STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676255	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Worth Transitional Care Center	850 12th Avenue Fort Worth, TX 76104

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 0695 Level of Harm - Immediate jeopardy to resident health or safety 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 observations, interviews, and record review, the facility failed to ensure respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, for 2 of 4 residents (Resident #71, Resident #8) reviewed for respiratory care.1.The facility failed to provide tracheostomy care and tracheal suctioning for Resident #71 when she experienced shortness of breath and was transferred to the hospital and had her trache replaced in the emergency room2.The facility failed ensure an Ambu bag (a handheld, self-inflating device that forces air or oxygen into the lungs during emergencies) an emergency equipment was available in Resident #8's room.3.The facility failed to monitor the Resident #8 oxygenation status during high-risk procedure when suctioning.4. The facility failed to ensure timely response to Resident #8 when he required suctioning.On 04/07/26 at 3:20 PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 04/08/26 at 6:00 PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.This failure could placed residents at risk of serious harm, respiratory compromise, and death.Findings included: Record review of Resident #71's Comprehensive MDS assessment, dated 01/11/2026, reflected She was a [AGE] year-old female admitted to the facility on [DATE]. No BIMs score was recorded indicating no interview was conducted. Her diagnoses included dysphagia(is a physical difficulty or discomfort with swallowing, often aphasia (muscle weakness or neurological issues like stroke), aphasia(a language disorder caused by brain damage), and respiratory failure (a critical condition where the respiratory system fails to perform its basic function of gas exchange, resulting in too little oxygen in the blood). Section K0520 was coded for feeding tubes. Record review of Resident #71's care plan initiated 03/27/2024 reflected Resident #71's has a tracheostomy. Interventions Ensure that trach ties are secured at all times. Monitor/document for restlessness, agitation, confusion, increased heart rate Provide good oral care daily and PRN. Record review of Resident #71's active physician dated 04/06/2026 reflected Change disposable trach 6.4mm inner cannula one time a day for mucous plugs, minimize secretions order start date 01/30/2025. Record review of Resident #71's active physician dated 04/06/2026 reflected Change trach collar and tubing with oxygen condensation trap at bedtime every 7-day(s) order start Date 01/01/2025. Record review of Resident #71's active physician dated 04/06/2026 reflected Suction trach every shift for copious secretions order start Date 03/31/2025. Record review of Resident #71's active physician dated 04/06/2026 reflected Trach care - Cleanse with normal saline with 4X4 around trach stoma, pat dry, apply T-drain sponge (pre-cut sponges that provide a snug fit around catheters), and secure with trache collar order start date 01/31/2026. Record review of Resident #71's nurses notes dated 4/5/2026 at 7:15 PM reflected the following approximately 12:15 PM, pt FM present, came to this nurse stating pt appeared to have a hard time breathing and states he would like her sent to hospital. This nurse went to assess, pt observed with labored breathing. V/S 158/79,95 bpm,20 RR , 153, glucose, 96%, o2 8L trach. Pt suctioned and administered scheduled albuterol nebulizer treatment (used to prevent and treat difficulty breathing, wheezing, (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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	shortness of breath, coughing, and chest tightness caused). No distress noted pts breathing improved post suctioning. Pt's FM continues to request pt be sent out. This nurse called NP and notified her. EMS called, EMS arrived and assessed pt. EMS states pt's FM would like pt sent out r/t large abdomen transported to [hospital]. This entry was written by LVN F. Record review of Resident #71's hospital nurses notes dated 4/5/2026 at 2:32 PM reflected the following Pt from NH with abdominal pain. Trach dependent patient, on 35% trach collar, 7 cuffless old style (? fenestrated) (a specialized airway device with holes in the outer cannula that allows air to pass through the upper airway, enabling speech and improved breathing, especially during weaning). Pt trach had foul smelling. Took the inner cannula out to clean, inner cannula was fully clogged with dry secretion, as soon as trach was out pt started to cough up blood. Decision made to change the trach. Trach exchanged to #7.0 Protex (tubes made from siliconized PVC to be soft yet kink-resistant) cuff less, placement verified with B/L BS, positive color change. ED attending and resident at the bedside. Placed on 28% trach collar Spo2 98%. During an interview 04/07/2026 at 10:21 AM, the hospital case manager revealed that Resident#71 was admitted to the hospital on [DATE] with complications of trache and clogged g-tube. She stated the resident had trache replacement in the emergency room and family had requested placement to a different facility after she discharged from the hospital. Observation on 04/07/2026 at 10:30 AM of Resident #71 in the local hospital Resident #71 was awake with eyes open, but she was uninterviewable. She was receiving oxygen via tracheostomy. During an interview on 04/07/2026 at 10:46 AM, the Hospital RN revealed that Resident #71 arrived at the hospital by Ems. She stated the family had concerns that she had shortness of breath and her abdomen was distended. She stated when the respiratory therapist attempted to suction Resident #71 the Respiratory therapist could not advance the suction catheter. She stated Resident #71 oxygen levels started to drop, attempts to hyper oxygenate the resident were unsuccessful, then the attending physician ordered to remove inner canula. She stated the inner cannula had a strong foul smell, it was completely occluded (when mucus or secretions form a plug inside a tracheostomy tube, restricting airflow) and calcified (accumulation of calcium deposits of the inner cannula often due to long-term use) the entire length of the tracheostomy. She stated when they removed the inner cannula had a foul smell that was so bad staff had to exit the room. She stated Resident #71 she was bleeding from the stoma, and the Respiratory therapist had to replace the trache ostomy. She stated that she reported to APS because per her assessment the tracheostomy was not being taken care of. During an interview 04/07/2026 at 10:50 AM, the hospital Respiratory therapist stated while Resident #71 was in the emergency room she had a lot of secretion. She stated when she attempted to suction the resident, there was difficulty advancing the suction catheter because the inner cannula was occluded. She stated she took the inner cannula out then Resident #71 coughed a large amount of blood. She stated the trache had a lot of dried mucous, it had a foul smell, so they had to replace the entire trache. She stated based on her assessment the inner cannula had not changed in a long time. She stated the inner cannula was supposed to be replaced at least daily and, in some cases, twice a day, while the actual trache needed to be replaced every three months. She stated the trache ties were dirty, indicating they had not been changed in a while. During an interview on 04/7/2026 at 12:45 PM, LVN F revealed she was Resident #71 the nurse she was transferred to the hospital. She stated the weekend supervisor asked her to replace the humidification water on Resident #71 tracheostomy. LVN F stated she suctioned Resident #71 and changed the water then she went down the hall. She stated Resident #71 FM then told her he wanted Resident #71 sent out to the hospital. LVN F stated the resident presented with signs of shortness of breath labored breathing. She stated she assessed the resident and suctioned the resident with positive result, Resident #71's breathing improved and she was not showing signs of respiratory distress, but the FM insisted he wanted her sent to the hospital. LVN F stated she notified the NP then and called EMS. She stated she gave EMS report and they went to take vital signs. She stated that whenever she was scheduled to work with the resident, she always changed the inner canula. She changed her cannula every time she was here. She stated (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the risk of not following physician order to trache care was infection, the resident could experience respiratory distress and even death. Record review of Resident #8's Comprehensive MDS assessment, dated 02/27/2026, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. BIMs score was recorded was 00 indicating no interview was conducted. His diagnoses included encounter for attention to tracheostomy (attention to tracheostomy, which includes cleaning, care, and changing or removing tracheostomy tubes). Section O -was coded for trache care, suctioning, and oxygen therapy. Record review of Resident #8's care plan Date Initiated: 02/23/2026 reflected Resident# 8has a tracheostomy. Interventions Monitor/document respiratory rate, depth, and quality. Check and document q shift/as ordered. Suction, as necessary. Record review of Resident #8's active physician orders 04/06/2026 revealed Change Trach Monthly on the 15th one time a day starting on the 15th and ending on the 15th every month order start date 02/21/2026. Record review of Resident #8's active physician orders 04/06/2026 revealed Suction trach as needed for copious secretions order start date 02/21/2026. Record review of Resident #8's active physician orders 04/06/2026 revealed Suction trach every shift order start 02/21/2026. Observation and interviews on 04/06/26 at 11:40 AM, during initial pool the surveyor noted that Resident #8 did not have an Ambu bag in his room, which was a requirement in the event the resident needed resuscitation. The surveyor observed Resident #8 FM suctioning Resident #8 using the non-sterile suctioning tube that connects to the cannister. Resident #8 was observed coughing thick mucus with audible rattling/gurgling noises. During an interview Resident #8's FM reported she frequently had to wait for a long time for his call light to be answered. Resident #8's FM stated she had not been trained on trache care, but when she suctioned his tracheostomy, it helped Resident #8 breath better. The surveyor activated the call light at 11:40 AM. At 11:49 AM, a CNA M entered the room, turned off the call light, and walked out of the room. When asked by the surveyor why the CNA M turned off the call light and did not ask what was needed, the CNA M stated she would be right back. The surveyor notified CNA M that Resident #8 needed to be suctioned. At 11:58 AM, the surveyor left the room to locate a nurse, as it had been 18 minutes since the call light had initially been activated. The surveyor met with ADON R on the hallway and notified her that Resident #8 was coughing up a lot of mucous. Resident #8 continued to cough thick mucus, audible rattling/gurgling noises, and thick/yellowish phlegm on the trach tie. At 12:00 PM the ADON R and LVN B entered Resident #8 room. During an interview at 12:03 PM with the ADON Q revealed every resident with trach there must have an Ambu bag in room in case they require resuscitation. She stated the risk to the resident was the staff would not be able to perform resuscitation to the resident and it could lead to serious harm including death. The surveyor observed the ADON R brought an Ambu bag and placed it in Resident# 8 room. Observation on 04/06/25 at 12:04PM, LVN B changed the trach tie and gauze for Resident #8. The resident was observed to continuously cough yellowish, thick phlegm. The nurse did not assess the resident's oxygen saturation after changing the trach tie, LVN B started to doff PPE without suctioning the resident. The surveyor asked if LVN B was going to suction the resident, and she stated she had suctioned the resident in the morning; the surveyor asked the nurse, per her assessment, the resident needed suctioning due to all the phlegm he had that his family member was cleaning with gauze. LVN B proceeded to suction the resident using sterile technique. The nurse did not hyper oxygenate the resident prior to suctioning, nor did the nurse did not check the resident's oxygen saturation before, during and after suctioning the resident. LVN B performed suctioning using inappropriate technique including applying suction while advancing the catheter and using a back-and-forth motion, which is inconsistent with accepted standards of care. During an interview with LVN B on 04/06/26 at 12:23 PM, she stated it was her first time working with Resident #8. She stated she was not aware of the physician order to suction trach as needed for copious secretions. She stated she had suctioned Resident #8 in the morning, and he was suctioned every shift. She stated she should have checked Resident#8 oxygen saturation before, during and after suctioning him. She could not identify what an Ambu bag was and or its purposes. She stated she had not been in (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	serviced on trach care at this job but at her other job she had been in serviced. During an interview on 04/07/26 at 12:33 PM, RT H stated she sees the residents with traches weekly but due to increased work assignment she has been seeing the residents every two weeks. She stated she last saw Resident #71 and Resident # 8 three weeks ago at that time there were no issues noted. She stated the nurses provided respiratory care such as suctioning, tracheostomy, ventilator, and/or emergency care. She stated procedures used to monitor the resident's respiratory status included change checking oxygen saturation, checking for changes in secretion, blood pressure, and auscultation of breath sounds. She stated that if there was a mucus plug the staff would know because they would not be able to pass the suction catheter and they would know to take out the inner cannula out. She stated she had classes on respiratory care and tracheostomy every two weeks on trache care, but she had no control on what nurses showed up for training. She stated if a trache was observed to have dried hard secretions, dirt and fouls smell would be indication of infection and not proper care of the trache. She stated the risk if not having an Ambu bag would be the resident would suffer serious harm respiratory distress to include death. Record review of an unnamed, undated, scanned book submitted by Regional Clinical Specialist as the facility policy, reflected: Tracheal suction involves the removal of secretions from the trache by means of a catheter inserted through the mouth or nose or a tracheal stoma, a tracheostomy tube. Before suctioning determine whether your facility requires a physician's order and obtain one if necessary Assess the patients' vital signs, breath sounds and general appearance to establish a baseline for comparison after suctioning. Use sterile technique, open suctions catheter kit, and put on the gloves. Using your sterile hand gently insert the suction catheter into the artificial airway. Advance the catheter, without applying suctions until you meet resistance. If the patients' coughs pause briefly and then resume advancement. After inserting the catheter, apply suction intermittently by removing and replacing the thumb of your non dominant hand over the control valve simultaneously, use your dominant hand to withdraw the catheter as you roll it between your thumb and for finger. Never suction more than 10 seconds at a time to prevent hypoxia. On 04/07/26 at 3:20 PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 04/08/26 at 6:00 PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The facility POR for immediate jeopardy was accepted on 04/08/2026 at 9:31 AM and reflected the following: On April 7, 2026, the surveyor notified the Facility that immediate jeopardy had been called, and the Facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements. The alleged Immediate Jeopardy allegations are as follows: Issue: F695 - Respiratory/Tracheostomy Care and Suctioning Actions for Residents Involved: Resident #71: On 04/06/2026, Resident #71 was transferred to the hospital for evaluation and treatment of respiratory distress. Upon notification, the facility initiated a review of respiratory care provided. The DON/Designee will review admission orders and documentation upon return during the clinical meetings and through rounding to ensure that all physician orders and assessments related to tracheostomy care are followed, and licensed nurses will inspect and document presence of Emergency respiratory equipment to include Ambu bag at bedside every shift. Resident #8: On 4/7/26, Resident # 8 was assessed by Respiratory Therapists, provided trach care and suctioning. On 4/7/2026 Resident #8 was assessed by Respiratory Therapist and received physician's order to send resident out to hospital to change current tracheostomy to cuffless tracheostomy. Identify residents who could be affected: On 04/07/2026 , a 100% audit of all residents with tracheostomies and respiratory care needs was conducted by the Director of Nursing and/or designee. This audit included respiratory assessment, verification of physician orders, presence of emergency equipment at bedside including Ambu bag, and review of documentation for respiratory care and suctioning. Any identified concerns were immediately addressed. Action Taken / System Change: The Director of (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nursing was immediately reeducated by Respiratory Therapist on 04/07/2026 regarding oversight of respiratory care services, including ensuring staff competency, adherence to physician orders, and availability of emergency equipment. LVN B was reeducated on 04/07/2026 by the Respiratory Therapist and received 1:1 education with return demonstration on the following: - Proper tracheostomy care and maintenance - Proper suctioning technique (including no suction upon insertion and correct withdrawal method) - Requirement to assess oxygen saturation before, during, and after suctioning - Recognition of signs and symptoms of respiratory distress - Proper use and purpose of emergency equipment, including Ambu bag By 04/08/2026, 100% of licensed nurses will be reeducated by the Director of Nursing, Respiratory Therapist and/or designee and pass return demonstration prior to start of next scheduled shift. - Tracheostomy care and infection control practices - Proper suctioning techniques and frequency based on resident need - Monitoring and documentation requirements, including oxygen saturation - Emergency response procedures for respiratory distress - Identification, location, and use of emergency equipment, including Ambu bag Beginning 4/7/26, Licensed nurses who are on PRN status/PTO/FMLA/Leave of absence will have the re-education completed and return demonstration prior to the start of next scheduled shift. Beginning 04/07/2026 and ongoing, licensed nurses are required to verify each shift and document on the MAR and replace supplies if not present at bedside. - Presence of emergency equipment at bedside including Ambu bag Beginning 04/07/2026, newly hired and agency staff will receive required training and must demonstrate competency prior to providing care to residents with tracheostomies. On 4/7/2026, Family members will be educated by the Respiratory Therapist that clinical procedures, including suctioning, are not to be performed by non-trained individuals. Completion Date: 04/07/2026 Monitoring: Beginning 04/07/2026 and ongoing, the Director of Nursing and/or designee will conduct monitoring and daily audits to ensure: - Compliance with tracheostomy care and suctioning procedures - Presence of required emergency equipment at bedside - Proper documentation of respiratory assessments and interventions The Director of Nursing, Respiratory Therapist and/or designee will conduct random observations of tracheostomy care and suctioning procedures to validate competency, and verification of presence of emergency medical equipment including ambu bag at bedside by rounding on residents with tracheostomy. Results of audits will be reviewed in the Quality Assurance Performance Improvement (QAPI) Committee, and additional interventions will be implemented as needed to sustain compliance. On 04/07/2026, an Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, and interdisciplinary team to review the Immediate Jeopardy and approve the Plan of Removal. Monitoring the facility's Plan of Removal included the following: Interviews with the following staff from 04/8/25 at 9:46 AM to 4:04 PM who worked all shifts and all days of the week revealed they had been in-serviced on tracheostomy care and infection control, and taken the competency assessment: LVN B, RN D, RN E, LVN F, LVN G, RN I, LVN K, RN L, ADON R. Record review of an QAPI Agenda, IJ F-695 Respiratory Tracheostomy Care/Suctioning, dated 04/7/26 reflected Administrator. DON and MD were in attendance. Record review of Resident #8 respiratory assessment revealed on 4/7/26, Resident # 8 was assessed by Respiratory Therapists, provided trach care and suctioning. On 4/7/2026 Resident# 8 received physician's order to send resident out to hospital to change current tracheostomy to cuffless tracheostomy. Record review of in-service sign-in sheets, dated 04/07/26 and titled Tracheostomy Care reflected the DON had signed and completed Tracheostomy Competency Assessment. Record review of in-service sign-in sheets, dated 04/07/26 and titled Tracheostomy Care reflected the LVN B had signed and completed Tracheostomy Competency Assessment. Record review of daily audits and monitoring reflected the Director of Nursing conducted audits on 04/07/2026 and 04/08/2026 on all three residents with tracheostomies. The audits included monitor nurse competency for trach q day, monitoring suctioning for trache care q day, monitoring emergency supplies at bedside q day. Record review of Respiratory assessments dated 04/07/2026 and 04/08/2026 reflected the Respiratory therapist conducted assessments were completed on three (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	residents with tracheostomy's. Record review of residents with tracheostomy reflected licensed nurses documented required to verify and presence of emergency equipment at bedside (including Ambu bag and suction equipment). Record review of tracheostomy care in-service, dated 04/07/26-04/08/2026, reflected 18 nursing staff had been in-serviced. Record review of in-service titled Call light Response dated 04/07/26-04/08/2026, reflected 53 staff members had been in-serviced. Observation on 04/08/2026 at 8:05 AM of residents with tracheostomies revealed that all requires emergency equipment and suction apparatus were present and readily available at the bedside, emergency equipment included an ambu bag, extra tracheostomy inner cannula(appropriate sizes), and suction supplies was observed to be set up and accessible for immediate use. During an interview 04/08/2026 at 10:05 AM, the MD Revealed Resident #71 was a long-term resident, the NP would see her monthly. He stated because of her neurological issues and trache she seemed to have a lot of medication issues see was seen on average on at least twice a month. He stated trache care is primarily by the nurses overseen by the respiratory therapist and if there were any issues with the trache they would call the respiratory therapist and she would communicate with him. He stated the times he saw the resident he had no concerns. He stated the risk when the trache was not cared for per physician's order to include suctioning and changing inner cannula as schedule was mucus plugs occluding the inner cannula which could lead to respiratory emergencies including hospital transfer. He stated he was notified of the immediate jeopardy and agreed with the plan of correction. He stated the retraining of the nursing staff and daily monitoring by the DON would ensure residents with trach are well taken care of. Interview 4/08/2026 at 10:55 AM, RT H stated, she assessed Resident #8 on 04/07/2026 and provided trach care and suctioning. She stated she received physician's order to send resident out to hospital to change current tracheostomy to cuffless tracheostomy which would make speaking much easier because it would allow air to flow around the tube, up through the vocal cords, and into the mouth, enabling sound production. She stated that she reeducated the Director of Nursing on 04/07/2026 regarding oversight of respiratory care services, including ensuring staff competency, adherence to physician orders, and availability of emergency equipment. She stated on 4/07/2026, she educated Resident #8 Family members that clinical procedures, including suctioning, are not to be performed by non-trained individuals. During an interview on 4/08/2026 at 11:03 AM, the DON stated she had been in serviced by the respiratory therapist and had completed the tracheostomy care competency assessment. She stated when Resident #71 returned to the facility she would ensure that all physician orders related to tracheostomy care are followed, including respiratory assessment. She stated she would monitor routine care and cleaning, suctioning, monitoring for complications and verify presence of Emergency respiratory equipment to include Ambu bag at bedside daily. She stated she would do random checks when the nurses were suctioning the residents with traches and will ensure all new staff are in- serviced and complete the tracheostomy competency assessment. She stated that she will audit PCC daily to make sure the nurses are documenting the availability of emergency equipment. She stated on 04/07/2026 LVN B was reeducated received 1:1 education with return demonstration on tracheostomy care. She stated Beginning 04/07/2026, all CNAs were reeducated on: Timely response to call lights, Immediate reporting of respiratory distress to licensed nursing staff, Infection control practices related to respiratory care. She stated that any new issues will be reviewed in QAPI meetings. She stated that no nurse will be allowed to work the floor before completing the tracheostomy Inservice and the competency assessment. During an interview on 4/08/2026 at 11:30 AM with Resident #8 FM revealed she was educated by the respiratory therapist on 04/07/2026 to only let the nursing staff suctions and care for the resident's tracheostomy. During an interview on 4/08/2026 at 11:45 AM 2026 LVN B stated she received 1:1 education on tracheostomy care and she was able to verbalize the steps and procedures in tracheostomy care and suctioning. During an interview on 4/08/2026 at 11:55 AM 2026 LVN F stated she received in-service on tracheostomy care and she was able to verbalize the steps and procedures in tracheostomy care and suctioning Observation on 4/08/2026 (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Some	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 observations and interviews, and record reviews the facility failed to ensure residents receiving enteral nutrition (g tube) received appropriate care, treatment and service to maintain nutritional status to prevent complications and ensure safe feeding practices consistent with professional standards of practice for 2 (Residents #71 and Resident #8) of 4 residents reviewed for enteral feeding. The facility failed to monitor for complications related to Resident #71 feeding tube and tube feeding when Resident #71 was transferred to the hospital and had part of the g-tube replaced. The facility failed to ensure LVN F allowed Resident's #8 medication to flow by gravity while administering through G-Tube on 04/07/2026 and not using force.This failure could put residents at risk of inaccurate delivery of prescribed nutrition and medication administration.Findings included: Record review of Resident #71's Comprehensive MDS assessment, dated 01/11/2026, reflected She was a [AGE] year-old female admitted to the facility on [DATE]. No BIMs score was recorded indicating no interview was conducted. Her diagnoses included dysphagia(is a physical difficulty or discomfort with swallowing, often caused by muscle weakness or neurological issues like stroke), aphasia(a language disorder caused by brain damage), and respiratory failure (a critical condition where the respiratory system fails to perform its basic function of gas exchange, resulting in too little oxygen in the blood). Section K0520 was coded for feeding tubes. Record review of Resident #71's care plan initiated 03/27/2024 Resident #71's requires tube feeding r/t dysphagia following CVA; G-tube in place and ordered NPO. Interventions Monitor/document/report PRN any s/sx of: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. Record review of Resident #71's active physician dated 04/06/2026 revealed Enteral Feed Order every shift for Aspiration Prevention Check for residual. If residual is greater than 100 cc call MD start date 03/31/2026. Record review of Resident#71's hospital records dated 04/06/2026 reflected: Sound Progress Note DOS: 4/6/2026 Chief Complaint: Abdominal Pain (Family reports abdominal distention x 2 days.) 76 y.o. with a PMH of seizure disorder, psychiatric disorder, chronic trach and PEG,nonverbal patient coming from nursing home as family was worried that she had abdominal distention and respiratory distress. Assessment & Plan Status post insertion of percutaneous endoscopic gastrostomy (PEG) tube (CMS/HCC) Present on admission: Not Applicable Abdominal distention in setting of PEG obstruction/complication- [hospital] report filed to nursing home as patient had clogged trach and G-tube was not being cared for. Case manager consulted for placement to a different nursing home strict bowel regimen will also need to be initiated as patient has moderate constipation noted on CT Patient is having bowel movements. Trach dependent -IR for PEG replacement on April 6, 2026 Continue with gentle fluids. Holding medicines and tube feeds we have PEG tube. Focused H&P Exam dated 04/06/2026 CC: Preoperative anesthesia evaluation HPI : Resident#71 is a 76 y.o. female with h/o seizure disorder, psychiatric disorder, chronic trach, and PEG. Patient is non-verbal at baseline. G-tube is clogged and malfunctioning. Patient presents to IR for gastrostomy tube exchange. H&P by [MEDICAL DOCTOR]at 4/6/2026 3:16 PM (continued) 4. Status post insertion of percutaneous endoscopic gastrostomy (PEG) tube (CMS/HCC) Case request interventional radiology: IR GASTRIC TUBE REPLACEMENT/EXCHANGE Case request interventional radiology: IR GASTRIC TUBE REPLACEMENT/EXCHANGE IR GASTRIC TUBE REPLACEMENT/EXCHANGE IR GASTRIC TUBE REPLACEMENT/EXCHANGE 4/6/2026 3:16 PM Procedure aborted post physician consultation with family the entry was written by Hospital MD. An attempt on 04/06/2026 at 4:00 PM to observe Resident #71 at the hospital was unsuccessful surveyor was notified that the Resident#71 was in the operating room to replace her G-tube. During an interview 04/07/2026 at 10:21 AM the hospital case (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Some	manager stated Resident #71 was admitted to the hospital on [DATE] with complications of trache and clogged g-tube. She stated the resident was scheduled to have the g tube replaced on 04/06/2026 but the decision was receded after consultation with MD and family. Observation on 04/07/2026 at 10:26 AM of Resident #71 at the local hospital revealed G-tube feeding infusing via g-tube and resident was observed to have trache. Resident#71 was in bed alert with eyes open. resident un-interviewable. An attempt on 04/07/2026 at 10:26 AM to interview Resident #71 FM was unsuccessful, left voicemail with call back number. During an interview 04/07/2026 at 10:46 AM, RN N (hospital staff) stated Resident#71 arrived at the hospital by Ems. She stated the family was concerned her abdomen was distended. She stated that when she went to assess the resident's G-tube it was occluded. She said the [NAME] valve (a three-way stopcock device, used with PEG or gastro-jejunostomy tubes to provide safe, closed-system access for feeding and medication administration) had no caps, it was dirty and occuled with dried brownish substance. She stated they attempted to de-clog the g-tube with no success. She stated they had to hold the residents medication and the resident was scheduled to have her g-tube replacement. She stated she reported to APS per her assessment the g-tube was not being taken care of by the nursing home. During an interview 04/07/2026 at 1:24PM, the DON stated Resident #71 was transferred to the hospital per family request. She stated she was notified by the nurse that Resident #71's FM wanted the resident sent to the hospital for shortness of breath. During an interview 04/08/2026 at 2:40 PM, LVN F stated she was the nurse that discharged Resident #71 to the hospital. She stated Resident #71 was transferred to hospital by EMS after the FM was concerned that she had shortness of breath. She stated she always flushed Resident #71's G-tube. Record review of Resident #8's Comprehensive MDS assessment, dated 02/27/2026, reflected He was a [AGE] year-old male admitted to the facility on [DATE]. BIMs score was recorded was 00 indicating no interview was conducted. His diagnoses included encounter for attention to gastrostomy (encounter for attention to a gastrostomy, covering routine care, cleaning, and tube changes/replacements). Section K0520 was coded for feeding tubes. Record review of Resident #8's care plan initiated 03/27/2024 Resident #8 requires tube feeding r/t dysphagia. Interventions Monitor/document/report PRN any s/sx of: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. Record review of Resident #8's active physician orders dated 04/08/2026 revealed NPO diet NPO texture, NPO (Nothing by Mouth) Active 02/21/2026 Record review of Resident #8's active physician orders dated 04/08/2026 revealed Enteral Feed Order every shift Osmolite 1.5 (a high-protein, low-residue, complete enteral tube-feeding formula designed for patients with increased calorie/protein needs, or those with limited volume tolerance) at 70mL/hr x20hr provides: Verbal Active 02/27/2026. Record review of Resident #8's active physician orders Enteral Feed Order every shift Flush feeding tube with 35 ml of water before and after medication administration. An observation on 04/07/2026 at 7:30 AM medication administration for Resident #8, LVN F was observed force-flushing 7 of 13 medication individually through the G tube. During an interview 04/07/2026 at 7:40 AM, LVN F stated it was her first time working with Resident #8 and stated she did not know how his g-tube worked. She stated g tube medication administration should be administered by gravity, but she pushed because there was difficulty with gravity flow and the resident needed his medication. She stated she should have stopped and notified the physician. During an interview 04/07/2026 at 8:24 AM, the DON revealed that G-tube medication should be administered by gravity and if the g tube was not patent while administering medication attempts should be made to de-clog the g tube and if attempts to de-clog were unsuccessful, the medication should be held and MD notified. Review of the facility's policy Enteral Tube Medication Administration Revised 10/01/2019 reflected the following:Put 15 - 30ml of water in syringe and flush tubing using gravity flow. Clamp tubing after the syringe is empty, allowing water to remain in the tube.Pour dissolved/dilute medication in syringe and unclamp tubing, allowing medication to flow by (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Some	gravity.Clogged tube - Clogging can occur from kinking of the tube or from internal blockage.Check first to see that the tube is not kinked.If clog is still present gently milk the tube from top to bottom to release any clog that may be in this part of the tube.Do NOT force-flush the tube or use a rigid object in an attempt to clear the tube. If the clog is persistent, contact the MD if the above techniques fail.

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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 label and store Drugs and biologicals under proper temperature controls in accordance with State and Federal laws on two residents (Resident#13,Resident# (300 and 200 hall nurses medication cart) of 4 medication carts reviewed for medication storage. 1.The facility failed to ensure Resident#13's opened vial of Lorazepam was not refrigerated and was stored in the medication cart.2. The facility failed to ensure opened Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (a long-acting human insulin) was properly labeled with resident name before it was stored in the medication cart.3. The facility failed to ensure two bottles of nystatin were properly labeled with patients label after opening and before it was stored in the medication cart.4. The facility failed to ensure a tube of ammonium lactate 12% was properly labeled after opening and before it was stored in the medication cart. These failures could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents.Finding IncludedObservation of 300 short hall nurses medication cart on [DATE] at 10:10 AM revealed the following:*Resident #13 Lorazepam Oral Concentrate 2 MG/ML was stored unrefrigerated in the medication cart, two bottles of nystatin100,000units/gram (anti-fungal medication use to treat skin infections caused by candida yeast) with no prescription labels and *ammonium lactate 12%(a prescription- strength medication designed to treat dry scaly skin conditions and server itching) with no prescription labels. During an interview on [DATE] at 10:13 AM with RN D, she stated she was not aware that lorazepam was supposed to be refrigerated and the nystatin bottles and ammonium lactate 12% did not have patients' labels. She stated the risk of not refrigerating medication that required refrigeration was that the drug would lose its potency and would not be effective to treat the residents' symptoms. She stated failure to have medication with labels was a risk for medication error. She stated the risk to the resident was medication error and medication not being effective if it was expired. She stated that she had been in-serviced on medication storage. 2.Observation of 300 long hall on [DATE] at 10:20 AM on the, revealed an opened Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (a long-acting human insulin) was not labeled with resident name before it was stored in the medication cart. During an interview on [DATE] at 10:22 AM with RN D revealed she was not aware the Lantus did not have the required label. She stated that all medications were supposed to have a label from pharmacy. She stated having insulin in the medication cart that did not have the proper label could result in administering insulin to the wrong resident which may result in hospitalization. She stated the nurses and medication aides had been serviced on medication administration and storage. During an interview on [DATE] at 10:20 AM with ADON R, revealed nurses and MAs were responsible for ensuring the medication carts were clean, all medications were labelled and stored per manufacturer's recommendation. She stated lorazepam should always be refrigerated because it loses its effectiveness when it was stored in temperatures higher than recommended, making it ineffective in treating the residents' symptoms. She stated the risk of having medication without labels was a medication error. She stated she audited the carts weekly and the pharmacists audited the carts monthly. She stated the nurses and medication aides had been serviced on medication administration and storage in the room. During an interview on [DATE] at 3:00 PM with the DON, revealed nurses and MAs were responsible for ensuring the medication was properly labeled and stored per manufacturer's recommendations. The DON stated the risk of unlabeled medications included the potential for medication error and unrefrigerated lorazepam would not be effective in treating the residents' symptoms. She stated the nurse and medication aides had been serviced on medication administration and storage in the room. Review of the facility's policy Medication Administration (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revised [DATE] reflected the following: Whenever you are preparing to give someone medication, it is important to understand the 10 rights of medication administration. Safety should be the first thing on your minds with medications. There is always a risk of giving the wrong pill, the wrong dose, or the wrong person's medication. If this happens, harm to the person can occur and some reactions can be deadly. While there has always been protocol for giving drugs, it is important for everyone to always know the safety rules for medication. IN THE PAST, YOU MAY have heard of the 5 rights of medication administration: right patient, right drug, right route, right time, and right dose. Medical practice have changed to include a few more rights.Right patient - make sure you are giving the right medication to the right person. Check the name, the order, and the patient. Use 2 identifiers. Always ask the patients name, check an ID band, pictures or whatever form of identification is being used and check the medication bottles/cards/tubes to compare before giving a medication.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions and services needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for one (Resident #119) of five residents reviewed for baseline care plans. The facility failed to complete a baseline care plan for Resident #119 within 48 hours of her admission. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services.Findings included: Review of Resident #119's Face Sheet, dated 04/08/26, reflected she was a [AGE] year-old female, who admitted to the facility on [DATE], with diagnoses including chronic multifocal osteomyelitis of the left ankle and foot (a rare inflammatory bone condition characterized by multiple sites of bone infection), type 2 diabetes mellitus (a chronic condition characterized by insulin resistance and high blood sugar levels), and acute kidney failure (a sudden loss of kidney function that occurs when the kidneys suddenly lose their ability to filter waste, excess fluids, and electrolytes from the blood). Review of Resident #119's electronic medical record on 04/08/26 reflected no evidence that a baseline care plan had been completed. There was a notification which indicated the baseline care plan was overdue. During an interview with the Interim DON on 04/08/26 at 12:17 PM, she stated she was responsible for overseeing the completion of baseline care plans. She said while the admitting nurse was required to initiate the baseline care plan, she reviewed to ensure completion within two days (48 hours) of a resident's admission to the facility. The Interim DON confirmed there was no evidence that Resident #119 had a baseline care plan completed within 48 hours of her admission. She stated the risk of baseline care plans not being completed included the potential for facility staff to not follow the resident's necessary plan of care. Review of the facility's Baseline Care Plan policy, dated 06/06/25, reflected, .1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #14) reviewed for comprehensive care plans. The facility failed to ensure Resident #14's comprehensive care plan identified bed rail use as an intervention for mobility assistance. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans. Findings included: Record review of Resident #14's MDS assessment dated [DATE], reflected a [AGE] year-old female, originally admitted to the facility on [DATE], with a BIMS score of 14 which indicated intact cognitive impairment and diagnoses that included: Cerebral infarction (a type of stroke caused by a blocked blood vessel in the brain, leading to brain tissue damage), Atrophy (when a part of the body, like a muscle or tissue, shrinks or wastes away from lack of use or disease), Morbid (severe) Obesity (extremely overweight which significantly increases health risks, daily care, and mobility) Anxiety Disorder (ongoing uncontrollable, and excessive worry, fear, or dread that significantly interferes with daily life), Depression (feelings of severe sadness and inability to initiate activity), and Schizoaffective Disorder (a serious mental illness blending symptoms of schizophrenia - psychosis like hallucinations/delusions, with mood disorders like depression or bipolar mania involving extreme mood swings, disorganized thinking, and disrupted reality perception.), and Functional Quadriplegia (inability to move arms and legs due to severe weakness or illness). Record Review of Resident #14's comprehensive care plan initiated on 11/27/2023, revealed the care plan did not address the use of one or both bed rails as a mobility intervention. Record review of Resident #14's Physician Orders dated 04/06/2026, revealed an active order with a start date of 02/07/2026 authorizing the use of one or both bed rails every shift for mobility assistance and repositioning. In an interview on 04/06/2026 at 10:17 AM with Resident #14, she reported she used the side rails on her bed every day. She reported she used them mostly to help her reposition herself. She reported the side rails are very helpful and denied the rails prevented her ability to get out of bed. During an interview on 04/08/2026 at 11:00 AM with MDSC F, she reported the resident had new orders for the side rails entered in February at the resident's re-admission. She reported the side rail use should have been added to the resident's care plan. She stated it not being added was an oversight on her part. The MDSC F reported the risk to residents who do not have accurate care plans was that staff would not know the side rails are to be used by the resident. During an interview on 04/08/2026 at 11:55 AM with DON, she reported there are two MDS nurses who complete the Baseline and Comprehensive Care Plans. She stated the MDSC F reviews Care Plans to ensure the information was accurate. She stated the risk to residents who do not have accurate care plans was that interventions may not be followed. Record Review of the facility Comprehensive Care Plan policy dated 10/24/2022, reflected in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. The comprehensive care plan will describe at minimum the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure correct use of bed rails and to assess the resident for risk of entrapment from bed rails for 1 (Resident #7) of 4 residents whose records were reviewed for the use of side rails. The facility failed to complete a quarterly bed rail assessment and have a current physician's order for the continued use of Resident #7's siderails. This failure could place residents at risk of entrapment or injury.Findings included: Record review of Resident #7's face sheet, dated 04/06/25, revealed she was admitted to the facility on [DATE] with diagnoses including Age-Related Physical Debility (geriatric syndrome characterized by a gradual decline in physiological reserve, muscle strength, and functional capacity), Functional Quadriplegia (a patient cannot move their limbs due to extreme physical frailty or advanced chronic illness), Hemiplegia and Hemiparesis following Cerebral Infarction (one-sided body impairments caused by brain or spinal cord damage, often from stroke, tumors, or trauma), Muscle Wasting and Atrophy (loss of muscle tissue) and Vascular Dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain). Record review of Resident #7's quarterly MDS assessment dated [DATE], revealed her BIMS score was 13 indicative of minimal cognitive impairment. Resident #7 required partial to moderate assistance with rolling left and right, from sitting to lying, and from lying to sitting on side of bed. Under Section P - Restraints and Alarms, revealed Resident #7 used a bed rail daily. Record review of Resident #7's Care Plan, reflected the following: Problem: [Resident #7] uses side rails to both sides of bed for bed positioning/mobility. Date Initiated: 01/30/25 Interventions: Discuss and record with the resident/family/caregivers, the risks and benefits of side rail use, when the side rails should/will be applied, routines while side rails are in use and any concerns or issues regarding side rail use. Date Initiated: 01/30/25Ensure valid consent on chart prior to initiating side rails. Date Initiated: 01/30/25 Problem: [Resident #7] has an ADL self-care performance deficit r/t debility, impaired cognition (having trouble with mental processes like memory, thinking, concentration, or decision-making), dementia (loss of memory, language, problem-solving and other thinking abilities), SAH (Subarachnoid Hemorrhage), functional quadriplegia. Date Initiated: 08/04/22 Interventions: Assist rails to both sides of bed for bed mobility. Date Initiated: 12/11/24 Record review of Resident #7's Side-Rail Use Assessment Form revealed under Section C - Recommendations, was not completed and there was no signature or date. Record review of Resident #7's Nursing - Side Rail Evaluation dated 12/12/24 revealed it was completed. Record review of Resident #7's Bed Rails/Device Informed Consent for Use was completed and signed on 12/17/24. Record review of Resident #7's Order Review Report dated 04/06/26 revealed a physician's order for Assist rails to both sides of bed for bed mobility, every shift with a start date of 01/12/26, an end date of 04/02/26 and an order status of Discontinued. Under the notes section it revealed, No longer has side rails. Observation and interview on 04/06/26 at 09:55 AM revealed Resident #7 in her room sitting in her wheelchair. Resident #7 stated she was doing okay and staff took good care of her. Resident #7 had half bedrails on both sides of her bed. Resident #7 stated she used the bedrails every day to reposition herself in bed. In an interview on 04/08/26 at 11:20 AM, MDSC F stated that nursing staff completed bed rail assessments. MDSC F stated the DON or ADON completed the assessments quarterly. MDSC F stated whoever completed any form that required a signature was responsible for obtaining the signature. MDSC F stated Resident #7's Physician's Order was initiated on 01/12/26 and discontinued on 04/02/26. MDSC F stated Resident #7 not having a fully completed assessment or current physician's order on file could result in harm. In an interview on 04/08/26 at 1:10 PM the MD stated that Resident #7 was not bedbound and she ambulated using a wheelchair. The MD stated if Resident #7 attempted to get out of bed during the middle of the night, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff may use the side rails as a precautionary basis. The MD stated staff must have a physician's order to start or discontinue the use of bed rails. In an interview on 04/08/26 at 1:50 PM the DON stated nursing staff completed Side Rail Evaluations in PCC. The DON stated the evaluations should be completed in PCC at admission, quarterly, or as needed. The DON stated the risk of not having a fully completed assessment or current physician's order could affect Resident #7's care by causing harm or entrapment. The DON stated the physician's order would be discontinued based on the resident's assessment if bed rails were no longer needed. The DON stated if a resident had bed rails, they needed a current doctor's order. The DON stated there was risk to the resident if the assessment was not completed entirely. The DON stated for example, if the resident needed a bed rail you were not helping the resident with their independence, being able to reposition themselves in bed if bed rail usage was not captured on the assessment. The DON said the purpose of having the evaluation and order for bedrails for a resident was to make sure they were appropriate for the resident. The DON said the nursing department was responsible for ensuring there was an order and assessment for the bedrails. In an interview on 04/08/26 at 2:30 PM LVN A stated that Resident #7 had bed rails because she was able to pull herself up in bed. LVN A stated Resident #7 had two different sized bed rails because her left side was weaker than her right side. LVN A stated nursing evaluated residents for bed rail usage. LVN A stated she was not made aware that Resident #7's bed rails would be removed. LVN A stated Resident #7 easily used both bed rails. An attempt was made on 04/08/26 at 2:55 PM to speak with RN E prior to exit. Review of facility policy, Restraints, dated 8/15/22 revealed the following: Policy Statement: It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well?being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: . - Using bed rails to keep the resident from voluntarily getting out of bed. 2. Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner unless the resident has previously made a valid refusal of the treatment in question. 4. A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676255	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Worth Transitional Care Center	850 12th Avenue Fort Worth, TX 76104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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, receiving, dispensing, administering and disposition of all controlled drugs for 2 (Resident #79, and Resident #3) of 10 residents reviewed for pharmacy services.1. The facility failed to ensure proper disposal of Resident#79's Tylenol 300/30mg (controlled medication) by taping the blister pack of a narcotic medication.2. The facility failed to ensure nursing staff reconstituted Resident#3's IV medication prior to administration.This failure could place residents at risk of drug diversion, medication errors, and risk of pills contamination due to broken seals.Findings Included1.Record review of Resident #79's Quarterly MDS Assessment, dated 01/20/26, reflected Resident #79 was a [AGE] year-old female, admitted [DATE] and readmitted [DATE].She had a BIMS score of 12, indicating moderate cognitive impairment. The resident had diagnoses including chronic pain syndrome, other low back pain. Record review of Resident #79's active Comprehensive Care Plan, revised 09/25/2024, reflected Resident #79 has acute/chronic pain r/t back pain. Interventions included Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/document for side effects of pain medication.Record review of Resident #79's active physician orders, dated 04/06/2026, reflected the resident had orders for Acetaminophen-Codeine Oral Tablet 300-30 MG (Acetaminophen w/ Codeine) Give 1 tablet by mouth every 4 hours as needed for breakthrough pain DO NOT ADMINISTER IS LESS THAN 2 HOURS OF SCHEDULED NORCO. Order start date 04/02/2026. An observation on 04/06/26 at 9:30 AM with RN C of the 300 Hall nurses' medication Cart, revealed Resident #79's Tylenol 300/30mg (controlled medication) had a damaged blister bubble and the capsule still inside, secured with taping the blister pack. During an interview with on 04/06/26 at 9:30 AM RN C revealed she did not notice the blister was damaged before the surveyor brought it to her attention. She stated the nurses and medication aides were responsible for inspecting the blister packs at every shift change when they did the narcotic count. She stated the risk was drug diversion and medication error because there was no evidence that the medication in the blister. 2. Record review of Resident# 3's Comprehensive MDS Assessment, dated 03/06/2026, reflected the Resident #3 was a [AGE] year-old male, admitted [DATE]. She had a BIMS score of 03, indicating severe cognitive impairment. The residents had diagnoses including SEPSIS UNSPECIFIED ORGANISM(systemic response to infection where the specific bacteria, virus, or fungus has not been identified) , and Multidrug-Resistant Organism (bacteria or fungi resistant to one or more classes of antimicrobial drugs, making infections difficult to treat) and Urinary Tract Infection (a bacterial infection in the urinary system, commonly causing burning pain, frequent urges to urinate, and cloudy or strong-smelling urine).Record review of Resident #3's Comprehensive Care Plan, dated 03/05/2026, reflected* The Resident has infection of UTI with E. coli, ESBL. Interventions included Administer antibiotic as per MD orders.* The resident is on IV Medications (SPECIFY medications) r/t UTI, MDRO (a medical term for germs (typically bacteria) that are resistant to three or more types of antimicrobial agents), sepsis. Intervention included Monitor/document/report PRN s/sx of infection at the site: Drainage, Inflammation, Swelling, Redness, Warmth. Monitor/document/report PRN s/sx of leaking at the IV site: Edema at the insertion site, Taut, shiny, or stretched skin, whitening/blanching, or coolness of the skin, slowing or stopping of the infusion, leaking of I.V. fluid out of the insertion site.Record review of Resident 3's active physician orders, reflected Ertapenem Sodium Solution Reconstituted 1 GM (a broad-spectrum carbapenem antibiotic used to treat serious bacterial infections, including pneumonia, urinary tract infections, and abdominal infections) Use 1 gram intravenously at bedtime for infection related to SEPSIS, UNSPECIFIED ORGANISM. Active 04/02/2026. Observation and interview on 04/06/26 at 9:45 AM of Resident#3 revealed there was completed IV medication Ertapenem Sodium Solution (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reconstituted 1 GM Use 1 gram hanging on the IV pole. The normal saline solution was completed but the medication was still in the vial. Resident stated he got his IV medication the previous night. During an interview on 04/06/26 at 10:15 AM with LVN B revealed she was Resident#3's nurse. She stated she did not notice that the IV Medication was still in the vial. She stated she did noted the saline was completed and thought the medication was properly administered. She stated the risk to the residents as ineffective treatment and medication error. During an interview on 04/06/26 at 9:50 AM with DON stated the medication should have been reconstituted with the normal saline prior to administering to the resident. She stated she would complete a medication error and notify the MD and inservice the nursing staff. She stated the risk to the resident was missing a dose of antibiotics and ineffective treatment of the resident infection. The DON stated once a narcotic blister pack seal was broken it should not be taped. The pill should be disposed witnessed by two nurses. The DON stated the risk would be losing the medication because the seal was broken. She stated nurses and Medication Aides were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON audits the medication carts weekly, then the pharmacy consultant audits the medication room, and the medication carts every month. She stated the nurses and the MAs had been in-serviced on medication storage, and narcotics were not to be taped if the blister seal was broken. Review of facility documentation dated 04/06/2026 at 11:27 AM reflected documentation of Resident#3 medication error. Review of the facility's policy Medication Administration Revised 10/01/2019 reflected the following: Medications are administered as prescribed in accordance with good nursing principled and practices and only by the persons legally authorized to do so.Medication are administered in accordance with written orders of the prescriber. Review of the facility's policy Parenteral Administration Revised 10/01/2019 reflected the following: To provide for the safe and accurate reconstitution of parenteral medications prior to administration manufacturer information is reviewed and aseptic technique is observed.Read medication package literature, medication label, or other appropriate reference to determine the correct diluent and quantity of diluent to be used. Note any special steps required (such as shaking).Review of the facility's policy Parenteral Administration Revised 03/22/2023 reflected the following: When a dose of control medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurse, and the disposal is documented on the accountability record/book on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single ampules and doses of controlled substances wasted for any reason.