Room were working properly on 04/20/26, 04/21/26, and 04/22/26.These failures place residents at risk for a diminished quality of life, poor vision, and clean homelike environment.Findings included:During an observation of the facility's Dining Room on 04/20/26 at 6:55 a.m., there were four Ceiling Fans above four tables in the Dining Room that were dusty. The observation revealed that there was one chandelier that was dusty which had one light bulb that was not working properly. The one chandelier was above two tables in the Dining Room. The observation revealed that there were 5 of 20 lightbulbs that were not working. The observation revealed that two lightbulbs were not working properly and were continuously flashing off and on.During an observation of the facility's Dining Room on 04/21/26 at 1:06 p.m., there were four Ceiling Fans above four tables in the Dining Room that were dusty. The observation revealed that there was one chandelier that was dusty which had one light bulb that was not working properly. The one chandelier was above two tables in the Dining Room. The observation revealed that there were 5 of 20 lightbulbs that were not working. The observation revealed that two lightbulbs were not working properly and were continuously flashing off and on.During an observation of the facility's Dining Room on 04/22/26 at 10:32 a.m., there were four Ceiling Fans above four tables in the Dining Room that were dusty. The observation revealed that there was one chandelier that was dusty which had one light bulb that was not working properly. The one chandelier was above two tables in the Dining Room. The observation revealed that there were 5 of 20 lightbulbs that were not working. The observation revealed that two lightbulbs were not working properly and were continuously flashing off and on.A confidential group meeting was held at an undisclosed date and time included ten residents, it was revealed that the lighting in the Dining Room was very dim. The residents stated that they ate their meals in the facility's Dining Room, the residents stated they had not noticed or observed the dust on the chandelier and ceiling fans. The residents stated they would prefer that all the light fixtures in the facility's Dining Room worked properly to prevent further damage to their vision. The residents stated that they would prefer to eat in the facility's Dining Room that included clean light fixtures and fans.During an interview on 04/22/26 at 10:14 AM with the Housekeeping Supervisor, she stated that she had been employed at the facility for three and a half years. She stated that she had six employees, which included three employees that were housekeeping department and three employees that worked in the laundry department. She was informed about the state surveyor's findings during the three days (04/20/23, 04/21/26, and 04/22/26) of observations revealed four of the four ceiling fans were dusty in the facility's Dining Room. The Housekeeping Supervisor was informed that the Dining Observations on three days (04/20/26, 04/21/26, and 04/22/26) revealed that the chandelier in the dining room was dusty and was above two dining room tables and had 1 light bulb that was not working. The Housekeeping Supervisor was informed that the Dining Observations revealed that 5 of the 20 light bulbs in the facility's Dining Room were not working properly and were continuously flashing off and on. The Housekeeping Supervisor stated that during her visits to the facility's Dining Room, she had never looked up and observed that the ceiling fans and chandelier were dusty. She stated that during her previous visits to the facility's Dining Room, she had not noticed that the light bulbs in the chandelier and Dining room were not working properly. (continued on next page)

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	676188	A. Building B. Wing	04/23/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated that she was always on the go and did not pay attention to the lights and ceiling fans in the facility's Dining Room. She stated that her department was not responsible for ensuring that the lights and ceiling fans were cleaned and working properly. The Housekeeping Supervisor stated that Maintenance Director was responsible for cleaning and dusting the light bulbs, replacing the light bulbs, vents and fans in the facility's Dining Room. She stated that her staff members have never cleaned the ceiling fans and lights in the facility's Dining Room. The Housekeeping Supervisor stated there were risks of dust being on the chandelier and ceiling fans in the facility, included a potential for dust fall on the table, on residents or into a resident's food while sitting at the table eating food. She stated that if someone was diagnosed with asthma and/or dust allergies, there was a risk for further breathing issues to incur. The Housekeeping Supervisor stated that harm could be caused to anyone that ingested dust from the chandelier and ceiling fans in the facility, included further breathing issues, or skin issues, if the dust which could be contaminated with allergens touched the skin. She stated that the risk of the light bulbs not working properly in the Dining Room could affect a person's vision, which could result in poor eyesight. The Housekeeping Supervisor stated that she would reach out to the Maintenance Director and come up with a plan to ensure that the ceiling fans and chandelier were cleaned on a regular basis, and the lights were all operating properly.During an interview on 04/22/26 at 10:38 AM with the Maintenance Director, he stated that he had been employed at the facility for one year. He stated that he was the only employee in the facility's Maintenance Department on 3 days (04/20/23, 04/21/26, and 04/22/26), revealed four of the four ceiling fans were dusty. The Maintenance Director was informed about the state surveyor's findings during the three days (04/20/26. 04/21/26, and 04/22/26) of Observations revealed four of the four ceiling fans were dusty. The Maintenance Director was informed that the Dining Observations on three days (04/20/26, 04/21/26, and 04/22/26) revealed that the chandelier in the dining room was dusty and was above two dining room tables and had one light bulb that was not working. The Maintenance Director was informed that the Dining Observations revealed that 5 of the 20 light bulbs in the facility's Dining Room were not working properly and were continuously flashing off and on. He stated that he was aware of the lighting issues in the facility's Dining Room. He stated that the light fixtures would need to be replaced and he had already ordered the replacement fixtures. He stated that he was not aware that the 4 ceiling fans and chandelier in the facility's Dining Room were dusty. The Maintenance Director stated that he was responsible for cleaning the dust on the light fixtures and the ceiling fans in the facility's Dining Room. He stated that the Housekeeping Department would not be responsible for ensuring the ceiling fans and chandelier were cleaned in the facility's Dining Room because he was the only one who had access to obtaining a ladder to reach the areas. He stated that he would replace the light bulb in the chandelier. He stated that he was not sure when the ceiling fans and chandelier were last cleaned. He stated that he would now ensure he had a cleaning schedule, which included the ceiling fans and light fixtures in the facility's Dining Room. He stated that the cleaning schedule would include checking the light bulbs in all light fixtures in the facility's Dining Room. He stated that he would have an In-Service Training with the staff to ensure that everyone was on the same page. He stated that staff would be advised to notify him via TELS (a software program that provided a specialized building maintenance, asset management, and compliance platform designed for senior living and healthcare facilities) if the lightbulbs and fixtures needed to be replaced, and if the light fixtures and ceiling fans in the facility's kitchen needed to be cleaned. The Maintenance Director stated that the facility did not have any Maintenance Request Logs but used the TELS system for all maintenance-related requests. He stated that the risk of dust being on the ceiling fans and chandelier in the facility's Dining Room was the dust could fall on the table into a resident's food and could be ingested. He stated that if dust is ingested, it could cause infections and food-borne illnesses. He stated that harm could be caused to a person's body if they ingest dust particles such as stomach sickness, breathing issues, and other sicknesses. He stated that the risk of the lighting in the Dining Room being dimmed could cause harm to a resident's vision, included a person being (continued on next page)

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	676188	A. Building B. Wing	04/23/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prescribed a new eye glass prescription due to their poor vision.During an interview on 04/23/26 at 2:50 PM with CNA A, she stated that she had been employed at the facility for about one and a half years. She was informed about the state surveyors findings during the 3 days (04/20/26, 04/21/26, and 04/22/26) of Observations revealed four of the four ceiling fans were dusty. CNA A was informed that the Dining Observations on three days (04/20/26, 04/21/26, and 04/22/26) revealed that the chandelier in the dining room was dusty and was above two dining room tables and had one light bulb that was not working. CNA A was informed that the Dining Observations revealed that 5 of the 20 light bulbs in the facility's Dining Room were not working properly and were continuously flashing off and on. CNA A stated that during her visits to the facility's Dining Room, she had not observed the ceiling fans and chandelier were dusty. She stated that during her previous visits to the facility's Dining Room, she had not observed the light bulbs in the chandelier and Dining room were not working properly. CNA A stated if she observed any lights in the facility's Dining Room were not dim and/or not working properly, she would verbally report the issues to the Maintenance Director and/or use the facility's TELS system to report the issue. CNA A stated she would report the dust on the chandelier and ceilings fans verbally to the Maintenance Director and/or use the facility's TELS system to report the issue. CNA stated that dimmed lighting could cause harm to a resident's vision and impaired vision. CNA A stated with impaired vision, there was a potential for someone to hit objects such as walls or another resident. CNA A stated that dust on the facility's ceiling fans and chandelier in the Dining Room could potentially cause harm by the dust particles falling from the fixtures and ceiling fans and possibly causing harm to anyone that has diagnoses of breathing and respiratory issues.Record review of an email from the Administrator on 04/23/2026 at 8:49 AM revealed a receipt for light fixtures that were purchased on 04/22/26 at 7:13 PM.Record review of the facility's policy titled, Accommodation of Needs, dated 08/2023, reflected, POLICY:It is the policy of this facility to assure that a resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.DEFINITIONS:Reasonable accommodations of individual needs and preferences means the facility's efforts to individualize the resident's physical environment including: .Facility's common living areasPROCEDURES:1. The facility will evaluate the resident's unique needs and make environmental accommodations to the extent reasonable.3.Furniture and fixtures in common areas should enhance residents' abilities to maintain their independence.

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	676188	A. Building B. Wing	04/23/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations that involved abuse, neglect, exploitation or mistreatment, that included injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. For 1 of 1 residents (Resident #56) reviewed for adequate supervision.LVN A failed to report an allegation of abuse to the Administrator, when Resident #56 reported that CNA K was a little too rough while providing care, which resulted in the Administrator not reporting the incident to HHSC. The failure could place residents at risk for delayed notification to HHSC and unreported harm.Findings included:During an observation and interview on 04/20/2026 at 9:15 a.m., Resident #56 was lying in bed with a soft cast on Resident #56's left hand. Resident #56 stated CNA K pushed her out of bed, on 04/11/2026, during incontinent care. Resident #56 stated she fell face down while wearing glasses, resulting in blood on the forehead and pain throughout the body. Resident #56 stated she only felt safe when other staff provided care instead of CNA K. The facility initially completed a change of condition, notified the medical director, received new order and sent out to emergency room for further evaluations, guardian was notified, staff were interviewed and provided statements, and in-services were completed.During an interview on 04/21/2026 at 10:00 a.m., while on initial tour, Resident #56 was observed lying in bed. Resident #56 was lying in bed. Resident #56 stated a follow up visit was scheduled for her left hand. During an observation and interview on 04/22/2026 at 9:30 a.m., Resident #56 was lying in bed awake. Resident #56 stated she had no concerns.During an observation on 04/23/2026 at 9:45 a.m., Resident #56 was in bed awake and stated she had no concerns. During an interview with Resident #56 on 04/20/2026 at 9:30 a.m., Resident#56 revealed that on 04/11/2026 during incontinent care CNA K pushed Resident #56 off the bed causing pain throughout Resident #56's body along with caused harm to Resident #56's left hand and forehead resulting in being transported to the emergency room.During an interview with The Administrator on 04/20 at 9:45 p. m. stated Resident #56 had fallen out of bed during incontinent care. The Administrator stated the fall did not warrant a report to HHSC. During an interview on 04/20/2026 at 4:24 p.m., with the Administrator indicated a facility investigations was completed but did not meet the qualifications needed to report to HHSC. The Administrator said Resident #56 never told her CNA K pushed her. The Administrator stated CNA K had wrote a statement and had left for a planned vacation beginning on 4/12/2026 or 04/13/2026 and was expected to return. During an interview on 04/21/2026 at 12:23 p.m., with the DON, stated she was employed for three years. The DON stated Resident #56 had a diagnosis of cerebral palsy and epilepsy. The DON stated Resident #56 changed her stories about events. The DON said Resident #56 was changed from one person assist to a two person assist after the fall. The DON said the therapy department normally assessed the resident at admission to determine if a resident required therapy services. The DON said Resident #56 told her she did not grab the turn bar and kept turning. The DON said if CNA K realized Resident #56 was not far enough up in the bed CNA.K should have asked for assistance. The DON stated CNA K was doing ADL care and when the CNA K turned Resident #56 over, Resident #56 continued to roll off the bed onto the floor. The DON said no one reported the resident was pushed. The DON stated she visited the resident daily after Resident #56 fell. The DON stated In-services on Falls and Abuse Prevention were completed. The DON said the nurse on duty did not report to her at any time that a resident was (continued on next page)

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	676188	A. Building B. Wing	04/23/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pushed. The DON stated if the floor nurse was informed of a resident being pushed, regardless of the resident's behavior, a report to HHSC had to be completed. The DON started in-services on Falls and Abuse Prevention were started after HHSC report made. During a telephone interview on 04/22/26 at 11:30 a.m., LVN J stated she was employed since 09/01/2025. LVN J said she did a lot of wound care and worked weekends. LVN J said no allegation of abuse or neglect was reported to her. LVN J stated If she knew of abuse she would send the alleged perpetrator home, ensure CNA K, and residents were safe, and call the Administrator. During an interview on 04/22/2026 at 11:45 a.m., LVN A stated Resident #56 fell out of bed on 04/11/26 during incontinent care with CNA K. LVN A stated she assessed Resident #56 and noted the laceration. LVN A said she sent Resident #56 to the emergency room due to the laceration and pain expressed by the resident. LVN A stated Resident #56 the following day, told her CNA K was rough with her. LVN A said she reported to LVN J that the CNA K, was a little too rough or something to that affect.In an interview on 04/23/2026 at 1:00 p.m., Administrator said she was not sure if it is Care Planned or not but Resident #56 exaggerated and her story changed a lot. The Administrator stated Resident #56 told the Administrator the push was not done with intent.In an interview on 04/24/2026 at 3:30 p.m., the Administrator said she was going to report to HHSC now after the new information. The Administrator said she did not think it was reportable at the time due to the resident. The Administrator stated the injury was considered a fracture and was not a substantial injury. The Administrator stated when there was a fracture that the facility did not know where it came from, it was reportable. During interviews on 04/21/26 at 11:30 a.m., CNA K was unsuccessfully contacted by telephone CNA K was on vacation. CNA K text back stated she boarded an airplane as she was on vacation. Record review of Resident #56's Care Plan, dated 04/21/2026, indicated Cerebral Palsy and Epilepsy. Resident#56's Care Plan reflected a focus for potential of a behavior problem related to yell out with any ADL care provided. Resident exhibits inconsistencies in conversations when talking to her. She embellishes or exaggerates most situations when spoken to or having conversations with Resident#56. Record review of Resident #56's quarterly MDS, dated [DATE], indicated a BIMS of 12 out 15 indicating moderate cognitive impairment.Record review of facility's policy titled Abuse: Prevention of and Prohibition Against, dated, 10/2023, reflected, Policy: It is the policy of this facility to assure that a resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.E. Identification1. Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor or the Facility administrator immediately. 2. Because some cases of abuse are not directly observed, understanding resident outcomes of an abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include but are not limited to: * Bruises, skin tears and injuries of unknown source; * Extensive injuries. * Injuries in an unusual location;H. Reporting/Response1) All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator.

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	676188	A. Building B. Wing	04/23/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Quarterly MDS Assessment for 1 of 6 residents (Resident #43) reviewed for Resident Assessments.The facility failed to ensure Resident #43's Quarterly MDS Assessment was completed within 90 days and included an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions to ensure that care.This failure could place residents at risk of not having their individual care needs met, which could cause a decline in physical health, psychosocial health, and quality of care.Findings included:Record review of Resident #43's admission face sheet, dated 04/20/26, reflected a [AGE] year-old female, admitted [DATE], with diagnoses that included: dementia (a progressive decline in mental ability-including memory, reasoning, and behavior-severe enough to interfere with daily life), (anxiety (the body's natural response to stress, manifesting as a feeling of fear, dread, or unease about upcoming events or uncertain outcomes), COPD (chronic pulmonary disease - a progressive, incurable lung disease that obstructs airflow, causing chronic breathing difficulties), chronic bronchitis (a form of COPD where your lungs get inflamed and fill with mucus) and Type 2 diabetes (a chronic condition where the body resists the effects of insulin or fails to produce enough to maintain normal blood glucose levels, leading to high blood sugar).Record review of Resident #43's Quarterly MDS Assessment, dated 12/19/25, reflected a BIMS score of 12 indicating moderate cognitive impairment.During an interview with the MDS Coordinator on 04/22/26 at 10:51 AM, she stated that she had been employed at the facility for 1 1/2 years. She stated she recently became the MDS Coordinator at the facility in December 2025. The MDS Coordinator stated she was unaware that the Quarterly MDS Assessment for Resident #43 was last completed on 12/19/25 and needed to be updated. The MDS Coordinator stated that Quarterly MDS Assessments should be completed for every resident every 90 days. She stated that she had been on Leave from work due to her family member being ill and during her Leave of Absence from work, the facility's MDS Resource was given the role of the MDS Coordinator for the facility. The MDS Coordinator stated that she was responsible for opening and closing the Quarterly MDS Assessment for each resident. The MDS Coordinator stated it was her responsibility to open the Quarterly MDS Assessment and inform the rest of the IDT it was open. The MDS Coordinator was asked to verify in the facility's EHR if Resident #43's most recent Quarterly MDS Assessment was completed on 12/19/25, and she stated it was not completed. The MDS Coordinator stated the Quarterly MDS Assessment for Resident #43 should have been completed, and it was on her for not being done within the 90-day timeframe. The MDS Coordinator stated a Quarterly MDS Assessment for Resident #43 was opened on 04/17/26 but was not completed. She stated that she would get with the MDS Resource and audit the MDS Assessments for the residents in the facility. The MDS Coordinator was asked if there was a risk to residents if a Quarterly MDS Assessment was not completed, and she stated that proper care with special instructions would not be followed for each resident's needs.Record review of The In-Service Training Report, dated 04/22/26 revealed, the MDS Resource reeducated the MDS Coordinator via In-Service Training on 04/22/26 for Following the RAI for MDS Completion of Quarterly Assessment.Record review of the Centers for Medicare & Medicaid Services RAI Manual for MDS Quarterly Assessment, dated September 24, 2025, reflected, ARD of Quarterly Assessment must be set within 92 days of the ARD of the previous OBRA Assessment.Federal requirements dictate that a minimum, three quarterly assessments be completed in each 12-month period (if no SCSA or discharge occurs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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 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 observation, interview, and record review, facility failed to ensure residents were protected from accident hazards by not providing adequate supervision, not maintaining a hazard-free environment, resulted in actual or potential harm for 1of 1 residents (Resident#56) reviewed for safe positioning during incontinent care. The facility failed to implement effective safety interventions that would have prevented the resident from falling off the bed, did not provide the level of supervision necessary to prevent avoidable accidents. The facility had 1 of 1 resident who were left in unsafe situations, placing them at risk for falls and injury.These failures could place residents at risk of accidents and injury.Findings Include:Observation at 9:15am on 4/20/26 on initial tour observed Resident #56 in her room lying in the bed, not in a low position as indicated in the care plan.In an interview with Resident #56 on 04/20/26 reflected that on 04/11/26 during incontinent care, the CNA K came in alone to provide her incontinent care. Resident #56 stated that she felt CNA K intentionally pushed her out of the bed resulting in her laceration and broken finger. During an interview on 4/21/2026 at 12:23pm with the DON said Resident #56 told CNA K she did not grab the turn bar and kept turning and rolled off the bed. DON said if the CNA K realized the resident was not far enough up in the bed CNA K should ask for assistance. In an interview on 4/22/2026 at 11:45am with LVN I stated that Resident #56 fell out of bed on 04/11/26 during incontinent care with CNA K. LVN I assessed Resident #56 noted the laceration. LVN I said she sent the resident to the emergency room due to the laceration and pain expressed by the resident. During interviews on 04/21/26 at 11:30 a.m., CNA K was unsuccessfully contacted by telephone. CNA K text back stated she boarded an airplane as she was on vacation. CNA K was on vacation. Record Review of Resident #56's Care Plan dated initiated and revised on 4/21/2026 identified diagnoses of Cerebral Palsy and Epilepsy. Review of Resident #56's MDS assessment dated [DATE] reflected that Resident#56 has a BIMS of 12 indicates a moderate cognitive impairment. Record Review of facility's Incidents By Incident Type report dated 10/20/2025-4/20/26 reflect' s Resident #56 listed in the Fall Incident column indicating a fall on 4/11/26 at 3:42pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 1 (Resident #65) of 3 residents reviewed with gastrostomy tubes (G-tubes) medical device inserted through the abdominal wall directly into the stomach to provide nutrition, fluids, and medication.) The facility failed to ensure CNA C did not manage Resident #65's feeding pump by turning the pump on and off during incontinent care. This failure could place residents with G- tubes at risk for complications, aspiration, and pneumonia.Findings included:Review of Resident 65's Quarterly MDS assessment dated [DATE], revealed a [AGE] year-old male admitted to the facility 05/06/25. Admitting diagnoses included hypertension (high blood pressure), muscle weakness, muscle waiting (thinning of muscles), lack of coordination, gastrostomy status (individual has a surgically placed gastrostomy tube (medical device inserted through the abdominal wall directly into the stomach to provide nutrition, fluids, and medication) and cognitive communication deficit. Resident #65 was always incontinent with bowels and bladder and required maximum assistance with toileting. Review of the care plan revised 02/16/26 reflected Resident #65 required tube feeding. Goal, Resident #65 will remain free of side effects or complications related to tube feeding. Interventions, Monitor/document/report to MD PRN: aspiration- fever, SOB, tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. In an observation on 04/20/2026 at 5:25 AM, revealed CNA C providing care to Resident #65. Resident #65's was connected to the feeding pump, and the feeding pump was on and the feeding infusing. CNA C was observed pausing the feeding pump before providing care, and when she completed providing care, she turned on the feeding pump. In an interview on 04/20/2026 at 6:08 AM, CNA C stated she normally paused the feeding pump when taking care of residents who had G-tube. She stated she did not inform the charge nurse to stop the feeding pump when providing care to the resident. CNA C stated during her training, the nurses did not pause the feeding pump, and she had not been pausing the feeding pump while proving care. CNA C stated she was a new hire in the facility, and she had not been educated on care with residents with G -tube. CNA C was not aware of any risk from her turning on and off the feeding pump. In an interview on 04/20/2026 at 6:44 AM, RN D she stated the CNA's were not supposed to be pausing or turning off the feeding pump, they were to inform the charge nurse when they were providing care to the residents with the G-tube, and the charge nurse would turn off/pause the feeding. RN D stated CNA C was assigned to Resident #65 who had a G-tube and she had not informed RN D to pause/turn off the feeding pump during care. RN D stated Resident #65 was at risk for aspiration and managing the feeding pump was not within CNA C's scope of practice. In an interview on 04/22/2026 at 10:38 AM, the DON she stated CNA C was not supposed to manage the feeding pump nor was any CNA's allowed to operate the feeding pump. She said the CNA's were expected to inform the charge nurse to turn off/pause the feeding pump during care. The DON stated CNA C had not been educated on taking care of residents with G-tube. The DON stated the CNA's were not to be managing the feeding pumps because of the risk for aspiration and not within the CNA's scope of practice. Review of the facility policy dated 01/2022 and titled, Gastrostomy Tube Care and Management reflected, It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes. The policy did not address who was to manage the feeding pump.