STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676237	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to personal privacy and confidentiality of his or her personal and medical records for one of five residents (Resident #1) reviewed for privacy and confidentiality.The facility failed to ensure Resident #1's medication prescription was not left on top of the medication cart on 04/21/26. This failure could place residents at risk of not having their personal privacy maintained while care was provided and their personal and medical record exposed to unauthorized individuals.Findings include: Record review of Resident #1's Face Sheet, dated 04/21/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with Glaucoma (eye disease).Record review of Resident #1's Comprehensive MDS Assessment, dated 01/28/2026, reflected the resident had severe cognitive impairment with a BIMS score of 3. The Comprehensive MDS Assessment indicated the resident had moderate impaired vision.Record review of Resident #1's physician orders, dated 04/21/26, reflected Artificial Tears Ophthalmic Solution 1%, instill 1 drop in both eyes two times a day.During an observation on 04/21/26 at 9:40 a.m., a medication cart on the 100-hall had medication with Resident #1's name on it. During an interview and observation on 04/21/26 at 9:42 a.m., ADON J observed the State Surveyor standing near the medication cart on the 100-hall. He removed the medication for Resident #1 which was sitting on top of the medication cart. He stated the medication should be always secured and the medication displaying Resident #1's name was a privacy concern.During an interview on 04/21/26 at 4:00 p.m., the DON was informed of Resident #1 having medication on the medication cart in plain view. She stated the medication should not be out in the open because it was going against HIPAA practice and a right to their privacy.During an interview on 04/21/26 at 1:11 p.m., LVN D stated she was informed by her ADON of Resident #1's medication left on top of the medication cart, and she stated it should have been secured in the medication cart. She stated the resident's name was shown and it was a privacy concern. She stated she had just finished administering the medication to the resident a had to run to the bathroom.Record review of the facility's policy, Resident Rights, dated 02/21, reflected Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;c. be free from abuse, neglect, misappropriation of property, and exploitation;d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptomsRecord review of the facility's policy Medication Labeling and Storage Nursing Services Policy and Procedure Manual for Long-Term Care revised 2023 reflected Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, lack of care plan interventions, and physician orders for oxygen administration for four of twelve residents (Residents #2, #3, #4 and #5) reviewed for respiratory care. 1. The facility failed to ensure Resident #2 had her nebulizer mask and nasal cannula bagged when not in use on 04/21/26. 2. The facility failed to ensure Resident #3's nasal cannula, connected to the oxygen concentrator, (medical device that extracts oxygen from room air by filtering out or separating the nitrogen from the oxygen) was properly stored on 04/21/26. 3. The facility failed to ensure Resident #4's nasal cannula, connected to the oxygen concentrator, was properly stored on 04/21/26. 4. The facility failed to ensure Resident #5's nasal cannula, connected to the mobile oxygen tank, attached to his wheelchair, was properly stored on 04/21/26. These failures could place residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met.Findings include: 1. Record review of Resident #2's face sheet, dated 04/21/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with COPD (breathing difficulty).Record review of Resident #2's Comprehensive MDS Assessment, dated 1/26/26, reflected Resident #2 had a BIMS score of 11, which indicated a moderate cognitive impairment. Resident #2 had an active diagnosis of COPD.Record review of Resident #2's Physician Order, dated 04/21/26, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3ml. 1 vial inhale orally via nebulizer every 4 hours as needed for shortness of breath. Oxygen at 2 L every shift for shortness of breath. During an interview and observation on 04/21/26 at 10:48 a.m., the State Surveyor and RN T observed Resident #2's Nebulizer mask sitting on top of her nightstand unbagged and a nasal cannula attached to the oxygen tank, unbagged in a pouch. She stated the items needed to be bagged to avoid contamination. She stated she had bagged the nebulizer mask earlier in the morning and was not sure how it became unbagged.During an interview and observation on 04/21/26 at 1:58 a.m., ADON J was informed by the State Surveyor of Resident #2's Nebulizer mask and nasal cannula unbagged when not in use. He stated the items needed to be bagged to avoid contamination. He stated it was the nursing staff's responsibility to ensure breathing devices were bagged when not in use.During an interview on 04/21/26 at 4:00 p.m., the DON was informed of Resident #2's Nebulizer mask and nasal cannula unbagged when not in use. He stated the items needed to be bagged to avoid contamination. She stated staff should be checking for these items to be bagged when not in use. 2. Record review of Resident #3's face sheet, dated 04/21/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included Chronic Diastolic (congestive) Heart Failure (a chronic, progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs) and Type 2 Diabetes (High blood sugar).Record review of Resident #3's April 2026 active Physician orders did not reflect any orders for oxygen administration. Record review of Resident #3's active care plan reflected no care plan problem goals, or intervention related to the resident's oxygen administration. During an observation on 04/21/26 at 9:47 a.m. revealed Residents #3's nasal cannula connected to the oxygen concentrator was observed hanging on her concentrator while the resident was in her wheelchair.3. Record review of Resident #4's face sheet, dated 04/21/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had a diagnosis which included Unspecified Diastolic (congestive) Heart Failure (a chronic, progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs). Record review of Resident #4's April 2026 active Physician orders did not reflect any orders for oxygen administration. Record review of Resident #4's active care plan reflected no care plan problem goals, or intervention related to the resident's oxygen administration.During an observation on 04/21/26 at 9:55 a.m., Resident #4's nasal cannula connected (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to oxygen concentrator was observed hanging on the head of the bed while the resident was out of the room. 4. Record review of Resident #5's face sheet, dated 04/21/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #5 had a diagnosis which included Chronic Obstructive pulmonary disease (a progressive, long-term lung disease that makes it hard to breathe). Record review of Resident #5's April 2026 active Physician orders did not reflect any orders for oxygen administration.Record review of Resident #5's active care plan reflected no care plan problem goals, or intervention related to the resident's oxygen administration. During an observation and interview on 04/21/26 at 10:00 a.m., Resident #5's nasal cannula, which was connected to his oxygen tank, was observed lying on the floor. The resident was in bed using the nasal cannula connected to his oxygen concentrator. The resident stated he was not aware the nasal cannula should be bagged, he stated he was not given a bag or instructed to bag the nasal cannula when not in use by any staff member. During an interview on 04/21/26 at 3:30 p.m. with CNA A, she stated the nasal cannulas should be stored in a bag and dated, she stated the CNAs and nurses were responsible for making sure they were bagged and dated. She stated if the nasal cannula was not bagged, it would become contaminated and result in an infection to the residents. She stated if she found it not bagged; she should put it in the designated bag.During an interview on 04/21/26 at 3:35 p.m. with CNA B, she stated the nasal cannulas should be stored in a bag and dated, she stated the CNAs and nurses were responsible for making sure they were bagged and dated. She stated if the nasal cannula was not bagged, it would become contaminated and result in an infection to the residents. She stated if she found the nasal cannula on the floor she reported to the nurse to have it changed, if not on the floor she put it back in the bag.During an interview on 04/21/26 at 3:45 p.m. with ADON K, she stated all nasal cannulas and any respiratory apparatus that came in contact with the respiratory system should be bagged and dated and changed weekly according to the facility policy for infection control purposes. She stated the nurses were responsible to change, date and bag the items and the CNAs were responsible for notifying the nurses if they saw it was not bagged and was exposed. She stated the risk of not storing the nasal cannulas would result in an infection. During an interview on 04/21/26 at 3:55 p.m. with LVN C, he stated the nasal cannula should be bagged and attached to the oxygen concentrator when not in use and the bag should be dated. He stated the nurses and CNAs were responsible for making sure the nasal cannulas were bagged, but the nurses should ensure the policy was implemented. He stated the nasal cannula not being bagged could result in contamination and infection and could make the residents sick. During an interview on 04/21/26 at 4:05 p.m. with the DON, she stated the nasal cannula and nebulizer mask should always be bagged when not in use for infection control purposes and it should be dated. She stated it was the responsibility of everyone to notify the nurse if they saw it was not bagged and dated to replace if needed. She stated the risk of not having the nasal cannula and nebulizer mask in a bag could result in them getting dirty, the residents could inhale germs from them and get sick with an infection. Record review of the Facility's Oxygen Concentrator Policy, dated 11/1/2025, reflected: The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators. Policy Explanation and Compliance Guidelines:1. Staff responsible for the use and care of oxygen concentrators receive training on oxygen safety and the functionality of the device.2. Oxygen is administered under orders of the attending physician, except in the case of an emergency. 4. Use of the Concentrator:a. The nurse shall verify physician's orders for the rate of flow and route of administration of oxygen (mask, nasal cannula etc.)i. Keep delivery devices covered in plastic bag when not in use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 6 of 8 (Residents #4, #6, #7, #8, #9, and #10) reviewed for medication storage. 1. The facility failed to ensure Resident #6 did not have a pink paste (moisture barrier cream) inside the room on [DATE]. 2. The facility failed to ensure a white powder (Nystatin) was not inside Resident #7's room on [DATE]. 3. The facility failed to ensure Resident #8 did not have a pink paste (moisture barrier cream) inside the room on [DATE]. 4. The facility failed to ensure Resident #9 did not have a Topical anesthetic spray and pink paste (moisture barrier cream) inside the room on [DATE] 5. The facility failed to ensure Resident #10 did not have Supplements and probiotic bottles inside the room on [DATE]. 6. The facility failed to ensure Resident #4 did not have Biofreeze inside the room on [DATE]. These failures could place residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings include: 1. Record review of Resident #6's Face Sheet, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included Pressure ulcer of right buttock (damage to the skin and underlying tissue, usually over bony areas, caused by prolonged pressure, friction, or shear, restricting blood flow). Record review of Resident #6's Comprehensive Care Plan, dated [DATE], revealed Pressure Ulcer Prevention with interventions of barrier cream and turn and reposition every 2 hours and as needed, keep body in good alignment. The comprehensive care plan revealed Resident #6 had an ADL self-care performance deficit and required assistance from staff. Record review of Resident #6's physician order, dated [DATE], revealed an order for: Wound care to sacrum, cleanse wound with normal saline, pat dry, apply barrier cream and leave open to air. Record review of Resident #6's Comprehensive MDS Assessment, dated [DATE], revealed the resident has Pressure ulcer of the right buttock. During an observation on [DATE] at 9:37 a.m., revealed Resident #6 was in her bed, awake. It was noted a pink barrier cream, in a medication cup was observed on the resident's nightstand. 2. Record review of Resident #7's Face Sheet, dated [DATE], revealed an [AGE] year-old male who was admitted to the facility on [DATE]. The resident has diagnoses which included Pressure ulcer of sacral region (damage to the skin and underlying tissue, usually over bony areas, caused by prolonged pressure, friction, or shear, restricting blood flow) and Dementia (A progressive loss of memory, reasoning and communication skills). Record review of Resident #7's Comprehensive Care Plan, dated [DATE], revealed Pressure Ulcer Prevention with interventions of barrier cream and turn and reposition every 2 hours and as needed, keep body in good alignment. The comprehensive care plan revealed Resident #7 had an ADL self-care performance deficit and required assistance from staff; it revealed the resident has impaired cognitive function/impaired thought process related to dementia. Record review of Resident #7's physician order, dated [DATE], revealed an order for: Nystatin External Powder 100000, apply to groin topically two times a day for Redness. Record review of Resident #7's Comprehensive MDS Assessment, dated [DATE], revealed under skin and ulcer/injury treatments an intervention for Applications of ointments/medications other than to feet. During an observation and interview on [DATE] at 9:40 a.m., revealed Resident #7 was in his bed, awake. Nystatin powder in a medication cup was observed on the residents' nightstand. The resident's representative stated the nursing staff put the powder on the residents' groin area after he was cleaned, she stated it was on the bedside table when she came into the room. 3. Record review of Resident #8's Face Sheet, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident has a diagnosis which included Pressure ulcer of the sacral region (damage to the skin and underlying (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tissue, usually over bony areas, caused by prolonged pressure, friction, or shear, restricting blood flow). Record review of Resident #8's Comprehensive Care Plan, dated [DATE], revealed Pressure Ulcer Prevention with interventions of barrier cream and turn and reposition every 2 hours and as needed, keep body in good alignment. The comprehensive care plan revealed Resident #6 had an ADL self-care performance deficit and was totally dependent on staff. Record review of Resident #8's Comprehensive MDS Assessment, dated [DATE], revealed under skin and ulcer/injury treatments an intervention for Applications of ointments/medications other than to feet. Record review of Resident #8's physician order, dated [DATE], revealed an order for: Skin preventive treatment: Apply house barrier cream to sacral area once daily and leave open to air every day shift for prevention treatment. During an observation on [DATE] at 9:43 a.m., revealed Resident #8 was in her bed, awake. A pink barrier cream in a medication cup was observed on the resident's nightstand. 4. Record review of Resident #9's Face Sheet, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident had diagnoses which included Pressure ulcer of multiple areas of the sacral area (damage to the skin and underlying tissue, usually over bony areas, caused by prolonged pressure, friction, or shear, restricting blood flow) and pain. Record review of Resident #9's active physician orders as of [DATE] did not reflect any ordered for barrier cream nor Topical Anesthetic. Record review of Resident #9's Comprehensive Care Plan, dated [DATE], revealed Pressure Ulcer Prevention with interventions of barrier cream and turn and reposition every 2 hours and as needed, keep body in good alignment. The comprehensive care plan revealed Resident #6 had an ADL self-care performance deficit and required assistance from staff. Record review of Resident #9's Comprehensive MDS Assessment, dated [DATE], did not reveal the resident had any Pressure ulcers. During an observation and interview on [DATE] at 9:45 a.m., revealed Resident #9 was in her bed, awake. A pink barrier cream in a medication cup and a bottle of topical anesthetic were observed on the resident's nightstand. The resident stated the cream was used for his abdominal rash and the CNAs' used it after he was cleaned and the topical anesthetic was used for wound dressing on his left arm. He stated the CNA brought in the Barrier cream each morning for when he would be cleaned but the topical anesthetic had always been in his room and the nurses used it when doing his wound dressing on his right hand. 5. Record review of Resident #10's Face Sheet, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included Muscle weakness (a noticeable lack of strength where your muscles do not respond the way they are supposed to). Record review of Resident #10's active physician order as of [DATE] revealed no orders for barrier cream. Record review of Resident #10's Comprehensive Care Plan, dated [DATE], revealed the resident was at risk for pressure Ulcer with interventions of barrier cream. The comprehensive care plan revealed Resident #6 had an ADL self-care performance deficit and required assistance from staff. Record review of Resident #10's Comprehensive MDS Assessment, dated [DATE], did not reveal the resident had any Pressure ulcers. During an observation and interview on [DATE] at 9:50 a.m., revealed Resident #10 was in her bed, awake. The resident had plastic bottles of supplements (daily energy and papaya enzyme supplement digestive aid) on her nightstand. The resident stated her family member brought the supplements in for her, and s he kept them on her nightstand and did not hide them so it's visible to all. She stated she did not inform the nurses but did not keep the medications a secret and anyone who walked into the room should be able to see them. 6. Record review of Resident #4's Face Sheet, dated [DATE], revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included Muscle weakness (a noticeable lack of strength where your muscles do not respond the way they are supposed to). Record review of Resident #4's active physician order as of [DATE] revealed no orders for barrier cream. Record review of Resident #4's Comprehensive Care Plan, dated [DATE], revealed care plan for pressure ulcer prevention with intervention of barrier cream. Resident #4 had an ADL self-care performance deficit and required assistance from staff. Record review of Resident #4's Comprehensive MDS Assessment, dated [DATE], revealed under skin and ulcer/injury (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatments an intervention for Applications of ointments/medications other than to feet. During an observation and interview on [DATE] at 9:55 a.m., revealed Resident #4 was in her bed, awake. A spray bottle of Biofreeze was observed on the resident's nightstand. The resident stated she used it for pain. She stated she did not tell the nurses about it but they were aware she had it in her possession. During an interview with CNA A on [DATE] at 3:30 p.m., she stated the pink barrier cream was given to her by the wound nurse for residents with pressure ulcers and redness. She stated she put the cream in the rooms and applied it to the residents as she performed incontinent care. She stated no medications should not be left in the residents' rooms, she stated if unsupervised it could be very dangerous and harm the residents if used improperly. During an interview with CNA B on [DATE] at 3:35 p.m., she stated no medication should be in the resident's room, she stated she should report any medication found in the resident's room to the charge nurse. She stated the medications brought in from outside could be expired, could be given at the wrong time and wrong does causing an overdose. During an interview with ADON K on [DATE] at 3:45 p.m., she stated no medications were allowed in any resident's room unsupervised. She stated the risk of having residents self-administer medications could lead to over medication or medication interaction. She stated if we didn't know what the resident was taking they could have an adverse effect that would be hard to pinpoint. During an interview with LVN C on [DATE] at 3:45 p.m., he stated no residents should have medications in their room per facility policy. He stated the nurses should monitor medications when administered. He stated the nurses usually informed new residents about the medication policy, that all medications should be administered by the nurse and placed in the medication cart even for over-the-counter medications. He stated the nurses obtained orders from the physician for any medication the family wanted the resident to have. He stated the nursing department was responsible for making sure no medications were left unsupervised. He stated the risk of not having medication supervised could result in overdosing. During an interview with the DON on [DATE] at 4:05 p.m., she stated the pink barrier cream should be placed in the drawer in the residents, out of reach of the resident for use only when the CNA was providing perineal care. She stated they should identify any items which included medications that should not be in the residents room during rounds and had them removed or reported to the charge nurse if found by a CNA. She stated no residents had an assessment to self-administer medications, as of today. She stated the risk of having medication unsupervised in resident rooms could be other residents who should not be taking them could get a hold of the medications and possibly have a reaction and the resident who had them could be overmedicated if they were already getting similar medications from the facility nurse.