STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the facility's only kitchen reviewed for food and nutrition services. The facility failed to ensure food items were properly stored in the facility's walk-in refrigerator and freezer on 12/02/25. These failures could affect residents who received their meals from the facility's kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 12/2/25 at 9:55 AM in the facility's walk-in refrigerator revealed boiled sweet potatoes covered in a baking tray did not have any date on it. One packet of bacon slices was left open and did not have an open date on it. There were two packets of beef roast that were thawing, covered in plastic wrap, without any date on it. Also, two packets of Swiss cheese slices that were wrapped in a plastic wrap without any date on it. Observation on 12/2/25 at 9:58 AM in the facility's walk-in freezer revealed about 30-40 frozen tater tots were left in an open brown bag, about a pound of frozen sliced carrots were left open in a cardboard box, and 20-30 frozen meat balls were left open in a brown box exposing them to frigid air. In an interview on 12/02/2025 at 12:35 PM with [NAME] D, she stated everyone in the kitchen including dietary aides, cooks, and manager were responsible for appropriate food storage. She stated that the meat was left to thaw by the evening cook and should have a pull date (date it was removed from freezer for thawing) on it. She stated all food items in the kitchen, especially in the refrigerator should be appropriately sealed and dated with either use-by date or open date. She added that items such as cheeses and bacon slices should have open date on it. She added that the risk of not covering or dating food items can lead to cross contamination of foods and food borne illness in residents. In an interview on 12/02/2025 at 2:52 PM with Dietary Aide revealed all food items in the kitchen should be dated and covered appropriately and it was usually the responsibility of the cooks to seal food in the freezer. She stated foods that are out of their original packing should have an open date on them. She added that the risk to residents of not appropriately covering food items was residents could get sick. In an interview on 12/04/2025 at 9:15 AM with the Dietary Manager, he stated that everyone in the kitchen was responsible for food storage, however cooks and himself were ultimately responsible for covering and dating food items. He stated his expectation was that all foods should be appropriately dated, covered, and sealed to prevent any freezer burns and loss of nutritional value. He added that he encouraged all staff to add open dates on items when they are out of the original packaging. He stated that for meats that are pulled from the freezer, his expectation is that the cooks write the date it was pulled-out for thawing and use-by date. He added the risk to residents of improper food storage that included dating, labeling, and covering food items was possibility of food borne illness in residents and cross contamination of food. He stated as the Dietary Manager he conducted daily kitchen rounds and provided in-services to the staff to ensure proper food storage. In an interview on 12/04/2025 at 1:37 PM with the Administrator, she said all food in the kitchen should be dated and labeled. She stated that the cooks and Dietary Manager were mainly responsible for it and her expectation was that all facility and state policies were followed to ensure safe food storage. Record review of the facility policy titled, Stock Dating undated ,reflected, Policy statement: Stock (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	will be routinely dated when received in the facility for the purpose of assuring proper stock rotation . Date stock with date of delivery (per facility policy and state regulations). Record review of the facility policy titled, Preventing Foodborne Illness -Food Handling dated 11/23/22 reflected, It is the policy of this community to store, prepare, handle and serve food so that the risk of foodborne illness is minimized. Review of the Food and Drug Administration Food Code, dated 2022, reflected, . Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of two residents (Resident #48) reviewed for catheter care. The facility failed to ensure CNA A and CNA B maintained Resident #48's foley catheter (foley catheter is a common type of indwelling catheter) drainage bag below the bladder level during transfer from wheelchair to bed on 12/03/25. This failure placed residents at risk for the development and/or worsening of urinary tract infections.Findings include: Record review of Resident #48's admission MDS assessment dated [DATE] reflected, Resident #48 was an [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included hip fracture, obstructive uropathy (condition in which urine cannot drain through the urinary tract), muscle wasting. She was dependent on staff for chair/bed-to-chair transfer. Record review of Resident #48's care plan initiated on 11/24/25 reflected, Focus: [Resident #48] has indwelling catheter (a catheter that drains urine from the bladder by inserting a tube through the abdominal wall and into the bladder) related to obstructive uropathy . Interventions: Catheter: . Position catheter bag and tubing below the level of the bladder and away from entrance room door . Review of Resident #48's Physician's Orders dated 11/16/25, reflected, Foley catheter care every shift every day and night shift for Urinary Retention. Observation on 12/3/25 at 1:41 PM revealed CNA A and CNA B entered Resident #48's room to transfer her from wheelchair to bed. Both the CNAs performed hand hygiene and wore PPE. CNA A adjusted Resident #48's bed to a moderately lower position, still higher than her wheelchair. CNA B unhooked the catheter bag from the wheelchair and put it flat on the bed, above the resident's bladder. CNA A put the gait belt on Resident #48. CNA A and CNA B assisted the resident from the wheelchair to bed. During this procedure, the urine was observed flowing back toward the resident's bladder. CNA A continued to adjust the resident in the bed and then took the gait belt off. Both CNAs disposed of the PPEs, performed hand hygiene, and exited the room. In an interview on 12/03/2025 1:52 PM with CNA A, he stated that Resident 48's catheter bag was put on the bed so that it did not touch the floor. He stated that he observed the urine in the tube go back and forth when CNA B placed the catheter bag on the bed. He then added that he was trained to always keep the catheter drainage bag below the bladder. He stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. In an interview on 12/03/25 at 1:58 PM with CNA B, he stated that he should have emptied Resident #48's catheter drainage bag before transferring the resident to avoid any back flow of urine. He stated that he was trained to keep the catheter drainage bag below the bladder. He stated that back flow of urine could cause urinary tract infections. In an interview on 12/03/2025 at 2:10 PM with LVN C stated that it was his expectation that CNAs always kept the catheter drainage bag and catheter tubing below resident's bladder. He stated that failure to do so can cause the urine to retract back to the bladder and increased chances of infection. In an interview on 12/03/2025 2:43 PM with the DON, he stated any resident with a foley catheter should always have the bag and tubing below the bladder, including during transfers. He stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of urinary tract infection and cross contamination. He stated that DON and ADON were ultimately responsible for quality of care provided to residents. He added that the facility conducted skills competency checks for the nursing staff and daily rounding on all residents to watch care and provide re-training as needed. Record review of CNA A's new hire competency check-off for catheter care revealed he was proficient in care as of 10/09/25. Record review of CNA B's annual competency check-off for catheter care revealed he was proficient in care as of 07/15/25. Review of the facility's policy titled, Urinary Catheter Care dated 1/27/24 reflected, . 3.The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of two residents (Residents #8) reviewed for feeding tubes. 1. The facility failed to have orders for Resident #8 for the required amount of water for dilution of crushed medications and the amount of water flushes between each medication given via the G-tube. 2. The facility failed to ensure LVN C diluted crushed medication and liquid medication with 30 ml of water and flushed with 15 ml of water after each medication per facility policy while administering Resident #8's medication via G-tube which resulted in the tube becoming clogged during the medication administration. These failures could place residents at risk of medication incompatibility and tube obstruction. Findings include: 1. Record review of Resident #8's admission MDS assessment, dated 10/23/25, reflected an [AGE] year-old male with an admission date of 10/15/25. Resident #8 had a BIMS score of 13 which indicated he was cognitively intact. Resident #8 had active diagnoses which included cancer of the oropharyngeal region (throat cancer) and dysphagia (difficulty when swallowing food or liquids), and he received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Record review of Resident #8's care plan revised on 11/05/25 reflected, The resident requires tube feeding Glucerna 1.5 bolus and Boost as ordered related to dysphagia.Goal.The resident will remain free of side effects or complications related to tube feeding through review date. Record review of Resident #8's Physician Order Summary report dated 12/03/25 reflected, .enteral Feed order every day and night shift Flush tube with 20-30 ml(cc) of water before and after each administration of medication pass. with a start date of 10/15/25. There were no orders for amount of water to dilute medication with, and the amount required between each medication administered. Record review of Resident #8's Medication administration record for December 2025 did not indicate how much water to dilute crushed or liquid medications with or the amount of water flush to use between each medication administered. An observation on 12/03/25 at 06:49 AM of G-Tube medication administration for Resident #8 revealed LVN C prepared medication for Resident #8. LVN C placed 1 tablet Aspirin 81 mg (analgesic), 1 tablet Carbidopa-Levodopa 25-100 mg (treat Parkinson's disease), 1 tablet Vitamin D 25 mcg (supplement), 1 tablet Doxazosin 1 mg (antihypertensive), 1 capsule Duloxetine delayed release 60 mg (antidepressant), 1 tablet Finasteride 5 mg (used to treat enlarge prostrate), Hydrocodone-acetaminophen 7.5-325 mg oral solution 15 ml, 1 tablet Metformin 500 mg (control blood sugar), 1 tablet Metoprolol 25 mg (blood pressure), and 1 capsule Omeprazole delayed released 40 mg (treats reflux) each medication in an individual plastic cup. LVN C opened the Duloxetine and Omeprazole capsules and placed them in a separate plastic cup and then crushed each tablet and placed each of them in separate cups and entered the resident's room. LVN C then filled a plastic cup with water from the bathroom sink and poured approximately 2.5 ccs of water into each medication cup, with the exception of the liquid Hydrocodone-acetaminophen. He then retrieved a 60-cc syringe and checked for residual and flushed the G-tube with 30 ccs of water. LVN C then administered each medication by gravity and did not flush with clear water between each medication. When the Omeprazole and Duloxetine granules were administered the g-tube became sluggish and remained stuck in the tube. LVN C the added 30 cc of water and the medication would not progress. LVN C milked the tube for approximately 15 minutes with the tube going up and down. LVN C then drew medication back out of tube with the syringe twice, and re-instilled with the medication slowly progressing but still had some visible clog in the tube. In the end, LVN C pushed approximately 10 cc of water through the tube to get the medication to progress. In an interview with LVN C on 12/03/25 at 07:12 AM he stated he diluted the medication with 2.5 ccs of water and then would add a little if the medication was still stuck in the cup. He stated he was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to flush before and after medication pass with 30 cc of water. He pulled up the physician orders and reviewed and stated it did not indicate how much to dilute medications with or how much to flush in between each medication administered. He stated it was important to flush before and after to prevent the tube from clogging. He stated the omeprazole and duloxetine granules he always gave last because they tended to clog the tube. In an interview with the DON on 12/04/25 9:20 a.m. he stated he had already started an Inservice on ensuring they had physician orders for the dilution of medication and the amount of water flushes in between each medication. He stated the purpose of good dilution of medications and flushes is to ensure all of the medication is administered and to prevent the g-tube from becoming clogged, which could result in the tube needing replaced and inability to give the resident their medications. He stated going forward he and the ADON would be auditing the orders to ensure they had the physician required amount of water for flushes both before, in between and after. In an interview on 12/04/2025 11:34 a.m. with the Facility Pharmacist stated the standard of care is to flush with approximately 5-10 cc between medications and generally dilute meds with 5-10 ml and flush with 20-30 cc of water before and after. He stated the main reason was to prevent clogging the tube. He stated medication was to be given by gravity and not pushed. He reviewed the medications administered to Resident #8 and stated none would have a significant interaction with each other. In an interview with the Administrator on 12/04/25 1:15 p.m. she stated they would be educating the staff on the protocol for medication flushes in between medications and reviewing to ensure everyone knows what batch orders to input on any new g-tube resident. She stated they would be reviewing their standards and guidelines and determining what will be the default flush orders to input, and the physician can add or adjust any of those orders. Record review of LVN C's annual competency checks dated 09/10/25 reflected that he was skilled at medication administration which included flushing the G-tube. Record review of the facility's Standards and Guidelines titled, Administering Medications through an Enteral Tube, dated June 2023, reflected, .Verify that there is a physician's medication order for the procedure.Administer each medication separately and flush between medications.Flush tubing with at least 15 ml warm purified water(or prescribe amount).Dilute medications.Dilute crushed (powdered) medications with at least 30 ml purified water (or prescribed amount).Dilute liquid mediation with 30 ml or more(depending on viscosity) purified water.Administer each medication separately.If administering more than one medication, flush with at least 15 ml warm purified water (or prescribed amount)between medications.When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm purified water (or prescribed amount).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for two of five residents (Resident #72 and Resident #73) reviewed for pharmacy services. 1. The facility failed to ensure RN G followed the manufacturer's instructions to prime (means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly) the Humalog pen (Insulin Lispro) (Hormone) prior to dialing in required amount of Insulin to be administered to Resident #73. 2. The facility failed to ensure RN F followed the manufacturer's instructions to prime the Humalog pen (Insulin Lispro) (Hormone) prior to dialing in required amount of Insulin to be administered to Resident #72. These failures placed residents at risk of not receiving full dosage of medication. Findings included: 1. Record review of Resident #73's, Face sheet, dated 12/04/25 reflected a [AGE] year-old female with an admission date of 11/28/25. Resident #73 had a diagnosis of Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy). Record review of Resident #73's Physician's Order report dated 12/04/25, reflected, Humalog Kwik Pen Subcutaneous Solution 100 UNIT/ML (Insulin Lispro) Inject 5 units subcutaneously before meals.inject as per sliding scale: if.350 - 399 =11 UNITS. with a start date of 11/30/25. An observation on 12/02/25 at 11:34 a.m. revealed RN G performed hand hygiene and put on gloves and gown and entered Resident #73's room to obtain a fingerstick blood sugar. The blood sugar reading was 388. RN G checked the computer to determine the amount of insulin per sliding scale was 5 units of Humalog (Lispro) insulin plus an additional 11 units per sliding scale for a total of 16 units. RN G retrieved the insulin pen from the medication cart and dialed in 16 units without priming the pen first. RN G then entered the resident's room and administered the insulin. In an interview with RN G on 12/02/25 at 11:42 a.m. she stated she was supposed to prime the pen before each dose to ensure the pen was working and to remove the air bubbles. She stated she forgot to prime it. She stated the risk of not priming the pen could result in the pen not working properly and the resident not getting the full amount of insulin required. 2. Record review of Resident #72's, Face sheet, dated 12/04/25 reflected an [AGE] year-old female with an admission date of 11/30/25. Resident #72 had a diagnosis of Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) Record review of Resident #72's Physician's Order report dated 12/04/25, reflected, Humalog Kwik Pen Subcutaneous Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if.200 - 249 = 2 PLUS ADDITIONAL 2 UNITS =4 UNITS. with a start date of 11/30/25. An observation on 12/02/25 at 11:45 a.m. revealed RN F performed hand hygiene and put on gloves and entered Resident #72's room to obtain a fingerstick blood sugar. The blood sugar reading was 232. RN F checked the computer to determine the amount of insulin per sliding scale was 4 units of Humalog (Lispro) insulin. RN F retrieved the insulin pen from the medication cart and dialed in 4 units without priming the pen first. RN F then entered the resident's room and administered the insulin. In an interview with RN F on 12/02/25 at 11:55 a.m. she stated she was supposed to prime the pen with 2 units before each dose to ensure the pen was working and to remove the air bubbles. She stated she forgot to prime it. She stated the risk of not priming the pen could result in the resident not getting the full amount of insulin required. In an interview with the DON on 12/04/2525 at 09:30 a.m. he stated the insulin pen was to be primed before each injection. He stated failure to do so could result in the resident not receiving the prescribed amount of insulin. He stated all of the nursing staff received competency checks upon hire and annually or more often if an issue was identified. He stated it was the expectation for staff to follow the manufacturer guidelines on administration of insulin pens. He stated he would in-service the nursing staff to ensure they were all aware of the proper procedure. Record review of RN G's annual competency checks dated 09/09/25 reflected that (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676189	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy at Willow Bend	6101 Ohio Ste 500 Plano, TX 75024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was skilled at medication administration. Record review of RN F's annual competency checks dated 09/22/25 reflected that she was skilled at medication administration. Record review of the facility's Standards and Guidelines titled, Administering Medications, dated June 2023, reflected, Each nurse's station has a current Physician Deks Reference (PDR) and/or other medication reference, as well as a copy of the surveyor guidance for F755-761 (Pharmacy Services) available. Manufacturer's instructions or user's manual related to any medication administration devices are kept with the devices or at the nurses' station. Review of the manufacture instructions for Lispro obtained from https://www.lillyinsulinlispro.com/ searched on 12/05/25 reflected, .Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the