STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident had a right to privacy and confidentiality of his or her personal and medical records and treatment for nine (Residents #1, #12, #23, #42, #45, #73, #81, #119, and #130) of eighteen residents reviewed for privacy and confidentiality.1. The facility failed to ensure LVN I secured Residents #1, #12, #23, #42, #45, #81, #119, and #130's medical information before leaving her nurse's cart on 02/18/2026. 2. The facility failed to ensure LVN I closed Resident #45's door while checking his blood sugar and administering his insulin on 02/18/2026.3. The facility failed to ensure Resident #73 had signed consent in the active section of the EHR for AEM to be conducted in the shared room by Resident #87 or their RP.The failures could place the residents at risk of their medical information being accessed by unauthorized individuals, having medical or personal information or conversations recorded or exposed to others, and at risk of not having their personal privacy maintained while treatment was provided that could result to the residents feeling uncomfortable during treatment.Findings included:Record review of Resident #73's admission Record, dated 02/18/2026, revealed a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #73 was noted to have diagnosis which included Restlessness and Agitation, Shortness of Breath, Need for Assistance with Personal Care, Other Lack of Coordination, Muscle Weakness (Generalized), Cerebral Infarction (blocked blood flow to the brain, usually caused by blood clots, leading to tissue death), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side (neurological conditions causing motor impairment on one side of the body due to brain injury), Dysphagia Following Cerebral Infarction (difficulty swallowing), Acute Respiratory Failure (when lungs cannot adequately oxygenate the blood or remove carbon dioxide, often due to rapid fluid buildup in the air sacs), Type 2 Diabetes Mellitus with Diabetic Neuropathy (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, resulting in damage to nerves particularly in the legs and feet), Other Recurrent Depressive Disorders (distinct, repeated depressive episodes that do not fit standard classifications), Memory Deficit Following Unspecified Cerebrovascular Disease, Other Speech and Language Deficits Following Cerebral Infarction, and Acute Embolism and Thrombosis of Unspecified Vein (sudden blockage of a vein by a blood clot that has not been specifically localized). Record review of Resident #73's Care Plan, last updated on 11/06/2025, revealed no focus or intervention related to AEM in the resident's room. Record review of Resident #73's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 13, which indicated intact cognition. Resident #73 was noted to utilize a wheelchair for mobility. Functional abilities revealed Resident #73 was dependent for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene, Resident #73 was noted to need partial/moderate assistance for oral hygiene, and only needed set up/clean up assistance for eating. Resident #73's mobility was noted as dependent for chair/bed-to-chair transfer and tub/shower transfers while substantial/maximal assistance was needed for roll left and right, sit to lying, and lying to sitting on side of bed. Record review of Resident #73's Miscellaneous Documents, dated 02/18/2026, revealed no consent for AEM was conducted in (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosed with hypertension (high blood pressure).Record review of Resident #12's Face Sheet, dated 02/19/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Record review of Resident #23's Face Sheet, dated 02/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Record review of Resident #42's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with atherosclerotic heart disease (the buildup of fats, cholesterol, and other substances in and on the artery walls of the heart).Record review of Resident #45's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hypertension.Record review of Resident #81's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with respiratory failure (condition where there is not enough oxygen in the body or too much carbon dioxide in the body).Record review of Resident #119's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with atrial fibrillation (an irregular, rapid heartbeat).Record review of Resident #130's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension. During an observation on 02/18/2026 at 7:51 AM revealed an untitled piece of paper was left on top of a nurse's cart parked in the hallway. On the piece of paper were Resident #1, #12, #23, #42, #45, #81, #119, and #130's temperatures, blood pressures, pulse rates, respiratory rates, and oxygen saturations. The nurse's cart was unattended and was facing the hallway with several staff and residents passing by the cart.During an observation and interview on 02/18/2026 at 7:53 AM, the DON stated the paper should be flipped over to prevent HIPAA violations. The DON then told ADON A to stay with LVN I who left the paper with vital signs unattended. During an observation and interview on 02/18/2026 at 7:55 revealed LVN I was about to go inside a resident's room to administer medication. She left the piece of paper again with the vital signs exposed. ADON A told LVN I to flip the paper because it contained medical information. ADON A said the piece of paper only had residents' rooms on it but the vital signs written on the sides were enough to provide medical information. She said the room numbers were protected health information that could be linked to the resident's identity. She said somebody might take the paper and could go room-by-room. She said there could be visitors that were clinicians and would know exactly what was written on the paper.During an interview on 02/18/2026 at 7:58 AM, LVN I stated the best practice was to secure any information about the residents before leaving the cart unattended. She said the piece of paper had the residents' vital signs and were confidential. She said she should have secured the paper and closed the laptop she was using before leaving the cart. Record review of Resident #45's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar).Record review of Resident #45's Comprehensive MDS Assessment, dated 01/11/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had diabetes mellitus and was taking insulin.Record review of Resident #45's Comprehensive Care Plan, dated 01/14/2026, reflected the resident did not have a care plan for diabetes mellitus.Record review of Resident #45's Physician Order, dated 02/01/2026, reflected Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 61 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units Re-check BS in 15 minutes. If still greater than 401, call MD and make RP aware., subcutaneously (administer under the skin) before meals and at bedtime for DM IF BS > 401 Re-check in 15 minutes. If Blood Sugar still 401 or greater, CALL MD.During an observation on 02/18/2026 at 11:45 AM revealed LVN I was about to check Resident #45's blood sugar. She went inside the resident's room and took the resident's blood sugar. She said the resident's blood sugar was 211 and the resident would get 4 units of insulin. She prepared the insulin, went inside the room, and administered the resident's insulin on his right upper arm. LVN I did not close the resident's door (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while checking the resident's blood sugar and when administering the resident's insulin. The treatment that she doing was visible from the hallway.During an interview on 02/18/2026 at 11:51 AM, ADON A stated the staff should close the door or pull the privacy curtain when they were providing care or doing treatment to the residents. She said the staff needed to get used to providing privacy during treatment so that individuals that did not have anything to do with the residents' care would not see the treatment being done. She said it did not matter if the residents minded or not, but the expectation was for the staff should be sensible enough that if they were in the residents' position, they might want their door closed during treatment. During an interview on 02/18/2026 at 11:54 AM, LVN I stated she should have closed the door while she was checking Resident #45's blood sugar and when she administered the resident's insulin. She said the door should be closed to provide privacy during treatment or care. She said the resident might get embarrassed that other people could see what his treatments were. During an interview on 02/18/2026 at 2:26 PM, Resident #45 stated that some nurses would close his door when getting his blood sugar and administer insulin, but others did not. He said not it mattered to him, but it would be nice if they would close the door.During an interview on 02/19/2026 at 6:44 AM, the DON stated the piece of paper with room numbers were not identifiable identification of the residents even though their vital signs were written beside the rooms. She said the scenario was not a HIPAA violation. She said the door should be closed every time the staff provided care or treatment to give privacy and prevent embarrassment and uncomfortable feeling that others could see what the resident was being treated for. She said the expectation was for the staff to close the doors every time they were providing treatment. She would start an in-service about providing privacy during treatment. During an interview on 02/19/2026 at 8:06 AM, the Administrator stated the piece of paper did have the names of the residents but only the room numbers of the residents and their vital signs so it would not constitute HIPAA. He said the staff must make sure that the residents were provided privacy when treatment was being done so they would be comfortable when treatment was provided. He said the expectation was for the staff to provide privacy when providing treatment. He said he would collaborate with the DON to re-educate the staff about the importance of providing privacy. He said the objective of the facility was to provide quality care.Record review of the facility's, undated, Resident Rights policy copyrighted 2025, revealed: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. 7.Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 10 of 20 resident rooms (Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) observed for cleanliness. The facility failed to ensure Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 were thoroughly cleaned and sanitized. This facility failure could place residents at risk of living in an unclean and unsanitary environment, leading to a decreased quality of life.Findings included: During an observation on 02/17/26 at 11:10 a.m., revealed room [ROOM NUMBER]'s the air conditioning unit had black dirt and dust between the vents and the air filter had thick dust. Observation revealed the bathroom floor had thick dark substances near the toilet. During an observation on 02/17/26 at 11:23 a.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The air filter had thick dust. During an observation on 02/17/26 at 11:29 a.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The air filter had thick dust. The shower floor had thick soap scum and rust like stains. During an observation on 02/17/26 at 11:34 a.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The air filter had thick dust. The bathroom floor had a pair of disposable gloves in a corner of the bathroom, near the toilet. During an observation on 02/17/26 at 11:40 a.m., revealed room [ROOM NUMBER]'s air conditioning unit reflected black dirt and dust all over the front of the unit and between the vents. The bedside table had stains all over the lower frame. The shower floor had thick soap scum and rust like stains. During an observation on 02/17/26 at 11:52 a.m., revealed room [ROOM NUMBER]'s bathroom floor had dark substances in the corners of the floor behind the toilet. During an observation on 02/17/26 at 11:59 a.m., room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The shower floor had a thick grayish substance. During an observation on 02/17/26 at 12:26 p.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The air filter had thick dust. The carpeted room floor had a large dark stain near the center of the room. The bedside table had red stains all over the lower frame. During an observation on 02/17/26 at 12:39 p.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The air filter had thick dust. The carpeted room floor had reddish stains along the front of the miniature fridge. During an observation on 02/17/26 at 12:54 p.m., revealed room [ROOM NUMBER]'s carpeted room floor had a large white stain near the center of the room.During an interview on 02/19/26 at 10:49 a.m., Housekeeping E stated he had been at the facility for two years. He stated they were supposed to clean the entire room, including the air condition units. He stated they were to also clean the entire bathroom. He stated he was responsible for cleaning the 700- hall. He was shown pictures of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated the floor tech was supposed to clean the carpets and he had pointed it out to them, but they had not cleaned it. He stated he was responsible for cleaning the areas and if not cleaned properly could result in respiratory problems.During an interview on 02/29/26 at 11:02 a.m., Housekeeping N stated she had been at the facility for nearly 2 years. She stated she sometimes cleaned the 400-hall. She stated they were supposed to clean the entire room. She was shown pictures of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. She stated she did not clean the air filters, but she was responsible for cleaning all the other areas. She stated the rooms not being thoroughly cleaned could have a negative impact on the residents.During an interview on 02/19/26 at 11:16 a.m., Floor Tech J stated he had just started at the facility. He stated he was responsible for cleaning the floors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He stated he walked around to check carpets for any spots he may have observed in the residents' rooms. He was shown photos of Rooms #8 and #10, and he stated he had shampooed the carpet for room [ROOM NUMBER] on 02/18/26. He stated his supervisor had instructed him to clean it. He stated the supervisor normally provided him a list of floors to clean and if a stain was reported to the supervisor, the supervisor would notify him. He stated if he was a resident or family member, he would not like to see those stains.During an interview on 02/19/26 at 11:27 a.m., the Housekeeping Supervisor was shown photos of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated he had been at the facility for 4 years. He stated housekeeping was responsible for cleaning the entire rooms, He stated maintenance was responsible for cleaning the air filters and he was unsure of when and how often they are cleaned. He stated there was a schedule for cleaning the resident rooms. He stated his team was responsible for cleaning the areas mentioned. He stated not cleaning the resident rooms thoroughly could not have pleasing appearance.During an interview on 02/19/26 at 12:04 p.m., the Maintenance Supervisor stated he was responsible for cleaning the air filters in the air-conditioning units. He stated the filters were cleaned quarterly. He stated he was the only one responsible for cleaning the filters and he could not get to them as frequently as he needed. He stated not cleaning the air filters could result in residents getting sick.During an interview on 02/19/26 at 12:57 p.m., the Administrator was informed of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated he expected housekeeping to thoroughly clean the rooms. He stated not cleaning the rooms thoroughly would not be a homelike environment and not cleaning the air conditioning filters could impact residents breathing.Record review of the facility's policy on Safe and Homelike Environment, dated 10/01/2025, revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from any physical or chemical restraints imposed for purposes of discipline or convenience, and that not required to treat the resident's medical symptoms for 1 of 4 residents (Resident #73) reviewed for abuse and neglect. The facility failed to ensure Resident #73 was not sedated with a medication prescribed for a condition or diagnosis not listed in the resident's EHR. This deficient practice could place residents at risk of unnecessary restriction of their freedom of movement (any change in place or position for the body or any part of the body that the person is physically able to control). Findings include: Record Review of Resident #73's admission Record, dated 02/18/2026, revealed a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #73 was noted to have diagnoses which included Restlessness and Agitation, Shortness of Breath, Need for Assistance with Personal Care, Other Lack of Coordination, Muscle Weakness (Generalized), Cerebral Infarction (blocked blood flow to the brain, usually caused by blood clots, leading to tissue death), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side (neurological conditions causing motor impairment on one side of the body due to brain injury), Dysphagia Following Cerebral Infarction (difficulty swallowing), Acute Respiratory Failure (when lungs cannot adequately oxygenate the blood or remove carbon dioxide, often due to rapid fluid buildup in the air sacs), Type 2 Diabetes Mellitus with Diabetic Neuropathy (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, resulting in damage to nerves particularly in the legs and feet), Other Recurrent Depressive Disorders (distinct, repeated depressive episodes that do not fit standard classifications), Memory Deficit Following Unspecified Cerebrovascular Disease, Other Speech and Language Deficits Following Cerebral Infarction, and Acute Embolism and Thrombosis of Unspecified Vein (sudden blockage of a vein by a blood clot that has not been specifically localized). No diagnosis of bipolar was located. Record review of Resident #73's Order Summary, dated 02/18/2026, revealed a pharmacy order for Seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for bipolar. Record review of Resident #73's eMar, dated July 2025, August 2025, September 2025, October 2025, November 2025, December 2025, January 2026, and February 2026 revealed Resident #73 was administered Seroquel nightly with the exceptions of the nights of 12/28/2025, 12/30/2025, and 01/25/2026. Record review of Resident #73's Care Plan, last updated on 11/06/2025, revealed no focus or intervention related to a diagnosis of bipolar disorder or the use of Seroquel. Record review of Resident #73's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 13, which indicated intact cognition. Resident #73 was noted to utilize a wheelchair for mobility. Functional abilities revealed Resident #73 was dependent for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene, Resident #73 was noted to need partial/moderate assistance for oral hygiene, and only needed set up/clean up assistance for eating. Resident #73's mobility was noted as dependent for chair/bed-to-chair transfer and tub/shower transfers while substantial/maximal assistance was needed for roll left and right, sit to lying, and lying to sitting on side of bed. Record review of Resident #73's Miscellaneous Documents, dated 02/18/2026, revealed a Controlled Drug Consent for Hydrocodone (brand names Vicodin, Norco, Lortab; potent, semi-synthetic opioid analgesic and antitussive used to treat moderate to severe pain and cough), dated 12/08/2025, and for Armodafinil (brand name Nuvigil; a prescription stimulant used to improve wakefulness in adults) dated 09/02/2025 and 01/04/2026. Record review of Resident #73's Progress Notes revealed a Nursing Psychoactive Medication Consent, dated 07/04/2025, for Seroquel Oral Tablet 25 MG||1 tablet||by mouth|| at bedtime for specific condition to be treated includes Bipolar Disorder verbally consented to by the resident. The prescriber is listed as Physician E. Interview on 02/19/2026 at 9:39 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM with LVN H revealed the medication Seroquel was prescribed by doctors for individuals who were experiencing anxiety. LVN H stated the medication would need signed consent from the resident or RP and a medical diagnosis related to the prescribed use to be documented in the EHR. Interview on 02/19/2026 at 9:55 AM with LVN I revealed the admitting nurses were responsible for entering medications in a resident's EHR at admission, the unit managers entered medications or medication changes after admission, and diagnosis was entered by the MDS , the nurse adding to the EHR would also ensure a signed consent was obtained from the resident and there was a corresponding diagnosis associated with the use of the medication. Interview on 02/19/2026 at 10:08 AM with ADON A revealed they may be the one who entered the diagnosis and entered medications in the EHR and if a resident were prescribed Seroquel they would ensure consent was obtained as well as ensured the medication use was care planned, and a direct diagnosis that supported the use was listed. ADON A stated the Pharmacy Consultant should review the medication periodically at a regular interview for gradual dose reduction or discontinuation, verify resident had a supporting diagnosis, and made any recommendations required. Interview on 02/19/2026 at 11:10 AM with the DON revealed antipsychotic classified medications required consent from the resident or RP. The DON stated Resident #73 was being followed by psychiatric services for medication management even though there were no records showing in the EHR. The DON stated a Pharmacy Consultant was contracted by the facility to review resident medications to ensure proper consent, diagnosis, and medication reduction regimens were followed. The DON stated for a medication to be prescribed for a specific diagnosis, and the diagnosis not be in the resident's EHR, it could be an improper use of the medication, or a new diagnosis might have missed being entered into the EHR. The DON stated this could cause probable harm to the resident. The DON stated Seroquel prescribed for Bipolar Disorder without a resident having that medical condition and diagnosis could lead to the medication having a sedative effect. The DON stated the provider, Physician E, would be asked why the Seroquel was prescribed for Resident #73 without a corresponding diagnosis. The DON agreed Seroquel could be used to help induce sleep for residents who were more nocturnal and that may create a risk to the residents. The DON attempted to reach the provider with psychiatric services to confirm Resident #73's diagnoses, however was unsuccessful and the call was not returned before the survey exit. Interview on 2/19/2026 at 3:00 PM, with Physician E revealed he provided medical care for Resident #73 for 2 to 2 1/2 years and was familiar with her conditions and diagnoses. Physician E stated the resident was diagnosed with Major Depressive Disorder and he managed the medications for this condition along with other routine medications. Physician E stated Resident #73 did not have a diagnosis of Bipolar Disorder and would be reviewing the diagnoses in the EHR and reconciling medications. Physician E was not able to provide a reason the pharmacy consultant had not reviewed medications for GDR for Resident #73, only providing recommendation for documentation when Voltaren gel was used. Record review of the facility's, undated, Resident Rights policy, copyrighted 2025, revealed: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. 2.Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: d. The right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Record review of the facility's Promoting/Maintaining Resident Dignity policy, dated 10/01/2025, revealed: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 6 of 18 residents (Resident #20, #45, #78, #106, #112 and #113) reviewed for care plan. 1. The facility failed to ensure Resident #20's care plan reflected a plan of care for the resident's use of a weighted spoon when eating his meals. 2. The facility failed to ensure Resident #45 was care planned for diabetes mellitus and hypertension. 3. The facility failed to ensure Resident #78 was care planned for his indwelling catheter. 4. The facility failed to ensure Resident #106 was care planned for her external catheter. 5. The facility failed to ensure Resident #112 was care planned for her g-tube and suprapubic catheter. 6. The facility failed to ensure Resident #113 was care planned for his nephrostomy tube (draining tube). These failures could place the residents at risk of not receiving the necessary care and services.Findings included: 1. Record review of Resident #20's Face Sheet, dated 02/18/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #20 had a diagnosis of dysphagia (difficulty swallowing). Record review of Resident #20's Quarterly MDS Assessment, dated 12/22/25, reflected Resident #20's BIM indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnoses of malnutrition and dysphagia. Record review of Resident #20's Physician orders, dated 02/18/26, Dietary Adaptive- Weighted Utensils -Weighted spoon used with meals effective 01/23/2025. Record review of Resident #20's Comprehensive Care Plan, dated 02/18/26, which was after the facility was informed of the exclusion of an intervention for the use of a Weighted spoon on 02/17/26, reflected, Provide weighted spoon as ordered with all meals. During an interview on 02/18/26 at 12:50 p.m., LVN H stated Resident #20 was on a pureed diet and he required a special utensil to eat. She stated the resident used a weighted spoon to eat. She stated she was not sure if it was care planned. She stated she had not seen the resident's care plan. She stated it should be care planned because it was a part of the resident's care. She stated the Unit Manager ensured the care plans were updated. During an interview on 02/18/26 at 12:55 p.m., ADON B and the DON were informed of Resident #20 not being care planned for needing a weighted spoon to eat his meals. ADON B stated Resident #20 was on a pureed diet and he had orders for the use of a weighted spoon for his meals. She stated it should have been care planned because it was part of his plan of care. She stated it was a collaborative effort to ensure the intervention was care planned. ADON B stated it was usually the ADONs, MDS nurse, and DON's responsibility to ensure it was care planned. ADON B and the DON stated not care planning the intervention could result in missed care. 2. Record review of Resident #45's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar) and hypertension (high blood pressure). Record review of Resident #45's Comprehensive MDS Assessment, dated 01/11/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and hypertension. Record review of Resident #45's Comprehensive Care Plan, dated 01/08/2026, reflected the resident did not have a care plan for diabetes mellitus and hypertension. Record review of Resident #45's Physician Order, dated 01/08/2026, reflected Insulin Glargine Solution 100 UNIT/ML Inject 5 unit subcutaneously one time a day for diabetes. Record review of Resident #45's Physician Order, dated 01/08/2026, reflected Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 100 mg by mouth two times a day for HTN Hold for SBP <110, DBP<60 or HR<60. During an observation on 02/18/2026 at 11:45 AM revealed Resident #45's blood sugar was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checked and his insulin was administered as per his sliding scale. 3. Record review of Resident #78's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with retention of urine (a condition where the blader cannot fully empty during urination). Record review of Resident #78's Comprehensive MDS Assessment, dated 12/22/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter bag). Record review of Resident #78's Comprehensive Care Plan, dated 06/10/2025, reflected the resident did not have a care plan for his indwelling catheter. Record review of Resident #78's Physician's Order, dated 11/12/2024, reflected Urinary Catheter Care: Check for patency, Empty foley bag every shift for F/C Catheter. During an observation and interview on 02/17/2026 at 9:29 AM revealed Resident #78 was in his bed, awake. It was observed that a catheter bag was hanging from the resident's bed. The resident said he had a catheter since year 2024. 4. Record review of Resident #106's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with overactive bladder (a bladder control problem which leads to a sudden urge to urinate). Review of Resident #106's Physician's Order, dated 11/12/2024, reflected Purewick System to be used while overnight and when patient is in bed. every shift for incontinence Insert Purewick at hs and as needed. Review of Resident #106's Quarterly MDS Assessment, dated 12/22/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment did not indicate that the resident was using an external catheter. Review of Resident #106's Comprehensive Care Plan, dated 03/14/2025, reflected the resident did not have a care plan for external catheter. During an observation on 02/18/2026 at 1:09 PM revealed Resident #106 was not inside her room. It was observed that the resident had an external catheter on top of her side table. During an observation and interview on 02/18/2026, LVN L stated Resident #106 had the external catheter for some time. He checked the resident's profile and saw she had an order for the external catheter. When he checked the resident's care plan, he said the resident did not have a care plan for her external catheter. He said there should be care plan. 5. Record review of Resident #112's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with displacement of gastrointestinal implants (devices used in treatment of gastrointestinal disorders to deliver medications or nutrients). Record review of Resident #112's Comprehensive MDS Assessment, dated 02/08/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #112's Physician's Order, dated 02/03/2026, reflected Enteral Feed Order in the evening Jevity 1.5 at 55 ml/hour via feeding tube. Up at 7pm, to run continuously until total volume of 660 ml administered. May remove for care and services. Record review of Resident #112's Physician's Order, dated 02/03/2026, reflected Catheter care every shift. Record review of Resident #112's Comprehensive Care Plan, dated 02/04/2026, reflected the resident did not have a care plan for her g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach) and for suprapubic catheter (device inserted into the stomach to the bladder to drain urine). During an observation and interview on 02/17/2026 at 11:25 AM revealed Resident #112 was in her bed, awake. It was observed that the resident had a catheter bag hanging on the left side of the bed. The resident said she had the catheter since she was admitted to the facility. During an observation and interview on 02/18/2026 at 7:01 AM revealed Resident #112 was in her bed, awake. It was observed that a formula was connected to her g-tube. She said would only have the formula every night until morning. 6. Record review of Resident #113's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with presence of urogenital implants (artificial devices implanted in the kidney to support draining of urine). Record review of Resident #113's Comprehensive MDS (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessment, dated 02/08/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a nephrostomy tube (draining tube). Record review of Resident #113's Comprehensive Care Plan, dated 02/03/2026, reflected the resident did not have a care plan for his nephrostomy tube. Record review of Resident #113's Physician's Order, dated 02/03/2026, reflected Nephrostomy Care every day shift Clean skin around Nephrostomy tube(s) with soap and water, pat dry and apply dressing as ordered. During an observation on 02/17/2026 at 11:15 AM revealed Resident #113 was inside his room. It was observed that the resident had two nephrostomy bags that were placed outside his pants. During an observation and interview on 02/18/2026 at 1:39 PM, the MDS Nurse stated if the resident had diabetes mellitus, hypertension, an indwelling catheter, an external catheter, g-tube, and nephrostomy tubes, then there should be care plan for all the concerns mentioned. She said care plans should be in place so the staff would know the interventions and goals for the residents and would be in sync in terms of the care to be provided. She logged onto her computer and saw that Resident #45 did not have a care plan for diabetes mellitus and hypertension, Resident #78 did not have a care plan for catheter, Resident #106 did not have a care plan for external catheter, Resident #112 did not have a care plan for g-tube and catheter, and Resident #113 did not have a care plan for his nephrostomy tubes. She said it was an oversight on her part and she would start putting in care plans for the concerns mentioned. She said if the residents did not have a care plan, there could be confusion in their care or care would be not provided at all. She said the nurses could also add a care plan so the residents would receive the appropriate care while they were in the facility. During an interview on 02/19/2026 at 6:10 AM, ADON A stated care plans were important so the staff would be in sync with the care of the residents. She said without the care plan, needed interventions might not be provided. She said she would also make some of the care plans of the new admissions. She said she might have missed doing a care plan for some of the residents. She said the expectation was all the issues of the residents were care planned so that appropriate interventions would be implemented. During an interview on 02/19/2026 at 6:44 AM, the DON stated that every resident needed a care plan to make sure the residents received the applicable and appropriate care needed. She said the care plan should be in place so that the staff providing care would be on the same page. She said the care plan was important because it would tell the staff the care needed by the residents. She said she would coordinate with the MDS Nurse to audit the care plans of the residents. During an interview on 02/19/2026 at 8:06 AM, the Administrator stated that all the residents should have a care plan appropriate to their needs. He said without the care plan, the staff would not know the goals and the interventions needed by the residents. He said the expectation was for all the residents were care planned appropriately. She said she would coordinate with the DON and the MDS Nurse to make sure all the residents were care planned. Record review of the facility's policy, Comprehensive Care Plans P & P Committee revised October 01, 2025 reflected Policy: 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 and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . Policy Explanation and Compliance Guidelines . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team for four (Residents #78, #84, #104, and #106) of twelve residents reviewed for care plans revision. The facility failed to ensure the care plan for Residents #78, #84, #104, and #106 were reviewed and revised after each comprehensive and quarterly assessment.This failure could place the residents at risk of care and needs not being met. Findings included:Resident #78Record review of Resident #78's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #78's Comprehensive MDS Assessment reflected the last MDS was done on 12/22/2025.Record review of Resident #78's Comprehensive Care Plan reflected the last care plan completed for the resident was on 06/10/2025.Resident #84Record review of Resident #84's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #84's Comprehensive MDS Assessment reflected the last MDS was done on 02/02/2026.Record review of Resident #84's Comprehensive Care Plan reflected the last care plan completed for the resident was 03/11/2025.Resident #104Record review of Resident #104's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review on of Resident #104's Comprehensive MDS Assessment reflected the last MDS was done on 01/18/2026.Record review of Resident #104's Comprehensive Care Plan reflected the last care plan completed for the resident was 05/03/2025.Resident #106Record review of Resident #106's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #106's Comprehensive MDS Assessment reflected the last MDS was done on 12/22/2025.Record review of Resident #104's Comprehensive Care Plan reflected the last care plan completed for the resident was 03/14/2025.During an observation and interview on 02/18/2026 at 1:39 PM, the MDS Nurse stated she was responsible in making and updating the care plans of the residents. She said the care plan should be updated quarterly or if the resident had a change in condition, had a fall, or had an infection. She logged onto her computer and checked the residents in question and saw that the residents' care plans were not updated. She said the said the residents had their quarterly assessments and the quarterly care plans should have followed. She said she would check also the care plans of the other residents.During an interview on 02/19/2026 at 6:10 AM, ADON A stated care plans were done during admission and were being updated quarterly. She said the care plans were also updated if there was a change in condition, new wound, or the resident had a fall. She said care plans should be updated so the staff would know if there were new interventions that needed to be done and to monitor the resident's response to the new interventions. She said if the care plans were not updated, it could mess up the monitoring side of the interventions.During an interview on 02/19/2026 at 6:44 AM, the DON stated every resident needed a thorough care plan to ensure the residents received the care they needed. She said the care plans should be updated because the care of the resident's changes. She said the care plan should be done quarterly or if there was change in condition. She said the expectation was for the care plans of the residents would be updated. She said she would coordinate with MDS Nurses to audit the care plans of the residents.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated that care plans were supposed to be updated quarterly to make sure that the care being given was still appropriate. He said the expectation was for all the residents to be care planned and that the care plans were updated quarterly and when needed. He said she would coordinate with the DON and the MDS Nurses to make sure the care plans were current.Record review of the facility's policy, Comprehensive Care Plans P & P Committee revised October 01, 2025, reflected Policy: It is the policy of this facility to develop and implement a comprehensive (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	person-centered care plan for each resident . Policy Explanation and Compliance Guidelines . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0693 Level of Harm - Minimal harm or potential for 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 observation, interview and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for three of four residents (Residents #1, #42, and #112) reviewed for feeding tube management.1. The facility failed to ensure Resident #1 had an order to check the placement for the resident's g-tube on 02/18/2026.2. The facility failed to ensure Resident #112 had an order to check the placement of the g-tube and to check the residual on 02/18/2026.3. The facility failed to ensure Resident #42 had an order to check the residual on 02/18/2026.These failures could place residents at risk for proper procedure being done that could result to clogging of the g-tube. Findings include:1. Record review of Resident #1's face sheet, dated 02/19/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing).Record review of Resident #1's Comprehensive MDS Assessment, dated 01/25/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube.Record review of Resident #1's Quarterly Care Plan, dated 01/08/2025, reflected the resident required tube feeding and one of the interventions was to check for g-tube placement and gastric contents (refers to what was inside the stomach).Record review of Resident #1's Physician Order, dated 02/13/2026, reflected Enteral Feed Order every shift Nutren 1.5 at 70 ml/hour via feeding tube. Down at 0700 [7:00 AM] and up at 1700 [5:00 PM], to run continuously x 14 hrs for a total volume of 980 mL is administered. May remove for care and services.Record review on 02/18/2026 of Resident #1's Physician Order reflected the resident did not have an order for checking the placement of the g-tube.2. Record review of Resident #112's face sheet, dated 02/17/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with displacement of gastrointestinal implants.Record review of Resident #112's Comprehensive MDS Assessment, dated 02/08/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube.Record review of Resident #112's Comprehensive Care Plan, dated 02/04/2026, reflected the resident did not have a care plan for her g-tube. Record review of Resident #112's Physician Order, dated 02/03/2026, reflected Enteral (delivery of food through feeding tube) Feed Order in the evening Jevity 1.5 at 55 ml/hour via feeding tube. Up at 7pm, to run continuously until total volume of 660 ml administered. May remove for care and services.Record review on 02/18/2026 of Resident #112's Physician Order reflected the resident did not have an order for checking the residual and placement.During an observation and interview on 02/18/2026 at 7:01 AM revealed Resident #112 was in her bed, awake. It was observed that a formula was connected to her g-tube. She said she would only have the formula every night until morning.3. Record review of Resident #42's face sheet, dated 02/18/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support).Record review of Resident #42's Comprehensive MDS Assessment, dated 12/08/2025, reflected the resident had severe impairment in cognition with a BIMS score of 02. The Comprehensive MDS Assessment indicated the resident had a feeding tube.Record review of Resident #42's Comprehensive Care Plan, dated 12/23/2025, reflected the resident required tube feeding and one of the interventions was to check for placement and gastric content.Record review of Resident #42's Physician Order, dated 12/04/2025, reflected Gabapentin Capsule 100 MG Give 2 ml via G-Tube three times a day for neuropathy (damaged nerves).Record review of Resident #42's Physician Order, dated 12/04/2025, reflected G-Tube- Flush (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before and After Med Administration Flush GT with 30cc water before and after medication administration.Record review on 02/18/2026 of Resident #42's Physician Order reflected the resident did not have an order for checking the residual.During an observation on 02/18/2026 at 2:12 PM revealed LVN I was about to give Resident #42's medication via g-tube. She sanitized her hands and put the liquid medication in a small plastic cup. She also prepared two small cups with 30 cc of water in both of them. She then went inside the resident's room, placed the small cups of medication and water on the resident's overbed table. She put on a gown and proceeded to administer the medication. She took a 60 ml piston syringe from a plastic bag hanging on an IV pole, turned off the machine, and disconnected the g-tube from the formula. After disconnecting the g-tube, she attached the syringe on the g-tube and pulled the plunger to check for residual. After checking the residual, she pulled the plunger and flushed the g-tube with 30 cc of water. After flushing the g-tube, she poured the liquid medication and flushed again with 30 cc. During an interview on 02/18/2026 at 2:50 PM, LVN I stated she did check for the residual but there should be an order for checking the residual so staff administering Resident #112's medications would not miss it.During an observation and interview on 02/18/2026 at 2:54 PM, RN C stated residual should be checked prior to flushing and administering medications to check if the resident's stomach had no problem with absorption and digestion. She said checking the residual was also to prevent aspiration. When asked if the resident had an order for checking for the residual, RN C logged on to her computer and checked for Resident #112's order for residual. She said there was no order to check the residual. She said, as a nurse, she knew she was supposed to check the residual but there should be an order for it. She said this should have been caught earlier by whoever was administering the resident's medications, so an order was put in place. She said she was partly at fault because she did not check if the resident had appropriate orders like checking for residuals and placements. She said, new nurses might not be familiar with how to administer medications via g-tube and end up not checking for residuals. She said there should be an order for everything done for the resident to ensure continuity of care.During an interview on 02/19/2026 at 6:10 AM, ADON A stated there should be orders for everything done for the residents. She said even though the nurses knew what to do, there should be an order in the resident's profile to check for the residual. She said it was an oversight for those administering the resident's medication. She said it was also an oversight on her part because she was supposed to check the orders as well. She said the expectation was for the staff to check if appropriate orders were in place. She said she would audit the orders of the residents with g-tube to check if orders were in place.During an interview on 02/19/2026 at 6:44 AM, the DON stated residuals were checked to prevent aspiration. She said if the stomach of the resident was still full, then feeding should be held because it meant the resident's stomach was not digesting well. She said even though the staff did the right procedure and knew the residual should be checked, there should still be an order for checking the residual. She said the expectation was for the nurses to check if appropriate orders for g-tube medication administration were in place. She said she would re-educate the staff about physician orders needed for g-tubes. During an interview on 02/19/2026 at 8:06 AM, the Administrator stated there were appropriate orders for the g-tube. He said he was not a clinician and would let the DON take a lead on the issue about g-tube.Record review of the facility's policy Medication Administration via Enteral Tube P & P Committee revised November 01, 2025, reflected, Policy: It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines . Policy Explanation and Compliance Guidelines . 7. A physician's order is required . 11. Procedure: a. Verify physician orders.Record review of the facility's policy, PHYSICIAN'S ORDERS Continuing Care network revised January 2020 reflected POLICY: It is the policy of this Facility that physician orders are maintained . PROCEDURE: 1. All physicians' orders shall be recorded on the Patients Medical Record . 3. Physician orders include . Special medical procedures required for the safety and well-being of the Patient.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review the facility failed to assess the resident for the risk of entrapment from bed rails prior to installation and review the risks and benefits of bed rails prior to installation for 5 of 8 residents (Resident #1, Resident #5, Resident #42, Resident #73, Resident #87) reviewed for grab/assist bars. 1. The facility failed to have evidence of informed consent for Resident #1, Resident #5, Resident #42, Resident #73, and Resident #87 for grab/enabler bars to be placed on the bed. 2. The facility failed to have evidence of assessment for Resident #5, Resident #73, and Resident #87, for risk of entrapment and ability to safely use the grab/enabler bars. These failures could place residents at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, and assessments not being completed for appropriateness. Findings include: 1. Record review of Resident #1's admission Record, dated 02/18/2026, revealed an [AGE] year-old male who originally admitted to the facility on [DATE]. Resident #1 was noted to have diagnoses which included Atherosclerotic Heart Disease of Native Coronary Artery (condition where plaque [fat, cholesterol] builds up inside the original, non-bypassed arteries supplying the heart), Nonrheumatic Mitral (Valve) Stenosis (progressive condition where the mitral valve narrows due to causes other than rheumatic fever), Chronic Obstructive Pulmonary Disease (lung disease characterized by long-term, persistent airflow obstruction, causing severe breathing difficulties, chronic cough, and mucus productivity), Need for Assistance with Personal Care, Unspecified Abnormalities of Gait and Mobility, Muscle Weakness (Generalized), Gastrostomy Status (presence of a surgically created opening [stoma] in the stomach, usually with a feeding tube inserted for long-term nutritional support or gastric decompress), Tracheostomy Status (presence of artificial, surgically created opening [stoma] in the trachea to facilitate breathing, typically required for long term ventilation, airway obstruction, or airway protection), Malignant Neoplasm of Hypopharynx (aggressive, rare head and neck malignancy [cancer] forming in the lower throat), Acute Respiratory Failure with Hypoxia (life threatening, sudden inability of the respiratory system to oxygenate blood), Sepsis due to Methicillin Resistant Staphylococcus Aureus (rapidly progressing condition where antibiotic-resistant bacteria enters the bloodstream, triggering an extreme, damaging immune response), and Pneumonia due to Pseudomonas (severe infection of the lungs, often hospital acquired, causing inflammation of the air sacs). Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMS score of 13, which indicated intact cognition. Resident #1 was noted to utilize a wheelchair for mobility. Resident #1 was dependent for all functional self-care abilities and noted to require partial/moderate assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Record review of Resident #1's Care Plan, last updated on 01/20/2026, revealed no focus or intervention related to grab bars or bed rails or any alternatives previously attempted. Record review of Resident #1's Miscellaneous Documents, dated 02/18/2026, revealed no consent for grab bars or bed rails signed by the resident or RP. Record review of Resident #1's Assist Rail/Enabler Device Assessment, dated 01/20/2026, revealed bilateral quarter bed rails were recommended. Observation of Resident #1's bed on 02/17/2026 at 12:50PM revealed the resident asleep and bilateral grab/enabler bars raised on the bed. 2. Record review of Resident #5's admission Record, dated 02/18/2026, revealed a [AGE] year-old female who originally admitted to the facility on [DATE] with most recent admission on [DATE]. Resident #5 was noted to have diagnoses which included Cerebral Infarction (stroke; blocked blood flow to the brain leading to tissue death), Type 2 Diabetes Mellitus with Diabetic Neuropathy (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resulting in damage to nerves particularly in the legs and feet), Dysphagia Following Cerebral Infarction (when stroke-related brain damage disrupts nerve control of swallowing muscles), Muscle Weakness (Generalized), Dementia in Other Diseases Classified Elsewhere, Severe, with Psychotic Disturbance (syndrome characterized by loss of cognitive function (memory, language, and problem solving) severe enough to interfere with daily life accompanied by hallucinations and/or delusions), Schizoaffective Disorder, Depressive Type (chronic mental health condition combining schizophrenia symptoms [hallucinations, delusions] with a mood disorder [depression]), Major Depressive Disorder (persistent intense sadness or loss of interest), Polyneuropathy (condition caused by damage to multiple peripheral nerves, often leading to symmetric numbness, burning pain, and weakness, typically starting in the hands and feet), Encephalopathy (disease or disfunction of the brain that alters its structure or function, often resulting in an altered mental status), Unspecified Systolic (Congestive) Heart Failure (when the left ventricle weakens and cannot contract effectively, reducing the body's blood supply), Dysphagia (difficulty swallowing), Need for Assistance with Personal Care, Acquired Absence of Left Leg Below Knee, Gastrostomy Status (presence of a surgically created opening [stoma] in the stomach, usually with a feeding tube inserted for long-term nutritional support or gastric decompress), Non-St Elevation (Nstemi) Myocardial Infarction (heart attack occurring when a coronary artery is only partially blocked, restricting blood flow and causing damage to the heart muscle). Record review of Resident #5's Quarterly MDS, dated [DATE], revealed a BIMS score of 12, which indicated moderate impairment. Resident #5 was noted to have functional abilities requiring partial/moderate assistance of upper body dressing and requiring substantial/maximal assistance of oral hygiene, lower body dressing, putting on/taking off footwear, and personal hygiene. Functional abilities Resident #5 was dependent for toileting hygiene, shower/bathing, and eating. Resident #5 required substantial/maximal assistance with roll left and right, and was dependent for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and tub/shower transfer. Record review of Resident #5's Care Plan, last updated on 01/06/2026, revealed focus of Assist Rail(s) - Quarter Rail(s) required as enabler in order to promote as much independence as possible and interventions of Complete Assist Rail/ Enabler Device assessment to determine appropriate use. Obtain Consent Assess PRN with Change of Condition. Patient uses quarter assist rails(s) as enabler to assist with bed mobility and transfer: Assist Rails x 2 Bilateral. Record review of Resident #5's Miscellaneous Documents, dated 02/18/2026, revealed no consent for grab bars or bed rails signed by the resident or RP. Record review of Resident #5's Assessment list, dated 02/18/2026, revealed no assessment for resident appropriateness or ability to use grab bars/bed rails safely. Observation of Resident #5's bed on 02/17/2026 at 11:25 AM revealed the resident asleep and bilateral grab/enabler bars raised on the bed. 3. Record review of Resident #42's admission Record, dated 02/18/2026, revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #42 was noted to have diagnoses which included Metabolic Encephalopathy (reversable, non-structural brain dysfunction caused by systemic metabolic issues, such as organ failure, diabetes, or infections), Dysphagia, Oropharyngeal Phase (difficulty initiating a swallow or transferring food from the mouth to the esophagus), Muscle Weakness (Generalized), Other Lack of Coordination, Need for Assistance with Personal Care, Atherosclerotic Heart Disease Of Native Coronary Artery (condition where plaque [fat, cholesterol] builds up inside the original, non-bypassed arteries supplying the heart), and Presence of Aortocoronary Bypass Graft (when healthy vein or artery is used to bypass blocked heart vessels to restore blood flow). Record review of Resident #42's admission MDS, dated [DATE], revealed a BIMS score of 2, which indicated severe cognitive impairment. Resident #42 was noted to have functional abilities requiring partial/moderate assistance with oral hygiene and upper body dressing, and requiring substantial/maximal assistance with toilet hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #42 was noted to need substantial/maximal assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. Record review of Resident #42's Care Plan, last updated on (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/15/2026, revealed no focus area or intervention related to the use of grab bars/bed rails. The intervention of The resident has an ADL self-care performance deficit r/t Encephalopathy and intervention of Bed Mobility: The resident is totally dependent on staff for repositioning and turning in bed. Record review of Resident #42's Miscellaneous Documents, dated 02/18/2026, revealed no consent for grab bars or bed rails signed by the resident or RP. Record review of Resident #42's Assist Rail/Enabler Device Assessment, dated 12/04/2025, revealed bilateral quarter bed rails were recommended. Observation of Resident #42's bed on 02/17/2026 at 12:55PM revealed the resident asleep and bilateral grab/enabler bars raised on the bed. 4. Record review of Resident #73's admission Record, dated 02/18/2026, revealed a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #73 was noted to have diagnoses which included Restlessness and Agitation, Shortness of Breath, Need for Assistance with Personal Care, Other Lack of Coordination, Muscle Weakness (Generalized), Cerebral Infarction (blocked blood flow to the brain, usually caused by blood clots, leading to tissue death), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side (neurological conditions causing motor impairment on one side of the body due to brain injury), Dysphagia Following Cerebral Infarction (difficulty swallowing), Acute Respiratory Failure (when lungs cannot adequately oxygenate the blood or remove carbon dioxide, often due to rapid fluid buildup in the air sacs), Type 2 Diabetes Mellitus with Diabetic Neuropathy (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, resulting in damage to nerves particularly in the legs and feet), Other Recurrent Depressive Disorders (distinct, repeated depressive episodes that do not fit standard classifications), Memory Deficit Following Unspecified Cerebrovascular Disease, Other Speech and Language Deficits Following Cerebral Infarction, and Acute Embolism and Thrombosis of Unspecified Vein (sudden blockage of a vein by a blood clot that has not been specifically localized). Record review of Resident #73's Care Plan, last updated on 11/06/2025, revealed no focus or intervention related to grab bars or bed rails or any alternatives previously attempted. Record review of Resident #73's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 13, which indicated intact cognition. Resident #73 was noted to utilize a wheelchair for mobility. Functional abilities revealed Resident #73 was dependent for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. Resident #73 was noted to need partial/moderate assistance for oral hygiene and only needed set up/clean up assistance for eating. Resident #73's mobility was noted as dependent for chair/bed-to-chair transfer and tub/shower transfers while substantial/maximal assistance was needed for roll left and right, sit to lying, and lying to sitting on side of bed. Record review of Resident #73's Miscellaneous Documents, dated 02/18/2026, revealed no consent for grab bars or bed rails signed by the resident or RP. Record review of Resident #73's Assessment list, dated 02/18/2026, revealed no assessment for resident appropriateness or ability to use grab bars/bed rails safely. Observation of Resident #73's bed on 02/17/2026 at 11:30 AM revealed the resident asleep and bilateral grab/enabler bars raised on the bed. 5. Record review of Resident #87's admission Record, dated 02/18/2026, revealed an [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #87 was noted to have diagnoses which included Diffuse Traumatic Brain Injury with Loss of Consciousness (microscopic, widespread damage throughout the brain's white matter from rapid brain acceleration/deceleration, causing widespread tearing of nerve fibers resulting in immediate coma or profound loss of consciousness), Acute Respiratory Failure with Hypoxia (where the lungs cannot adequately transfer oxygen to the blood and manifests as severe shortness of breath, confusion, and cyanosis), Unspecified Dementia (when symptoms of cognitive decline, such as severe memory loss, impaired thinking, and reduced social abilities, are present, but the underlying cause is unknown), Nontraumatic Intracerebral Hemorrhage, Intraventricular (severe form of bleeding directly into the brain's ventricles, usually occurring as an extension of an underlying spontaneous intracerebral hemorrhage or vascular rupture), Chronic Obstructive Pulmonary Disease (lung disease (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	characterized by long-term, persistent airflow obstruction, causing severe breathing difficulties, chronic cough, and mucus productivity), Dysphagia, Oropharyngeal Phase (difficulty initiating a swallow or transferring food from the mouth to the esophagus), Type 2 Diabetes Mellitus without Complications (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly), and Major Depressive Disorder (persistent, intense sadness or loss of interest). Record review of Resident #87's Quarterly MDS, dated [DATE], revealed a BIMS could not be completed as the resident was rarely/never understood. Staff Assessment for Mental Status revealed a score of 3, which indicated Resident #87 was severely impaired, never/rarely making decisions. Resident #87's assessment of functional abilities indicated the resident was dependent for all self-care and mobility. Record review of Resident #87's Care Plan, last updated on 11/26/2025, revealed a focus area of Assist Rail(s) - Quarter Rail(s) required as enabler in order to promote as much independence as possible and Interventions of Complete Assist Rail/ Enabler Device assessment to determine appropriate use. Obtain Consent Assess PRN with Change of Condition. Patient uses quarter assist rails(s)as enabler to assist with bed mobility and transfer: Assist Rails x 2 Bilateral. Record review of Resident #87's Miscellaneous Documents, dated 02/18/2026, revealed no consent for grab bars or bed rails signed by the resident or RP. Record review of Resident #87's Assessment list, dated 02/18/2026, revealed no assessment for resident appropriateness or ability to use grab bars/bed rails safely. Observation of Resident #87's bed on 02/17/2026 at 11:45 AM revealed the resident asleep and bilateral grab/enabler bars raised on the bed. Interview on 02/19/2026 at 9:39 AM with LVN H revealed most or all resident beds in the facility had grab/enabler bars or bed rails. LVN H stated they were not sure of anything needed for the grab bars/bed rails to be on the beds as the grab bars/bed rails were there for resident safety and to have something to grab on to during personal care. LVN H stated residents should have an assessment for safety with using the grab bars/bed rails. Interview on 02/19/2026 at 9:55 AM with LVN I revealed all beds in the facility had some type of grab or assist bar/rail. LVN I stated an assessment and consent should be documented in the EHR to confirm resident ability to use the grab bar/bed rail safely. LVN I stated the assessments and consents were in the resident's nurses progress notes, in the resident's care plan, and also on the MDS. Interview on 02/19/2026 at 10:08 AM with ADON A revealed all beds in the facility had some kind of grab bar/bed rail and resident/RP consent was gained on admission, the resident was assessed quarterly and also asked if they still wanted the grab bars/bed rails. ADON A stated assessments were completed by nursing staff; the admitting nurse was to obtain all consents from residents/RP such as psychotropic medications, grab bars/bed rail, etc. ADON A stated consents were usually verbal and documentation was under the corresponding assessment. Interview on 02/19/2026 at 11;10 AM with the DON revealed for grab bars/bed rails to be on a resident bed an assessment was needed. The DON also agreed the grab bars/bed rails were also Care Planned and consent should be documented. The DON stated the risks to a resident from grab bars/bed rails could be an injury and they could be a safety concern. Record review of the facility's undated Resident Rights policy, copyrighted 2025, revealed: The right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

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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 drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and 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 nine of eighteen residents (Resident #27, #29, #69, #78, #82, #84, #90, #112, and #114) reviewed for labelling of drugs and biologicals.The facility failed to ensure Resident #27's zinc oxide was not left on top of the resident's drawer on 02/17/2026.The facility failed to ensure Resident #29's zinc oxide was not left on top of the resident's side table on 02/17/2026.The facility failed to ensure Resident #69's zinc oxide was not left on top of the resident's side table on 02/17/2026.The facility failed to ensure Resident #78's cough syrup was not left on top of the resident's side table on 02/17/2026.The facility failed to ensure Resident #84's eye drops was not left on top of the resident's side table on 02/17/2026.The facility failed to ensure Resident #114's eyedrops was not left on top of the resident's side table on 02/17/2026.The facility failed to ensure Resident #84's epi-pen was not stored inside the refrigerator on 02/18/2026.The facility failed to ensure a change of instruction label was placed on Resident #90's tramadol after a change to the order on 02/18/2026.The facility failed to ensure Resident #112's zinc oxide was not left on top of the resident's side table on 02/17/2026.The facility failed to ensure Resident #82 did not have a bottle of pain medication on his nightstand. These failures could place residents at risk of wrong medication administration, not getting the getting the full benefit of the medication, accidental overdose, misuse of medications, and possible adverse reactions.Record review of Resident #27's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness). Record review of Resident #27's Quarterly MDS Assessment, dated 02/03/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated the resident was incontinent for bowel.Record review of Resident #27's Comprehensive Care Plan, dated 02/08/2026, reflected the resident had urinary tract infection and one of the interventions was to check at least every 2 hours for incontinence. Record review on 02/17/2026 for Resident #27's Assessment Notes reflected the resident did not have an assessment for self-administration of medications.During an observation and interview on 02/17/026 at 9:08 AM revealed Resident #27 was in his bed, awake. There was a tube of zinc oxide (a form of barrier cream used to treat skin irritations, diaper rash, and other skin conditions) observed on top of the resident's side table. He said the staff would use it every time they changed his brief.During an interview on 02/17/2026 at 9:11 AM, LVN D stated the barrier cream should not be within reach of the resident to prevent misuse of the medication. She said confused residents might consume the cream or put them in their eyes resulting in irritation.Record review of Resident #29's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with retention of urine (inability to empty the bladder). Record review of Resident #29's Quarterly MDS Assessment, dated 12/18/2025, reflected the resident had severe impairment with a BIMS score of 02. The Quarterly MDS Assessment indicated the resident was incontinent (unable to control) for bladder and bowel.Record review of Resident #29's Comprehensive Care Plan, dated 02/08/2026, reflected the resident was on pressure ulcer prevention and one of the interventions was to monitor for skin breakdowns.Record review on 02/17/2026 for Resident #29's Assessment Notes reflected the resident did not have an assessment for self-administration of (continued on next page)

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	676256	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications.During an observation on 02/17/2026 at 9:27 AM revealed Resident #29 was not inside her room. A tube of skin barrier was observed on top of the residents side table and a box of single vial eye drops was on top of the resident overbed table.Record review of Resident #69's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dysuria (painful urination). Record review of Resident #69's Quarterly MDS Assessment, dated 01/30/2026, reflected the resident had moderate impairment with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident was incontinent for bowel and bladder.Record review of Resident #69's Comprehensive Care Plan, dated 12/11/2025, reflected the resident had a urinary tract infection and one of the interventions was to evaluate for urinary incontinence.Record review on 02/17/2026 for Resident #69's Assessment Notes reflected the resident did not have an assessment for self-administration of medications.During an observation and interview on 02/17/2026 at 9:26 AM revealed Resident #69 was in her bed, awake Two tubes of barrier creams were observed on the resident's side table. The resident said the staff used the creams so she would not have rashes from the brief.Record review of Resident #78's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with Parkinson's disease (movement disorder). Record review of Resident #78's Quarterly MDS Assessment, dated 12/22/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident was incontinent for bladder and bowel.Record review of Resident #78's Comprehensive Care Plan, dated 06/10/2025, reflected the resident did not have a care plan for self-medication.Record review of Resident #78's Physician Order, dated 02/07/2026, reflected Tussin DM Oral Liquid 20-200 MG/10ML (Dextromethorphan-Guaifenesin) Give 10 ml by mouth three times a day for Cough for 14 Days.Record review of Resident #78's Clinical Assessment reflected the resident's assessment for self-administration was only created on 02/17/2026.During an observation and interview on 02/17/2026 at 9:29 AM revealed Resident #78 was in his bed awake. A bottle of cough syrup was observed on top of the resident's side table. At the side of the bottle of cough syrup was a small cup. The resident said he was taking a cough syrup for days. He said he was the one administering the cough medication. He said the staff knew he was the one giving it to himself and said it was the family member who brought the medication. Record review of Resident #82's Face Sheet, dated 02/18/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #82 had a diagnosis of depression and kidney failure. Record review of Resident #82's MDS Assessment, dated 02/06/26, reflected the resident's BIMS indicated an intact cognitive response. The MDS Assessment reflected the resident had active diagnoses of depression. The MDS did not indicate the resident's need for pain management. Record review of Resident #82's Physician's orders, dated 02/18/26, reflected Tylenol Oral tablet 325 MG. Give 2 tablet every 6 hours as needed for pain.During an observation on 02/17/2026 at 9:14 a.m., revealed a full bottle of Tylenol sitting on top of Resident #82's nightstand.During an interview and observation on 02/17/2026 at 9:16 a.m., LVN H was shown the bottle of Tylenol sitting on top of Resident #82's nightstand. She stated the resident's family must have brought the medication in for the resident. She stated the resident should not have the medication because he could take too much and overdose. She stated staff should check for this when observing the residents and their environments. During an interview on 02/18/2026 at 9:16 a.m., ADON B was informed of the bottle of Tylenol sitting on top of Resident #82's nightstand. She stated residents were not allowed to have that type of medication at their bed side because the resident may self-medicate, take too much, and overdose. She stated staff should observe resident's room for any medication they were not to have access to. During an interview on 02/19/26 at 1:25 p.m., the DON was informed of the bottle of Tylenol sitting on top of Resident #82's nightstand. She stated the resident should not have the medication in his room because he could take the medication in combination with other pain medication given to him by staff an overdose. Record review of Resident #84's Face Sheet, dated 02/17/2026, reflected a [AGE] year-old male who was admitted to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #84's Quarterly MDS Assessment, dated 02/02/2026, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Quarterly MDS Assessment indicated the resident had dementia.Record review of Resident #84's Comprehensive Care Plan, dated 03/11/2025, reflected the resident had impaired cognitive functions due to dementia and one of the interventions was to administer medications as ordered. Record review on 02/17/2026 of Resident #84's Physician Order reflected the resident did not have an order for eye drops.Record review on 02/17/2026 of Resident #84's Clinical Assessment reflected the resident did not have an assessment for self-medication.During an observation on 02/17/2026 at 10:55 AM reflected Resident #84 was not inside his room. A bottle of eyes drops was observed on top of his overbed table.During an observation and interview on 02/17/2026 at 10:59 AM, LVN E stated if the resident were administering their own medications, then there should be an assessment that it was safe for the resident to take his medication by himself. He said if there was no assessment, then there should be no eyedrops inside their rooms because the resident might use the eye drops more than what was recommended. He said he did not notice the medications inside the residents' room when he did his rounds. He said Resident #78 was in his right mind and could take his cough medication. When asked if the resident had a diagnosis of dementia, LVN E did not answer. He also said that skin barriers should not be inside the rooms of the residents or were not within the reach of the residents because some residents might be confused and misuse the barrier creams. He said, most probably, the CNAs were the ones leaving the skin barriers because they were the ones using the cream.Record review of Resident #90's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with liver cell carcinoma (cancer cells).Record review of Resident #90's Comprehensive MDS Assessment, dated 02/10/2026, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had liver cell carcinoma and received pain medication.Record review of Resident #90's Comprehensive Care Plan, dated 02/06/2025, reflected the resident was on pain medication and one of the interventions was to monitor adverse reactions to analgesic (medication used for pain management) therapy.Record review of Resident #90's Physician's Order, dated 02/05/2026, reflected Tramadol HCl Tablet 50 MG *Controlled Drug* take 1 tablet by mouth every six hours as needed for pain.Record review of Resident #90's Physician's Order, dated 02/11/2026, reflected Tramadol HCl Tablet 50 MG *Controlled Drug* Give 1 tablet by mouth every 8 hours for moderate to severe pain.During an observation on 02/18/2026 at 7:36 AM revealed LVN H was preparing Resident #90's medication. one of the medications being prepared was tramadol. When inspected, the order in the eMAR was to give every eight hours while the resident's blister pack for tramadol indicated to give every six hours as needed. ADON B was beside LVN H while she was preparing the resident's medication. She told LVN H there should be a sticker on the blister pack saying there was a change in order so the staff would be alerted that there was a change in physician orders.In an interview on 02/18/2026 at 7:39 AM, ADON B stated she told LVN H to put a sticker saying there was a change in the order on the resident's blister pack for tramadol. She said if there was a change in order and the staff would still use the old blister pack because it was the same milligrams, then a sticker which indicated a change in order should be placed on the blister pack to avoid confusion in administering the medication. She said it was the proper thing to do. She said she missed putting the sticker.Record review of Resident #112's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #112's Quarterly MDS Assessment, dated 02/08/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated the resident was incontinent for bladder and bowel.Record review of Resident #112's Comprehensive Care Plan, dated 02/04/2026, reflected the resident was on pressure ulcer prevention and one of the interventions was to apply barrier cream. During an observation and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 02/17/2026 at 11:37 AM revealed Resident #112 was in her bed, awake. A tube of skin barrier was observed on top of the resident's side table. The resident said the staff used the cream when they changed her brief.During an observation and interview on 02/17/2026 at 11:39 AM, CNA F stated the barrier cream should be stored on the resident's shelf away from the residents when not in use. She said the resident might mistakenly use it as a toothpaste or use it as a moisturizer. She said there would be confused residents in the facility that might consume the barrier cream. She took the tube of barrier cream and placed it on the resident's shelf, that was high enough, where the residents could not reach it.Record review of Resident #84's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with kidney disease. Record review of Resident #84's Comprehensive MDS Assessment, dated 02/02/2025, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Quarterly MDS Assessment indicated the resident had kidney disease.Record review of Resident #84's Comprehensive Care Plan, dated 03/11/2025, reflected the resident did not have a care plan for anaphylaxis (severe allergic reaction).Record review on 02/18/2026 of Resident #84's Physician Order reflected no order for epinephrine injection (medication used to treat severe allergic reactions).During an observation and interview on 02/18/2026 at revealed Resident #84's EpiPen was inside the refrigerator. The instruction on the epinephrine box said do not refrigerate. ADON A stated if the instruction said do not refrigerate, then the EpiPen should be inside the cart and not inside the fridge because it might affect the effectiveness of the medication. She took the medication and said she would put it inside the cart. She said she would also check if the resident had an order for the epinephrine. She also said she did not know how long the medication was inside the refrigerator. She said orders were necessary to make sure that the resident needed the EpiPen.During an interview on 02/19/2026 at 6:44 AM, the DON stated medication should not be inside the rooms of the residents because it could cause probable harm such as overmedication, undermedication, or allergic reactions. She said the residents should have an assessment for self-medication to determine if they were able and if it was safe for the residents to administer their own medications. She said the same rationale applied to the zinc oxides. She said confused residents might use the creams inappropriately. She said if the instruction for the epinephrine was not to refrigerate, then the medication should not be inside the refrigerator because it might alter the potency of the medication. She said she would start an in-service about medication storage.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated he was not a clinician and would let the DON take the lead about the issues discussed. Record review of the facility's, undated, policy Medication Storage reflected Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms . and sufficient to ensure proper . temperature . Policy Explanation and Compliance Guidelines . 1. General Guidelines . a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) . b. Only authorized personnel will have access to the keys to locked compartments.Record review of the facility's, undated, policy Medication Administration reflected 10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of fifteen residents (Residents #42 and Resident #112) reviewed for infection control. 1. The facility failed to ensure CNA F performed hand hygiene, changed her gloves, and wore a gown during Resident #112's incontinent care on 02/17/2026.2. The facility failed to ensure CNA F and CNA G wore gowns when Resident #112, who was on enhanced barrier precautions due to having a g-tube, was transferred to his wheelchair on 02/17/2026. 3. The facility failed to ensure CNA F wore a gown when fixing Resident #112's beddings on 02/17/2026. 4. The facility failed to ensure LVN D placed a cap on Resident #112's PICC line after disconnecting her IV on 02/17/2026.5. The facility failed to ensure CNA J performed hand hygiene and changed her gloves during Resident #42's incontinent care on 02/18/2026.These failures could place residents at risk of cross-contamination and development of infections.Findings include:1. Record review of Resident #112's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with gastrointestinal implant (devices used in treatment of gastrointestinal disorders to deliver medications or nutrients). Record review of Resident #112's Comprehensive MDS Assessment, dated 02/08/2026, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had a feeding tube and a catheter.Record review of Resident #112's Comprehensive Care Plan, dated 02/04/2026, reflected the resident did not have a care plan for her g-tube and catheter. Record review of Resident #112's Physician Order, dated 02/03/2026, reflected Enteral Feed Order in the evening Jevity 1.5 at 55 ml/hour via feeding tube. Up at 7pm, to run continuously until total volume of 660 ml administered. May remove for care and services.Record review of Resident #112's Physician Order, dated 02/03/2026, reflected Catheter care every shift.During an observation on 02/17/2026 at 11:27 AM revealed CNA F was about to do Resident #112's incontinent care, who had a catheter that was hanging on the left side of the bed and a g-tube. She went inside the room and put on a pair of gloves. She did not wash her hands before putting on her gloves. She also did not wear a gown before doing incontinent care. She took a brief from the cabinet of the resident, opened it, and placed it on the resident's overbed table. She turned the resident towards the right, to lower the resident's pants. In the process of turning and lowering the resident's pants, it was observed that CNA F had direct contact with the resident's catheter by leaning on it. She then turned the resident towards the left and then to her back. CNA F was still leaning on the catheter. She then started incontinence care. It was observed there were no gloves and sanitizer on the table. She cleaned the resident's perineal (area between the thighs) area and then assisted the resident to roll to her side again. She then cleaned the resident's bottom. After cleaning the resident's bottom, she pulled the soiled brief and threw it to the trash can. She took the opened brief from the overbed table, placed it under the resident, and fixed it. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. She took off her gloves and told the resident she would call somebody to help transfer her. There was a sign outside the resident's room that stated the resident was on EBP and a gown was required when changing the brief. The sign also indicated to clean the hands before entering and when leaving the room.2. During an observation on 02/16/2026 at 11:40 AM revealed CNA F and CNA G were about to transfer Resident #112 using the stand and pivot technique. Both CNAs did not wash their hands, did not wear a gown and gloves prior to transferring the resident. CNA F started to reposition the resident and put the gait belt around her waist. Both CNAs then assisted the resident to her wheelchair and CNA G rolled the resident to the therapy room. CNA G did not wash her hands after the transfer. There was a sign observed outside the resident's room that the resident was on EBP and a gown was required (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during transfer. The sign also indicated to clean the hands before entering and when leaving the room.3. During an observation on 02/17/2026 at 11:46 AM revealed after Resident #112 was ushered to the therapy room by CNA G, CNA F started to fix the resident's linens without a gown and gloves. She had direct contact with the linens of the bed by leaning on it while fixing it.During an interview on 02/17/2026 at 11:54 AM, CNA F stated she should have worn a gown because Resident #112 had a catheter and a g-tube. She said the sign outside indicated to wear gloves and a gown during care for residents with a catheter and g-tube. She said she should have worn a gown when she did incontinent care, transfers, and when she fixed the resident's linen. She said the gown served as an added protection so to prevent cross contamination. She said hands should be washed before and after incontinent care to make sure her hands were clean before touching the resident. She said she was supposed to change her gloves after cleaning the resident's bottom and before touching the new brief to prevent using dirty gloves that could result in cross contamination. She said she applied the skin barrier using dirty gloves. She said gloves should also be worn when transferring the resident.During an interview on 02/17/2026 at 12:19 PM, CNA G stated CNA F called her to assist in transferring Resident #112. She said she should have washed her hands first before helping CNA F with transferring the resident to make sure her hands were clean. She said gloves and a gown were a must in transferring the resident to prevent cross contamination.4. Record review of Resident #112's Comprehensive Care Plan, dated 02/12/2026, reflected the resident had an infection and the intervention was to administer antibiotics. Record review of Resident #112's Physician Order, dated 02/11/2026, reflected Ceftriaxone Sodium Solution Reconstituted 2 GM Use 2 gram intravenously (administration of the medications directly to the veins) one time a day for infection for 10 Days.During an observation and interview on 02/17/2026 at 11:39 AM revealed Resident #112 was in her bed, awake. There was an IV (intravenous: administering fluids or medications directly into a vein) pole with an empty IV bag hanging on it. The resident said she was getting an antibiotic because of her UTI. She said the one hanging on the IV pole was her last one. She showed her PICC line and the PICC access port was not covered. She said she was not sure if the staff was covering the port. In an interview on 02/17/2026 at 12:03 PM, LVN D stated she was the one who disconnected Resident #112's IV. She said the resident had a UTI and it was her last bag of antibiotics. She said she was supposed to cover the PICC line access port, even though it was the resident's last dose, to prevent any microorganism to crawl inside but the facility did not have any green cap used to cover the access port.5. Record review of Resident #42's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness.Record review of Resident #42's Comprehensive MDS Assessment, dated 12/08/2025, reflected the resident had severe impairment in cognition with a BIMS score of 02. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #42's Comprehensive Care Plan, dated 12/23/2025, reflected the resident had ADL self-care performance deficit and one of the interventions was to assist during toilet use. During an observation on 02/18/2026 at 8:49 AM revealed CNA J was about to do Resident #42's incontinent care. She washed her hands, put on a pair of gloves and a gown, and started to clean the resident's perineal area. In the process of cleaning the perineal area, CNA J pulled downward the skin from the shaft of the resident's penis and cleaned the neck of the penis. After cleaning the neck of the penis, she took off her gloves, sanitized her hands, and put on a new pair of gloves. She took some wipes and cleaned the resident's base of the shaft towards the anus. After cleaning the resident's base of the shaft towards the anus, she pulled upward the skin of the shaft toward the head of the penis, touching the urethral opening. She then proceeded to clean the resident's bottom.During an interview on 02/18/2026 at 9:20 AM, CNA J stated she should have not touched the head of the penis after cleaning towards the anus. She said she should have taken off her gloves, sanitized her hands, and put on a new pair of gloves if she wanted to pull up foreskin of the penis. She said she might transfer any germs she got from cleaning the resident towards his anus.During an interview on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/19/2026 at 6:10 AM, ADON A stated the staff should be mindful they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, after, and during any care. She said the staff should change their gloves after cleaning the resident's bottom to make sure the staff were not using soiled gloves when they touched the new brief. She said another way to prevent the spread of infection was to wear PPE when residents were on EBP. She said residents with catheters and g-tubes were on EBP to prevent any microorganism from the residents that cling to the clothes of the staff. She said the purpose of EBP was to prevent the spread of MDRO (Multi-Drug Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics). She said, during incontinent care, the procedure would always be from clean to dirty, meaning gloves should have been changed before touching the head of the penis. She also said the port of the IV should be covered and the facility had covers for the IV port. She said the expectation was for the staff to practice infection control, hand hygiene, change gloves, sanitize between changing of gloves, and to wear PPE when needed.During an interview on 02/19/2026 at 6:44 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care, said gloves should be changed after cleaning the resident's bottom and before touching the new brief, said soiled gloves should not be used in holding the head of the penis where the urethral opening was located. She said microorganisms could be transferred to the opening. She said if there was an EBP sign outside the residents' rooms, then staff were required to wear a gown in addition to gloves to protect the residents from cross contamination and probable infection. She said the expectation was for the staff to adhere to the policy of hand washing and infection control. She said she would start an in-service about hand hygiene and infection control.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated staff should always wash their hands before and after any care, change their gloves when needed, and put on a gown when the residents required EBP. He said the concerns discussed could attribute to the development and spread of infection. He said she would coordinate with the DON regarding the issues discussed.Record review of the facility's policy Enhanced Barrier Protection P & P Committee revised December 01, 2025 reflected Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines . 2. Initiation of Enhanced Barrier Precautions . b. An order for enhanced barrier precautions will be obtained for residents with any of the following . urinary catheters . 4. High-contact resident care activities include . Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters . transferring.Record review of the facility's policy Hand Hygiene P & P Committee revised November 01, 2025 reflected Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Policy Explanation and Compliance Guidelines . 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . Before applying and after removing personal protective equipment (PPE), including gloves . Before and after handling clean or soiled dressings, linens . Before performing resident care procedures . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . When, during resident care, moving from a contaminated body site to a clean body site.Record review of the facility's policy Incontinence P & P Committee revised December 01, 2025 reflected Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services . Policy Explanation and Compliance Guidelines . 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.

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	676256	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #113) of eight residents reviewed for resident rights.The facility failed to treat Resident #113 with dignity and promote enhancement of his quality of life when the resident was not provided privacy for his nephrostomy bags (collects urine from the urinary bladder) on 02/17/2026.This failure could place residents at risk of not having their right to a dignified existence maintained and a decline in their quality of life.Findings included: Record review of Resident #113's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed malignant (conditions that are dangerous to health) neoplasm (abnormal growth of tissue in the body) of the prostate.Record review of Resident #113's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 02/08/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 13. The Comprehensive MDS Assessment indicated the resident had a nephrostomy tube (thin, flexible catheter inserted through an incision in the kidney).Record review of Resident #113's Comprehensive Care Plan, dated 02/03/2025, reflected the resident did not have a care plan for his nephrostomy tubes nor a plan about non-compliance of putting the nephrostomy bags (external medical device that collects urine directly from the kidney) inside his pants.Record review of Resident #113's Physician's Order, dated 02/04/2026, reflected Nephrostomy (medical procedure that creates an artificial opening between the kidney and the skin to allow urine to drain) Care every day shift Clean skin around Nephrostomy tube(s) with soap and water, pat dry and apply dressing as ordered.During an observation on 02/17/2026 at 11:15 AM revealed Resident #113 was inside his room with a family member. The resident had two nephrostomy bags that were placed outside his pants. The bags and the urine inside the bags could be seen from the hallway. Record review of Resident #113's Progress Notes, dated 02/04/2026 to 02/17/2026, reflected no documentation that the resident refused to put his nephrology bags inside his pants.During an interview on 02/17/2026 at 11:21 AM, CNA F stated Resident #113's nephrostomy bags had always been placed outside his pants since he was admitted to the facility. She said that was how the resident and the family member wanted it. She said the nephrostomy bags were outside the resident's pants even when he walked in the hallways or when he went to the dining area. She said, by right, the resident's bags should not be visible to others to avoid embarrassment in case a visitor would come or would pass by. During an interview on 02/17/2026 at 11:30 AM, Resident #113 stated he never told anybody he wanted his urine bags out in the open. He said nobody talked to him that his bags needed to be inside his pants so it would not be visible to others. During an interview on 02/17/2026 at 11:32 AM, Resident #113's family member stated that nobody from the facility talked to her and Resident #113 about putting the nephrostomy bags inside the pants. The family member said that she preferred the bags to be inside the resident's pants for dignity issue, but nobody talked to them about it. She said it could be embarrassing if everybody could see his urine. She said if somebody from the facility talked about it, then she could have raised some questions how it would be easier for the staff to empty the bags.During an interview on 02/17/2026 at 12:23 PM, ADON A stated she put a care plan about resident #113's non-compliance with covering the nephrostomy bags only when somebody started asking questions why they were outside the resident's pants. ADON A said she did not talk to the resident and the family member about placing the bags inside the pants to provide dignity.During an observation on 02/17/2026 at 1:56 PM revealed Resident #113 was inside his room. It was observed that the nephrostomy bags were not outside the resident's pants.During an interview on 02/19/2026 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 6:44 AM, the DON stated the resident had the right to refuse if he did not want his nephrostomy bags inside his pants. When told per the family member that nobody talked to them about putting the bags inside the pants and that the staff only put the care plan for non-compliance when somebody started asking why the bags were exposed, the DON did not reply.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated that the nephrostomy bags should be not visible from the hallway or should not be outside his pants when walking down the hall to provide dignity. He said the expectation was for the staff to explain to the resident about putting the bags inside his pants. He said they would re-educate the staff about providing dignity to the residents. Record review of the facility's policy, Resident Rights undated, reflected The resident has the right to a dignified existence.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one of six residents (Resident #86) reviewed for the resident rights. The facility failed to ensure the call light system in Resident #86 room was in a position that was accessible to the residents on 02/17/26. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Record review of Resident #86's Face Sheet, dated 02/19/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #86 had diagnoses of lack of coordination and weakness. Record review of Resident #86's Quarterly MDS Assessment, dated 02/19/26, reflected the Resident's BIMS indicated a severe cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnosis of congestive heart failure. During an observation on 02/17/26 at 09:11 a.m., Resident #86 was observed lying in her bed. The resident call light was observed under her bed and out of her reach.During an interview and observation on 02/17/26 at 09:13 a.m., LVN H and CNA N were shown by the Surveyor Resident #86's call light under the resident's bed. They stated the call light needed to be within reach of the resident in case they needed help.During an interview on 02/18/26 at 12:55 p.m., ADON B was informed of Resident #86's call light observed under her bed and out of her reach. She stated the resident's call light needed to be within reach of the resident so they could contact staff if she needed assistance. She stated staff was responsible for ensuring call lights were within reach of the residents. During an interview on 02/19/26 at 1:25 p.m., the DON was informed of Resident #86's call light observed under her bed and out of her reach. She stated the residents' call light needed to be within reach of the resident so they could contact staff for assistance. She stated staff was responsible for ensuring all call lights were within reach of the residents. She stated that was also something checked for when they completed their Angel rounds. Record review of the facility's policy on Call Lights: Accessibility and Timely Response, undated, revealed, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure assessments accurately reflected the resident's status for two (Resident #23 and Resident #106) of eight residents reviewed for accuracy of assessments.1. The facility failed to ensure Resident #23's Quarterly MDS assessment dated [DATE] accurately reflected that the resident had a tracheostomy.2. The facility failed to ensure Resident #106's Quarterly MDS assessment dated [DATE] accurately reflected that the resident had an external catheter.This failure could place the resident at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health.Findings included:1. Record review of Resident #23's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with tracheostomy (is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) status.Record review of Resident #23's Physician Order, dated 01/15/2026, reflected Trach - Tracheostomy Cannula (device used to keep the hole in the windpipe open for breathing) Care every night shift every Tue, Thu, Sat Three TimesWeekly.Record review of Resident #23's Comprehensive MDS Assessment, dated 02/10/2026, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 00. The Comprehensive MDS Assessment did not indicate that the resident had a tracheostomy.Record review of Resident #23's Comprehensive Care Plan, dated 01/14/2026, reflected the resident had a tracheostomy and one of the interventions was to ensure that tracheostomy ties were secured.During an observation on 02/17/2026 at 9:56 AM revealed Resident #23 was in her bed with eyes closed. It was observed that the resident had a tracheostomy. 2. Review of Resident #106's Face Sheet, dated 02/19/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with overactive bladder (a bladder control problem which leads to a sudden urge to urinate).Review of Resident #106's Physician Order, dated 11/12/2024, reflected Purewick System to be used while overnight and when patient is in bed. every shift for incontinence Insert Purewick (a female external catheter positioned externally to wick away urine) at hs and as needed.Review of Resident #106's Quarterly MDS Assessment, dated 12/22/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Quarterly MDS Assessment did not indicate that the resident was using an external catheter (non-invasive device used to manage urinary incontinence).Review of Resident #106's Comprehensive Care Plan, dated 03/14/2025, reflected the resident did not have a care plan for external catheter.During an observation on 02/18/2026 at 1:09 PM revealed Resident #106 was not inside her room. It was observed that the resident had an external catheter on top of her side table.During an interview on 02/18/2026 at 1:12 PM, CNA K stated Resident #106 had the external catheter for approximately more than six months. She said she would empty the external catheter every morning.During an interview on 02/18/2026 at 1:26 PM, Resident #106 stated she had the external catheter since she was admitted to the facility, and the staff would empty it every morning.During an observation and interview on 02/18/2026 at 1:39 PM, the MDS Nurse stated the purpose of the MDS was to collect and record pertinent data about the resident. She said the MDS was used to do a basic assessment of the resident that could be from the documentation of the nurses or through a face-to-face. She said the data collected would be the basis for the residents' care plans. The data collected were the resident's demographics, cognition, behavior, functional abilities, diagnoses, and if the resident was using any kind of special treatment. She turned on her computer and saw that Resident #23 was not coded for a tracheostomy and Resident #112 was not coded for external catheter. She said it was an oversight on her part and missed the resident was using an external catheter and another one with tracheostomy. She said she would audit the MDS' of the residents and would make sure that everything was coded appropriately. She said if the residents were not properly (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed, the needs would not be met, and there could be confusion in the provision of care and in doing the care plan. During an interview on 02/19/2026 at 6:10 AM, ADON A stated she was not familiar with MDS assessments but if a resident had a external catheter then it should be coded on the resident's profile. She said the same went with the resident with tracheostomy.During an interview on 02/19/2026 at 6:44 AM, the DON stated the MDS Nurse was responsible in making the MDS assessment of the residents. She said MDS was done upon admission, discharge, or if there was a change in condition. She said the purpose of the MDS was to capture significant quality measures that could be basis of residents' care. She said if resident was using an external catheter, then the resident's MDS should reflect it. She said if the resident had a tracheostomy during admission, then the MDS should reflect it. She said if the assessment in the MDS was not accurate, the care needed by the resident might not be met.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated the MDS was done to reflect the current condition of the resident. He said if there was no accurate assessment, there could be a misunderstanding about the care needed. He said he would coordinate with the MDS Nurses to evaluate and resolve the issue.A request for a policy for accurate assessments was requested on 02/18/2026 at 1:00 PM and on 02/19/2026 at 12:17 PM via email to the Administrator.During an interview on 02/19/2026 at 12:37 PM, the Administrator stated the facility did not have a policy about Accurate Assessment.

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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 observations, interview and record reviews the facility failed to implement care plans for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care and was developed within 48 hours of the resident's admission for one of two residents (Resident #117) reviewed for baseline care plans. The facility failed to ensure a sufficient baseline care plan was completed for Resident #117 that identified the Pleural Effusion (Pleural effusion, commonly called fluid on the lungs) care needed within 48 hours of the resident's admission. This failure could place residents at risk of not being informed of their initial goals and services, receiving continuity of care and communication among nursing home staff, increased resident safety and safeguard against adverse events that were most likely to occur right after admission. Findings include: Record review of Resident #117's face sheet, dated 02/17/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #117 had diagnosis which included Pleural Effusion (Pleural effusion, commonly called fluid on the lungs). Record review of Resident #117's progress note dated 02/13/2026 revealed that LVN D drained 250 ounces of bright red blood from the rocket drain. Record review of Resident #117's baseline care plan, dated 02/10/2026, revealed no evidence of assessment, treatment, or care documentation for Pleurex drainage placed at the hospital for Pleural Effusion. During an interview with Resident #117 on 02/18/2026 at 12:27 PM, she stated the facility was not familiar with her Pleurex drainage, and the responsible party was going to come show them how to care for it since he did so at home. She told someone about draining the pleurex but had not heard back and she did not remember who she told. During an interview with LVN D on 02/18/2026 at 12:41 PM, LVN D stated she drained the Pleurex drainage on 02/13/2026. When asked if she knew whether the order was a physician orders or a care plan, she stated no but that it should be. She did not know who updated the care plan. During an interview with ADON A on 02/18/2026 at 12:51 AM, she stated Resident #117's care plan for the pleurex drainage should be in the comprehensive is due in 21 days after admission. During an interview with the MDS nurse on 02/18/2026 at 1:25 PM, she stated a baseline care plan should be completed within 48 hours of admission and a comprehensive care plan within 21 days per facility policy. She stated the care plan directs the care of the residents to meet their needs. She stated the risk of not having a care plan could result poor care, neglect, and inability to anticipate needs. The MDS nurse stated she is responsible to assess residents for level of care that was needed. MDS nurse stated, she is responsible for completing the care plan and updating MDS. During an interview with the Regional Clinical Nurse on 02/19/2026 at 9:10 AM, he stated the baseline care plan should be completed within 48 hours of admission to ensure proper and adequate care of residents needs on admission. During an interview with the DON on 02/19/2025 at 10:25 AM, she stated a baseline care plan should be completed within 48 hours of admission to reflect the immediate needs of the resident and ensure how those needs were met.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one (Residents #12) of four residents reviewed for quality of care. The facility failed to ensure that Resident #12's ulcer to the right lateral ankle was covered as per physician order on 02/19/2026. This failure could place the residents with ulcers at risk for worsening of the existing ulcers and infection.Findings included: 1.Record review of Resident #12's face sheet, dated 02/17/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #12 had relevant diagnoses which Alzheimer's disease, Dementia, Type 2 Diabetes with Polyneuropathy (Polyneuropathy is a general term for damage to multiple peripheral nerves throughout the body), Peripheral Vascular Disease (commonly refers to Peripheral Vascular Disease, a slow-progressive circulation disorder causing narrowed, blocked, or spasming blood vessels outside the heart, usually in the legs), Chronic Kidney Disease stage 3A (CKD Stage 3 represents moderate kidney damage with a significant decrease in function), Pressure Ulcer of Sacral region, stage 3 (A stage 3 sacral pressure ulcer is a full-thickness loss of skin, presenting as a deep, crater-like wound where adipose (fat) is visible, but muscle, tendon, or bone are not exposed). Record review of Resident #12's Quarterly MDS Assessment, dated 01/22/2026, reflected the Resident has a BIMS score of 2. The Quarterly MDS Assessment reflected the resident was at risk for pressure ulcers. Record review of Resident #12's care plan initiated 05/07/2025 reflected that the resident was at risk for infection. Record review of Resident #12's physician's order dated 10/21/2025, listed wound treatment as Xeroform every dayshift, every Tuesday, Thursday, and Saturday. Cleanse wound to right lateral (the outer side of the ankle joint) ankle with normal saline or skin cleanser, pat dry. Apply Xeroform to wound. Cover with dry dressing. Record review of wound consult for Resident #12 dated 02/19/2026, listed chief complaint as patient has wounds on her right lateral ankle; left third finger. Dressing treatment plan for wound on right, lateral ankle full thickness was listed as follows on the wound consult: Primary Dressings - Xeroform gauze apply three times per week and as needed: if saturated, soiled, or dislodged. For 23 days and secondary dressings as Gauze Island with bordered dressing, apply three times per week and as needed: if saturated, soiled, or dislodged. For 23 days. Observation on 02/19/2026 at 9:15 am, revealed Resident #12 was noted in bed with a wound on her right lateral ankle open to air. During an interview on 02/19/2026 at 10:20 am with ADON A and the Treatment Nurse, they stated that the wound should be closed to avoid infection per the wound orders; and if a change was noted in wound condition, the orders and care plan should be updated to reflect the change. During an interview on 02/19/2026 at 10:25 am the DON stated that the wound for Resident #12 should have been covered per doctors' orders to prevent infection which could delay healing. During an interview and observation on 02/19/2026 at 12:05 PM with CNA L, she stated if she noticed a wound without a dressing, she must notify the nurse immediately. She stated it was important to do so to prevent infection, cross contamination and bacteria. A dressing change was observed dated 02/19/26.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown and infection for two (Resident #42) of four residents reviewed for pressure ulcers. The facility failed to ensure that LVN A did not use only one gauze to pat dry Resident #42's pressure ulcer to his sacrum as well as the surrounding skin of the pressure ulcer on 02/18/2026.This failure could place the residents with pressure ulcers at risk for worsening of the existing pressure ulcers and infection.Findings included: Record review of Resident #42's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with failure to thrive (significant decline in overall health).Record review of Resident #42's Comprehensive MDS Assessment, dated 12/08/2025, reflected the resident had severe impairment in cognition with a BIMS score of 02. The Comprehensive MDS Assessment indicated that the resident had an unstageable (full damage of the skin cannot be determined) pressure ulcer (wound on the skin caused by prolonged pressure to specific area of the body).Record review of Resident #42's Comprehensive Care Plan, dated 12/23/2025, reflected the resident had an unstageable pressure ulcer to the sacrum (bone of the bottom) and one of the interventions was to administer treatment as ordered and monitor for effectiveness.Record review of Resident #42's Physician's Order, dated 02/17/2026, reflected Wound Treatment - Calcium Alginate w/Silver (a type of wound dressing) every day shift for Wound Care Cleanse wound to sacrum with Normal Saline or Skin Cleanser. Pat Dry. Apply Calcium Alginate w/ Silver to wound bed. Cover with Dry Dressing.During an observation and interview on 02/18/2026 at 8:24 AM revealed the Treatment Nurse was about to do Resident #42's wound care. She said the resident had an unstageable pressure ulcer to his sacrum and the treatment would be to clean with normal saline, apply calcium alginate with silver, pat dry, and cover with a dry dressing. She sanitized her hands and put on a gown and a pair of gloves. She placed some normal saline bullets, gauzes, calcium alginate, and a bordered dressing on a covered overbed table. She assisted the resident to roll on his side, unfastened the brief and took off the old dressing. She took off her gloves, sanitized her hands, and put on a new pair of gloves. She squeezed the normal saline bullet on a couple of gauzes and started to clean the resident's pressure ulcer. After cleaning the pressure ulcer, she patted dry the inside of the pressure ulcer. With the same gauze, she dried the surrounding skin of the pressure ulcer and then, with the same gauze she used to dry the surrounding skin, she patted dry the inside of the pressure ulcer again. After drying the pressure ulcer, she put on the collagen with silver and covered the wound with a dry dressing.During an interview on 02/18/2025 at 9:58 AM, the Treatment Nurse stated she was not aware she used the gauze that she used to dry the surrounding skin of the pressure ulcer and dried again the inside of the pressure ulcer. She said the right procedure in drying the wound was to dry it from inside to outside and not to use the gauze that was already used again. She said she should have discarded the first gauze that she used to dry the inside of the wound, used another gauze to dry the surrounding skin of the pressure ulcer, and used another gauze if she wanted to dry the inside of the wound again. She said microorganisms collected from drying the surrounding skin/wounds and were introduced to the pressure ulcer because she used the same gauze that could result to infection of the pressure ulcer. She said she would be mindful the next time she did wound care not to use soiled gauze to dry the pressure ulcer.During an interview on 02/19/2026 at 6:10 AM, ADON A stated using the gauze used to dry the surrounding skin of the pressure ulcer to dry the inside of the pressure ulcer could lead to probable infection. She said the proper procedure in drying the pressure ulcer would be from inside out and then discard the gauze, get another gauze, dry the surrounding skin, and then discard the gauze, and so on and so forth. She said if the same gauze just went back and forth from inside to outside and to inside again, it would be as if the microorganisms (continued on next page)

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	676256	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	went back and forth again. She said, if there were bacteria in the surrounding skin, then it could be introduced to the pressure ulcer. She said the expectation was to keep the bacteria out and not introduce germs from the surrounding skin. During an interview on 02/19/2026 at 6:44 AM, the DON stated there could be probable harm if the gauze used to dry the surrounding skin was used to dry the inside of the wound because of the possibility of introducing another set of microorganisms in the pressure ulcer. She said the purpose of cleaning the pressure ulcer was to eliminate the microorganisms that could cause probable infections. She said the expectation was for the staff doing wound care to do the right procedure. She said she would do an in-service about proper technique in wound care.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated improper wound care could lead to infection by transferring what was outside of the pressure ulcer. He said the expectation was to do wound care the right way according to wound care technique. He said he was not a clinician and would let the DON take a lead on the issue about wound care.Record review of the facility's policy Clean Dressing Change P & P Committee revised December 01, 2025, reflected Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination . 12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 2 of 6 residents (Resident #25 and #101) reviewed for accident prevention. The facility failed to ensure Resident #25's used syringes were safely discarded.The facility failed to Resident #101's bed was in a low position for fall prevention per the care plan. This failure could prevent the residents from having an environment that was free from hazards. Findings include:Record review of Resident #25's Face Sheet, dated 02/18/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #25 had a diagnosis of Type 2 Diabetes (insulin resistance). Record review of Resident #25's MDS Assessment, dated 02/02/26, reflected the resident's BIMS indicated an intact cognitive response. The MDS Assessment reflected the resident had active diagnoses of diabetes.Record review of Resident #25's Physician orders, dated 02/18/26, Insulin Glargine Solution 100 Unit/ML, Inject 25 units subcutaneously one time a day for diabetes.During an observation on 02/17/2026 at 11:11 a.m., in Resident #25's bathroom, was two used syringes sitting on top of a sharps container (container for discarding used syringes), and not inserted into the container.During an interview and observation on 02/17/26 at 11:15 a.m., LVN D was shown the used syringes located on top of the container. She stated the syringes should have been discarded into the container once the resident was given his insulin. She stated not discarding the syringes properly could result in the resident tampering with the needle and getting an infection and he could also harm himself.During an interview on 02/18/26 at 10:55 a.m., ADON B was informed of Resident #25's used syringes not discarded safely. She stated all staff were responsible for ensuring the syringes were discarded correctly to avoid infection and the residents harming themselves. She stated once the resident was given his insulin, the syringes should have been discarded into the container. During an interview on 02/19/26 at 1:25 p.m., the DON was informed of Resident #25's used syringes not discarded safely. She stated it was the nurse's responsibility to ensure syringes were discarded in the syringe container in the resident's bathroom to protect the residents from harming themselves. Record review of Resident #101's Face Sheet, dated 02/18/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #101 had a diagnosis of muscle weakness. Record review of Resident #101's MDS Assessment, dated 01/30/26, reflected the resident's BIMS indicated severe cognitive impairment. The MDS Assessment reflected the resident had active restless leg syndrome and blindness in one eye. Record review of Resident #101's Comprehensive Care Plan, dated 11/09/25, reflected Resident #101 being a fall risk and an intervention was to ensure the resident's bed was kept in the lowest position. During an interview and observation on 02/17/26 at 11:58 a.m., revealed Resident #101's bed was waist high and not in the lowest position while she was lying in the bed. LVN H was observed entering the resident's room, checking on the resident, and exiting the room without lowering the resident's bed to the lowest position possible. LVN H was asked by the Surveyor if the resident was a fall risk and she stated the resident was a fall risk. She stated the resident was required to have a fall mat alongside her bed and the bed kept at the lowest position to help minimize the risk of injury if the resident fell out of her bed. During an interview on 02/18/2026 at 9:16 a.m., ADON B was informed of Resident #101's bed not in the lowest position while she was lying in the bed and LVN H was observed entering the resident's room, checking on the resident, and exiting the room without lowering the resident's bed to the lowest position possible. She stated the resident's family raised the resident's bed when they visited her. She was informed no one was in the resident's room when the nurse went to check on the resident. She stated the resident was a fall risk and needed the bed in the lowest position for all prevention. She stated if the bed was not at the lowest position, the resident could injure herself if she fell out of bed. During an interview on 02/19/26 at 1:25 p.m., the DON was informed of Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#101's bed not in the lowest position while she was lying in the bed and LVN H was observed entering the resident's room, checking on the resident, and exiting the room without lowering the resident's bed to the lowest position possible. She stated the resident's family members liked to raise her bed when they visited. She was informed the resident was observed lying in her bed and no one was inside the room and LVN H was in the resident's room and had failed to lower the bed. She stated the resident was a fall risk and needed to have her bed in the lowest position to minimize risk of injury if she fell out of bed. Record review of the facility's policy on Safe and Homelike Environment, dated 10/01/2025, revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of six residents (Resident #36 and #82) reviewed for respiratory care.The facility failed to ensure Resident #36 and #82's breathing treatment masks were properly stored in a bag when not in use on 02/17/26. The facility failed to ensure Resident #36's nasal canula was properly stored in a bag when not in use on 02/17/26. These failures could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #36's Face Sheet, dated 02/18/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had a diagnosis of COPD (obstructed airflow).Record review of Resident #36's Quarterly MDS Assessment, dated 02/11/26, reflected Resident #36's BIMS indicated an intact cognitive response. The Quarterly MDS Assessment reflected the resident had an active diagnosis of COPD.Record review of Resident #36's Physician's Orders, dated 02/18/26, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML inhale every 6 hours as needed for shortness of breath. No Physician orders were found for oxygen use. During an observation on 02/17/26 at 11:51 a.m., Resident #36's nebulizer mask was observed sitting in her nightstand unbagged. The resident was also observed to have a small portable oxygen tank attached to a nasal canula in a tote bag hanging from her wheelchair. The nasal canula was not properly stored in a bag.During an interview and observation on 02/17/26 at 11:53 a.m., LVN H and ADON B observed Resident #36 breathing equipment not properly stored. They stated the equipment needed to be properly bagged to avoid the residents getting an infection. They stated the resident was just discharged to the hospital but the equipment should have been bagged or removed until the resident had returned. The resident returned to the facility on [DATE].Record review of Resident #82's Face Sheet, dated 02/18/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #82 had a diagnosis of congestive heart failure. Record review of Resident #82's MDS Assessment, dated 02/06/26, reflected the resident's BIMS indicated an intact cognitive response. The MDS Assessment reflected the resident had active diagnoses of congestive heart failure and atrial flutter (heart rhythm disorder). Record review of Resident #82's Physician's orders, dated 02/18/26, reflected CPAP at bedtime for sleep apnea. During an interview and observation on 02/17/26 at 9:14 a.m., LVN H was shown Resident #82's CPAP mask and breathing treatment device not properly stored and LVN H stated it was the nurse's responsibility to ensure the equipment was properly bagged to avoid the resident getting an infection. During an interview on 02/18/26 at 11:53 a.m., ADON B was informed by the surveyor of Resident #82's CPAP mask and breathing treatment device not properly stored. She stated it was the nurses' responsibility to ensure the equipment was properly bagged when not in use to avoid the resident getting an infection.During an interview on 02/19/26 at 1:25 p.m., the DON was informed by the surveyor of Resident #36 and #82's breathing equipment observed improperly stored on 02/17/26. She stated it was the nursing staff's responsibility to ensure all breathing masks, nasal cannulas, and breathing treatment devices were bagged when not in use to avoid residents from getting an infection. Record review of the facility's policy Oxygen Concentrator, revised 11/01/2025, reflected POLICY: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . PROCEDURES . 1. Oxygen Tanks, Connectors and Concentrators . E. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms . 2. Nebulizer Equipment Procedures . F. Store, clean, and dry until next use.

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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 assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for two of eight residents (Resident #45 and Resident #118) reviewed for pharmaceutical services.1. The facility failed to ensure LVN I clicked Y next to each of Resident #118's medication being prepared or was about to administer on 02/18/2026.2. The facility failed to ensure LVN I checked Resident #45's blood pressure before administering Resident #45's anti-hypertensive medication on 02/18/2026.These failures could place residents at risk of not receiving medications as ordered.Findings include: 1. During an observation on 02/18/2026 at 7:49 AM revealed LVN I was preparing Resident #118's medications. As she was preparing the medications, she would just glance at the medication administration record and then would pop the medications in a cup. It was also observed the eMAR screen was still on white meaning the system was not yet refreshed.During an observation and interview on 02/18/2026 at 7:54 AM, ADON A stated the eMAR screen was still on white because LVN I had not refreshed the system. She told LVN I to refresh the system and the eMAR screen became yellow. At this point, LVN I started clicking the Y of the medications she already prepared. ADON A said the best practice was after pulling a medication, click the Y box of the medication to acknowledge the medication was already prepared. She said this way, the one preparing the medications would not be confused which medications were already prepared. She said the risk would be the possibility of preparing a medication twice or not able to prepare a medication at all. She said once the medication was administered, the staff would hit save to acknowledge all the medications prepared were taken by the resident. She said if the medications were refused, the staff would click the N box. She said the medication administration system was designed that way to prevent overdose, underdose, and even medication errors.During an interview on 02/18/2026 at 8:03 AM, LVN I said she should prepare medications one-by-one and clicking yes when she put the medication in the cup to prevent confusion. She said the eMAR was made in a manner that each medication was acknowledged when prepared to prevent preparing medications twice or not preparing the medication. She said the resident might be overdosed or underdosed.During an interview on 02/19/2026 at 12:07 PM, ADON B stated the right procedure for medications was to click yes once the medication was placed in a cup to remind the staff the medication was already pulled. She said there was a save button the staff would hit once the medications prepared were administered to the residents.2. Record review of Resident #45's Face Sheet, dated 02/18/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure). Record review of Resident 45's Comprehensive MDS Assessment, dated 01/11/2026, reflected the resident was cognitively intact with a BIMS 15. The Comprehensive MDS Assessment indicated the resident had hypertension.Record review of Resident #45's Comprehensive Care Plan, dated 01/08/2026, reflected the resident did not have a care plan for hypertension.Record review of Resident #45's Physician Order, dated 01/08/2026, reflected Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 100 MG (Metoprolol Succinate) Give 100 mg by mouth two times a day for HTN Hold for SBP <110, DBP<60 or HR<60.During an observation on 02/18/2026 at 7:59 AM revealed LVN I was preparing Resident #45's medications. One of the medications being prepared was an anti-hypertensive medication, Metoprolol. After preparing all the medications for the resident, LVN I was about to administer the medications when ADON A told her to check the resident's blood pressure. LVN I said she just took the resident's blood pressure around twenty minutes ago. ADON A told LVN I to take the resident's blood pressure again and told her to get the hypertensive medication from the cup of medications and put it in a separate cup. LVN I went inside the room and took the resident's blood (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure again. there was no observation that LVN 1 took the resident's blood pressure prior to preparing the medications.During an interview on 02/18/2026 at 8:03 AM, ADON A said the best practice was to get the blood pressure of the residents on the time of the administration for safety of the residents. She said getting the blood pressure on the time of administration could prevent administering it even the blood pressure was already low. She said what if the blood pressure was taken two hours ago and during that span of time, the resident's blood pressure dropped, and anti-hypertension was still given. She said it might cause dizziness and fainting. She said she told LVN I to get the anti-hypertensive medication from the medications that were already prepared just in case the resident did not need it. She said considering that somebody was observing the medication pass, the more the blood pressure should have been gotten prior to administering the anti-hypertensive medication.During an interview on 02/18/2026 at 8:05, LVN I stated she should take the blood pressure before administering anti-hypertensive medications to see if the medication should be held or not. She said she did take Resident #45's blood pressure before starting medication administration but said she should take them prior to giving the anti-hypertensive medication to check if the resident needed the medication or not.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated the expectation was that blood pressure was taken in real time because there might be changes from the time it was taken and for the staff to make sure, they would not be confused in preparing the resident's medications. Record review of the facility's, undated, policy Medication Administration, reflected Policy Explanation and Compliance Guidelines . 3. Identify resident by photo in the MAR . 6. Explain purpose of visit . 8. Obtain and record vital signs . 10. Ensure that the six rights of medication administration . 11. Review MAR to identify medication to be administered . 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.Policy for preparing medications and on how to give anti-hypertensive medication requested on 02/18/2026 at 3:23 PM and on 02/19/2026 at 12:17 PM via email to the Administrator but was not provided prior to exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for 1 of 4 residents (Resident #73) reviewed for unnecessary medications. The facility failed to ensure Resident #73's medical chart and drug regimen were reviewed at least monthly. This failure could place residents at risk for receiving medications without a corresponding diagnosis, informed consent, or reviewed for gradual dose reduction.Findings include: Record review of Resident #73's admission Record, dated 02/18/2026, revealed a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #73 was noted to have diagnoses which included Restlessness and Agitation, Shortness of Breath, Need for Assistance with Personal Care, Other Lack of Coordination, Muscle Weakness (Generalized), Cerebral Infarction (blocked blood flow to the brain, usually caused by blood clots, leading to tissue death), Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side (neurological conditions causing motor impairment on one side of the body due to brain injury), Dysphagia Following Cerebral Infarction (difficulty swallowing), Acute Respiratory Failure (when lungs cannot adequately oxygenate the blood or remove carbon dioxide, often due to rapid fluid buildup in the air sacs), Type 2 Diabetes Mellitus with Diabetic Neuropathy (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, resulting in damage to nerves particularly in the legs and feet), Other Recurrent Depressive Disorders (distinct, repeated depressive episodes that do not fit standard classifications), Memory Deficit Following Unspecified Cerebrovascular Disease, Other Speech and Language Deficits Following Cerebral Infarction, and Acute Embolism and Thrombosis of Unspecified Vein (sudden blockage of a vein by a blood clot that has not been specifically localized). Record review of Resident #73's Care Plan, last updated on 11/06/2025, revealed no focus or intervention related to a diagnosis of bipolar disorder or use of Seroquel. Record review of Resident #73's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 13, which indicated intact cognition. Resident #73 was noted to utilize a wheelchair for mobility. Functional abilities revealed Resident #73 was dependent for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene, Resident #73 was noted to need partial/moderate assistance for oral hygiene, and only needed set up/clean up assistance for eating. Resident #73's mobility was noted as dependent for chair/bed-to-chair transfer and tub/shower transfers while substantial/maximal assistance was needed for roll left and right, sit to lying, and lying to sitting on side of bed. Record review on 02/18/2026 of the facility's Pharmacy Review binder for the months of August 2025, September 2025, October 2025, November 2025, December 2025, and January 2026 revealed Resident #73 was only mentioned once in September 2025 related to recommendation of staff documenting amount of Voltaren External gel applied. No other mention of Resident #73 was located or provided by the facility. Interview on 02/19/2026 at 10:08 AM with ADON A revealed the licensed pharmacist for the facility should review each resident's medications regularly, but was unsure at what exact intervals, for gradual dose reductions, diagnosis, and make recommendations to either continue, reduce, or stop medications. Interview on 02/19/2026 at 11:10 AM with the DON revealed the facility did contract a licensed pharmacist to review resident medications and medical charts as required. The DON stated she was not aware Resident #73 only appeared once in the binder containing all of the licensed pharmacists logs of charts reviewed and recommendations since admission on [DATE]. Interview on 2/19/2026 at 3:00 PM with Physician E revealed he provided medical care for Resident #73 for 2 to 2 1/2 years and was familiar with her conditions and diagnoses. Physician E stated the resident was diagnosed with Major Depressive Disorder and he managed the medications for this condition along with other routine medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician E could not provide a reason the pharmacy consultant had not reviewed medications for GDR for Resident #73, only providing recommendation for Voltaren External gel documentation by staff.