STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676297	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rio at Mission Trails	6211 S New Braunfels Ave San Antonio, TX 78223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review the facility failed to implement a grievance policy that included ensuring that all grievances shared in resident council were transcribed to grievance forms and submitted to the Grievance Official for 6 out of 6 residents that were present for Resident Council at any given time and complained month to month anonymously. The facility failed to address resident grievances mentioned in the resident council through the appropriate processes. This failure could place the residents at risk for a decreased quality of life and care within their living environment, and/or not having their needs met. The findings included:Record reviews of the Resident Council minutes from 03/2025-02/2026 revealed that every month a complaint of staff on their personal cells phones while providing care or while standing in resident common areas were documented by Activity Director. Record review of the facility's Grievance logs, dated 03/2025-02/2026, revealed no grievance forms related staff cell phone usage. Interview with residents in the Resident Council meeting on 03/24/2026 at 2:14 pm, revealed 6 residents who wanted to maintain anonymity participated. The resident stated they notified staff of their concerns regarding cell phone usage and that it may improve for a short time but was still always a concern. The residents stated that the staff started putting earphones in their ears, so it was not obvious that they were on the phone.Interview with the Activity Director on 03/25/2026 at 11:20 am revealed that she did not complete a grievance form for concerns shared during the Resident Council. The Activity Director stated that she brought the minutes into stand-up and they discussed what was mentioned in the council meeting. The surveyor asked how they made sure that they addressed the residents' concerns if they were not filling out the grievance forms. The Activity Director stated that the Administrator followed up on the items discussed. The Activity Director stated that she knew they had addressed it because she remembered signing In-services regarding cell phones.Interview with the Administrator on 03/25/2026 at 1:30pm revealed that facility had addressed the issues brought up in Resident Council and that he was sure that there were in-services regarding cell phone usage. Administrator provided in-services that spanned over a year and not one in-service produced specifically mentioned cell phone usage.The surveyor requested a policy from the facility related to the resident council on 03/24/2026 at 3:45 pm and 03/25/2026 at 12:45 pm as well as 5:15 pm. A policy was not provided.Record review of facility's in-services for 03/2025-02/2026 revealed no in-service regarding cell phone usage specifically. Record review of facility Grievance Policy, DATED 11/21/2016, revealed that the facility must make prompt efforts to resolve any grievances the resident may have. Policy also reflected that the facility was to keep record of grievance results for a period of no less than three years from issuance of the grievance decision. Record review of Resident Council policy could not be accomplished as policy was never presented to surveyors. Surveyor asked for policy on 03/24/2026 at 3:45 pm and 03/25/2026 at 12:45pm and 5:15pm. A policy was not provided.

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse of at least 8 consecutive hours a day, 7 days a week for 9 of 59 days reviewed (2/17/2026, 2/21/2026, 2/23/2026, 2/24/2026, 2/26/2026, 3/3/2026, 3/7/2026, 3/12/2026, 3/21/2026) reviewed for RN coverage as well as having a designated Director of Nursing from 02/14/2026 through 3/24/2026.The facility failed to ensure they had an RN charge nurse on duty on 2/17/2026.2/21/2026, 2/23/2026, 2/24/2026, 2/26/2026, 3/3/2026, 3/7/2026, 3/12/2026, 3/21/2026.The facility failed to ensure that an RN served as a designated Director of Nursing from 2/14/2026 through 3/24/2026.This failures could place the residents at risk of missed nursing assessments, interventions, care and treatment.Findings include:Record review of the February 2026 overall RN hours reflected less than 8 hours worked by an RN on 2/17/2026 4 hours by one RN and 5 hours by another- not consecutive, 2/21/2026 7.8 hours by one RN and 7.7 by another RN- not consecutive, 2/23/2026 one RN 7.6 hours, 2/24/2026 one RN 6.8 hours and another RN 6.3 hours- Not consecutive, 2/26/2026 one RN 2 hours.Record review of the March 2026 overall RN hours reflected less than 8 hours worked by an RN on 3/3/2026 one RN for 2 hours, 3/7/2026 on RN for 2 hours, 3/12/2026 one RN for 2 hours, 3/21/2026 one RN for 7.5 hours and another RN for 2.1 hours- not consecutive.Record reviews of timecard punches for days showing less than 8 hours of RN coverage revealed 11 of 59 days reviewed did not have 8 consecutive hours of RN coverage.During an interview on 3/24/2026 at 11:38 am, the Administrator revealed that the facility had not had a designated DON since the previous DON left on 2/13/2026. The Administrator also stated that they had a corporate nurse come in 1-2 times a week. The Administrator went on to state that the new DON would be starting that week. During an interview on 3/23/2026 at 1:35 pm, RN I stated that he was unaware of who his supervisor was since there was not a designated DON at the moment. RN I stated that he was unsure who to report to and he also stated that he did not know who the corporate RN was. During an interview on 3/25/2026 at 11:30 am, the Human Resources Coordinator (HRC) stated that the last DON worked 2/13/2026 and they were onboarding a new DON. The HRC stated that a corporate nurse was coming into the facility to assist but they did not clock in and out while in building to verify which days they were there and which days they were not.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a medication error rate was not 5 percent or greater. The facility had a medication error rate of 8%, based on 2 errors out of 25 opportunities, which involved 2 of 6 residents (Residents #47 and #75) and 3 of 4 staff (LVN B, and LVN C) reviewed for medication administration reviewed for medications errors. LVN F administered Resident #47's Injectable insulin without first priming the pen-injector.LVN L failed to administer Resident #75's insulin. These failures could place residents at risk of not receiving therapeutic effects of their medications and possible adverse reactions.The findings include: 1, A record review of Resident #47's admission record dated 3/25/2026 revealed an admission date of 2/19/2025 with diagnoses which included type II diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar levels). A record review of Resident #47's quarterly MDS assessment dated [DATE] revealed Resident #47 was a [AGE] year-old male admitted for long term care with supports for insulin injection therapies. Resident #47 was assessed with a BIMS score of 12 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #47's physician's orders revealed the physician prescribed for Resident #47 to receive insulin aspart via an injection before meals per a sliding scale according to his blood sugar level, Insulin Aspart (with Niacinamide)) Inject as per sliding scale: if 150 - 199 = 2 units ; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; . During an observation and interview on 3/25/2026 at 4:38 PM revealed LVN F assessed Resident #47's blood sugar level as 342 and prepared and administered 8 units of insulin aspart to Resident #47 without first priming the injector pen. LVN F stated he had administered Resident #47's insulin without first priming the insulin injector pen. LVN F stated he was vaguely familiar with priming insulin syringes but was not certain if the practice applied to insulin injection pens. LVN F stated the practice of not priming insulin injections could be that residents would not receive the dose as prescribed by the physician. 2. A record review of Resident #75's admission record dated 3/25/2026 revealed an admission date of 3/14/2026 with a diagnosis of diabetes type II. A record review of Resident #75's admission MDS assessment dated [DATE] revealed Resident #75 was a [AGE] year-old female admitted for long term ADL care. A record review of Resident #75's physician's orders revealed the physician prescribed for Resident #75 to receive an injection of Lantus (a long-acting, man-made insulin used once daily to control high blood sugar in adults with type 2 diabetes) insulin glargine solution 100 units / ml, inject 20 units subcutaneously twice a day, mornings and evenings. During an observation and interview on 3/24/2026 at 7:23 AM revealed LVN L had assessed Resident #75 with a blood sugar of 61 and decided not to administer Resident #75's prescribed insulin glargine because LVN L believed she had standing orders from the Medical Director to hold insulin glargine when a person's blood sugar levels were below 70. LVN L stated she was taught this by LVN C. During an interview on 3/25/2026 at 4:00 PM the Regional Clinical RN stated the policy, training, and professional standard was for nursing staff to administer medications per the physicians' orders and to follow the drug manufactures instructions for using their medication administration devices e.g., insulin injection pens which should be primed prior to administering the injection and to administer long acting insulin regardless of current blood sugar levels if the physician's orders did not specify parameters. The Regional Clinical RN stated if the nurse had a professional concern to withhold a medication the nurse should assess the resident and give a report to the physician. The Regional Clinical Nurse stated there were no standing orders to hold long-acting glargine insulin. The Regional Clinical Nurse stated the potential negative outcome could be residents would not receive their intended effects from their medication. A record review of the facility's undated policy Medication Administration and General Guidelines revealed, Medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices and only by persons legally authorized to do so. procedure: . Medications are (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered at the time they are prepared medications are not pre poured. This person then records the administration on the residence medication administration record at the time the medication is given at the end of each medication passed the person administering the medication reviews the medication administration record to ascertain that all necessary doses were administered and documented . If a dose of regularly scheduled medication is withheld, refused, forgiven at other than the scheduled time, the physician must be notified.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free from significant medication administration errors for 5 of 12 Residents (Residents #2, #40, #60, #68, and #78) reviewed for medication administration of medications with parameters. -The facility failed to ensure nursing staff administered blood pressure medications to Residents #2, #40, #60, #68, and #78 per their prescribed orders. This failure could place residents at risk of not receiving the intended therapeutic effects of their prescribed medications. The findings include: A record review of Resident #2's admission record dated 3/23/2026 revealed an admission date of 11/3/2025 and a discharge date of 11/9/2025 with a diagnosis of hypertension (high blood pressure.) A record review of Resident #2's admission MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for long term care and supports for his tracheostomy. A record review of Resident #2's physician's orders revealed on 11/4/2025 at 5:51 pm the physician prescribed for Resident #2 to receive hydralazine (a vasodilator medication used to lower high blood pressure by relaxing blood vessels) 25mg as needed for high blood pressure episodes, give 1 tablet via g-tube [a medical device inserted through the abdominal wall directly into the stomach to provide nutrition, fluids, and medication when oral intake is insufficient] every 6 hours as needed for SBP [systolic blood pressure, the top number in a blood pressure reading, measuring the force of blood against artery walls when the heart contracts] greater than 160 and/or heart rate greater than 90. A record review of Resident #2's November 2025 medication administration record (MAR) revealed:- On the evening of 11/4/2025 LVN C assessed Resident #2 with a heart rate of 94, greater than 90, and had not administered Resident #2's hydralazine as prescribed by the physician.- On the Morning of 11/6/2025 LVN M assessed Resident #2 with a SBP of 165, greater than 160, and had not administered Resident #2's hydralazine as prescribed by the physician.- On the evening of 11/6/2025 LVN N assessed Resident #2 with a SBP of 165, greater than 160, and had not administered Resident #2's hydralazine as prescribed by the physician.- On the evening of 11/7/2025 LVN N assessed Resident #2 with a SBP of 177, greater than 160, heart rate of 112, greater than 90 and had not administered Resident #2's hydralazine as prescribed by the physician.- On the morning of 11/8/2025 LVN A assessed Resident #2 with a SBP of 177, greater than 160, a heart rate of 112, greater than 90 and had not administered Resident #2's hydralazine as prescribed by the physician.- On the evening of 11/8/2025 LVN A assessed Resident #2 with a heart rate of 92, greater than 90, and had not administered Resident #2's hydralazine as prescribed by the physician. A record review of Resident #40's admission record dated 3/23/2026 revealed an admission date of 12/17/2025 with a diagnosis of spina bifida (a common neural tube birth defect where the spine and spinal cord do not form properly, leaving an opening in the backbone. It ranges from mild to severe, often causing physical and neurological challenges like leg paralysis or bladder issues, typically requiring lifelong care, treatments, and surgery.) A record review of Resident #40's quarterly MDS assessment dated [DATE] revealed Resident #40 was a [AGE] year-old female admitted for long term care with ADL's and supports for her tracheostomy and ventilator. Resident #40 was assessed with a BIMS score of 12 out of a possible 15 which indicated mild cognitive impairment. A record review of Resident #40's physician's orders revealed on 8/14/2025 the physician prescribed for Resident #40 to receive midodrine (a medication used to treat low blood pressure, particularly orthostatic hypotension, by constricting blood vessels to raise blood pressure) 10mg, hold for blood pressure greater than 110. A record review of Resident #40's March 2026 medication administration record revealed:- On 3/1/2026 at 11:30 AM LVN A assessed Resident #40 with a SBP of 141, greater than 110, and administered Resident #40's midodrine contrary to the physicians' orders. - On 3/1/2026 at 5:00 PM LVN A assessed Resident #40 with a SBP of 120, greater than 110, and administered Resident #40's midodrine contrary to the physicians' orders. - On 3/2/2026 at 11:30 AM LVN B assessed Resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#40 with a SBP of 107, less than 110, and had not administered Resident #40's midodrine per the physicians' orders. - On 3/5/2026 at 5:00 PM LVN C assessed Resident #40 with a SBP of 108, less than 110, and had not administered Resident #40's midodrine per the physicians' orders. - On 3/7/2026 at 5:00 PM LVN A assessed Resident #40 with a SBP of 128, greater than 110, and administered Resident #40's midodrine contrary to the physicians' orders. - On 3/22/2026 at 11:30 AM LVN A assessed Resident #40 with a SBP of 136, greater than 110, and administered Resident #40's midodrine contrary to the physicians' orders. A record review of Resident #60's admission record dated 3/25/2026 revealed an admission date of 6/16/2025 with a diagnosis of hypertension (high blood pressure.) A record review of Resident #60's quarterly MDS assessment dated [DATE] revealed Resident #60 was a [AGE] year-old female admitted for long term care with supports for ADL and high blood pressure. Resident #60 was assessed with a BIMS score of 14 out of a possible 15 which indicated intact cognition. A record review of Resident #60's physician's orders dated 3/25/2026, revealed on 11/21/2025 the physician prescribed for Resident #60 to receive hydralazine 10mg every 6 hours as needed for high blood pressure, give IF SBP is greater than 170. A record review of Resident #60's March 2026 medication administration record revealed:- On the morning of 3/3/2026 MA O recorded Resident #60's SBP as 178, greater than 170, and had not administered Resident #60's hydralazine as prescribed by the physician. - On the morning of 3/19/2026 MA O recorded Resident #60's SBP as 173, greater than 170, and had not administered Resident #60's hydralazine as prescribed by the physician. A record review of Resident #68's admission record dated 3/25/2026 revealed an admission date of 7/20/2025 with a diagnosis of hypertension (high blood pressure.) A record review of Resident #68's quarterly MDS assessment dated [DATE] revealed Resident #68 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 15 out of a possible 15 which indicated intact cognition. A record review of resident #68's physician's orders revealed on 12/19/2025 the physician prescribed for Resident #68 to receive hydralazine 25mg via her gastronomy tube, give 1 tablet via g-tube every 8 hours as needed for SBP greater than 160. A record review of Resident #68's March 2026 medication Administration record revealed:- On the morning of 3/11/2026 LVN L assessed Resident #68 with a SBP of 162, greater than 160, and had not administered Resident #68's hydralazine per the physician's orders. - On the evening of 3/11/2026 LVN L assessed Resident #68 with a SBP of 162, greater than 160, and had not administered Resident #68's hydralazine per the physician's orders. - On the morning of 3/19/2026 LVN L assessed Resident #68 with a SBP of 164, greater than 160, and had not administered Resident #68's hydralazine per the physician's orders. A record review of Resident #78's admission record dated 3/25/2026 revealed an admission date of 3/27/2025 with a diagnosis of hypertension (high blood pressure.) A record review of Resident #78's quarterly MDS assessment dated [DATE] revealed Resident #78 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 3 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #78's physician's orders dated 3/25/2026 revealed on 7/21/2025 the physician prescribed for Resident #78 to receive hydralazine 25mg as needed for high blood pressure, give 1 tablet by mouth every 6 hours as needed for high blood pressure greater than 170. A record review of Resident #78's March 2026 medication administration record revealed:- On the morning of 3/2/2026 MA P documented a SBP for Resident #78 as 173, greater than 170, and had not administered resident #78's hydralazine per the physician's orders.- On the morning of 3/3/2026 MA P documented a SBP for Resident #78 as 173, greater than 170, and had not administered resident #78's hydralazine per the physician's orders. During an interview on 3/25/20026 at 3:50 PM the Medical Director stated his expectation was for nursing staff to follow physicians' orders and if needed to call the physician and clarify the orders. During a joint interview on 3/25/2025 at 4:20 PM the Administrator and the Regional Clinical RN stated the policy, training, and the expectation was for nursing staff to administer medications by following physicians' orders and if needed to report to physicians and obtain order clarifications. A record review of the facility's undated policy Medication Administration (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and General Guidelines revealed, Medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices and only by persons legally authorized to do so. procedure: . Medications are administered at the time they are prepared medications are not pre poured. This person then records the administration on the residence medication administration record at the time the medication is given at the end of each medication passed the person administering the medication reviews the medication administration record to ascertain that all necessary doses were administered and documented . If a dose of regularly scheduled medication is withheld, refused, forgiven at other than the scheduled time, the physician must be notified.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon staff interview, review of medical records, and review of the policy, the facility failed to ensure each resident is screened for a Mental Disorder (MD) or Intellectual Disability (ID) prior to admission of 2 residents in the sample of 6 (Resident #4 and Resident #50) reviewed for Preadmission Screening and Resident Review (PASRR).The facility failed to ensure Resident #4 had an accurate PASRR Level 1 (PL1) Screening for mental disorder or intellectual disability prior to admission. The facility failed to ensure that Resident #50 had an accurate PASRR Level 1 Screening which indicated a diagnosis of mental illness. These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. The findings include: 1. Review of Resident #4's admission record, dated 03/25/2026, reflected a [AGE] year-old male. He was admitted on [DATE] and re-admitted on [DATE]. Review of Resident #4's diagnosis report dated 03/24/2026, reflected diagnoses which included schizophrenia, bipolar disorder, and vascular dementia. Review of Resident #4's quarterly Minimum Data Set (MDS) dated [DATE], reflected the resident had a BIMS score of 14, which indicated he was cognitively intact. The resident was mobile via wheelchair, required assistance with transfers, incontinence care, and opening food items. Resident #4's active diagnoses included bipolar disorder and schizophrenia, and he was taking antianxiety and antidepressant medications. Review of Resident #4's initial PASRR Level I (PL1) dated 04/25/2019 reflected a positive determination that there was evidence or an indicator this was an individual that had a mental Illness. A second PL1 Screening dated 04/26/2019 reflected a negative determination that there was no evidence or an indicator this was an individual that had a mental illness. A change of ownership prompted a PL1 Screening dated 08/24/2022 reflected a negative determination that there was no evidence or an indicator this was an individual that had a mental illness. The medical record did not contain PL1 Screening using the revised June 2023 pre-admission screening form. The medical record did not contain a PASRR level II evaluation prior to admission to the facility. Review of Resident #4's current care plan dated 03/19/2026 documented that the resident had an impaired cognitive function/dementia or impaired thought processes [related to] BIPOLAR DISORDER, UNSPECIFIED, VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE, SCHIZOPHRENIA, UNSPECIFIED. During an interview on 03/24/2026 at 6:08 p.m., the MDS LVN revealed that she submitted the CHOW PL1 on 8/24/2022 for Resident #4 and said dementia was his primary diagnoses and they do have evidence from a doctor that dementia is the primary diagnosis so his PL1 was negative and a PE was not required. She said she was trained to code Section C C0100. Mental Illness with No indicating there was no evidence or an indicator this was an individual that had a mental illness if the individual's primary diagnosis was dementia. The MDS LVN said she understood that if a PE was not completed on a resident the facility would not know if they would have qualified for PASRR services and it could be a concern for their care as the individual with a mental illness could receive additional mental health services. She said she was aware that Resident #4 was an individual with a mental illness, but his primary diagnosis was dementia, therefore requiring her to code question C0100. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mental Illness with No. The MDS LVN reviewed the former PL1 screening form, and it did not reflect if there was evidence that dementia was the primary diagnosis for Resident #4 as what was revised with the June 2023 Version 4.0 form. During an interview on 03/24/2026 6:54 p.m., the Regional MDS Nurse revealed that Resident #4's primary diagnosis was dementia, and they do have evidence from a doctor that dementia is the primary diagnosis and the mental illness diagnosis is secondary, therefore a PL1 would not be required. He said he has worked with PASRR for more than 20 years and knows how it works and said to the MDS LVN not to worry if there is a citation for non-compliance as it would not be an issue and would not pass enforcement. He said PASRR PL1 was completed for Resident #4 at admission and it was negative for PE. He said the former MDS LVN was good at her job and completed the screening correctly and was trained to omit the mental illness if dementia was a primary diagnosis. The Regional MDS Nurse said that the referring entity marked the initial 04/25/2019 PL1 incorrectly and coded that there is evidence or an indicator that Resident #4 had a mental illness but made the correction on the 04/26/2019 PL1 and coded there is no evidence or indicator that Resident #4 had a mental illness, despite a diagnosis of schizophrenia and bipolar disorder. The Regional MDS Nurse said he is aware the PASRR Level 1 Screening form was revised in June 2023; however, he did not believe Resident #4 required a new PL1 to reflect there is evidence that dementia is the primary diagnosis for this individual. He said the initial PL1 was sufficient to meet the pre-admission screening criteria. He said he understands the importance of providing residents with mental health services if they are evaluated and found eligible for services. During an interview on 03/25/2026 at 6:30 p.m., the Administrator said he was not well versed in PASRR but said he is working with his staff to ensure pre-admission screenings are completed for every resident admitted to the facility. He said he is working with the staff to ensure they are accurately screening residents as inaccurate screenings can be a concern with the services provided to a resident. 2. Record review of Resident #50's face sheet, dated 03/24/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included Schizophrenia (chronic, severe brain disorder affecting >1% of the population, causing hallucinations, delusions, and disorganized thinking), Huntington's Disease (fatal, inherited neurodegenerative disorder caused by a faulty dominant gene that causes progressive breakdown of nerve cells in the brain), Depression (common, serious mood disorder characterized by persistent sadness, loss of interest, fatigue and sleep/appetite changes), Anxiety (common, intense, and persistent fear or worry that interferes with daily life), Hydrocephalus (an accumulation of cerebrospinal fluid (CSF) within the brain's ventricles, causing increased pressure , tissue damage, and potential long-term developmental issues),and Altered Mental Status (broad term for any, often sudden, change in brain function, including confusion, decreased alertness, agitation, or hallucinations). Record review of Resident #50's admission MDS, dated [DATE], revealed diagnoses which included schizophrenia and a BIMS level of 02. Record review of Resident #50's care plan, dated 03/22/2026, revealed the resident took an anti-psychotic medication for schizophrenia. The care plan also reflected that Resident # 50 took an anti-anxiety medication for anxiety, an anti-depressant for depression, and had impaired cognitive function or impaired thought processes related to Huntington's disease. Record review of Resident #50's admission paperwork from the referring facility, dated 02/15/2026, (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed a list of diagnoses and medical history to include schizophrenia. Record review of Resident #50's Level 1 PASRR screening that was completed by the referring entity, completed on 02/23/2026, indicated in section C0100 that there was no evidence of this individual having a mental illness. Record review of Resident #50's clinical chart, dated 03/24/2026, revealed under the Miscellaneous Chart tab, where uploaded clinical documentation from outside entities is saved, that there was not a secondary Level 1 PASRR assessment by the facility to confirm that the resident's Level 1 PASRR was accurately marked as negative despite the diagnosis in the clinical assessment data received by the facility from the referring entity. [NAME] review of a PASRR facility policy dated 03/06/2019 revealed facility stance of reviewing the PL1 Screening Form for completion and correctness prior to admission and submit the PL1 form per regulations. During an interview on 03/24/2026 at 10:37 am the MDS LVN stated that Resident #50's PL1 was marked negative and that she did not double check the PL1 against what the hospital sent to verify accuracy. The MDS LVN was unsure of the protocol verifying the accuracy of the PL1 that the referring entity filled out. The surveyor asked the MDS LVN if there was a reason why, despite having an approved diagnosis for a positive PL1 Resident #50 may have been marked negative in section C0100 and the MDS LVN replied that a primary diagnosis of dementia cancels out the mental illness diagnosis. The surveyor asked the MDS LVN what Resident #50's primary diagnosis was and MDS LVN revealed that the primary diagnosis for Resident #50 was Huntington's Disease. The surveyor asked the MDS LVN if Huntington's Disease would affect the PL1 outcome and MDS LVN revealed that it should not. During an interview with the MDS LVN on 03/24/2026 at 2:35 pm it was revealed that the facility submitted a positive PL1 for Resident #50 into the database and was awaiting the Local Authority to schedule a day and time for a PASRR Evaluation for Resident #50. The MDS LVN felt that since it had not a full 30 days after admission into the facility Resident #50 not having the positive PL1 should not be a problem. The surveyor asked the MDS LVN if a policy for the facility had the 30 days listed as the window of time to provide a correct PL1 for any resident admitting to the facility. The MDS LVN stated that she would have to verify the facility policy for PL1's. During an interview with the Regional MDS Nurse on 03/24/2026 at 09:08 am, the Regional MDS Nurse stated that Resident #50's PL'1 is to be entered into the system as it was written by the referring entity. The Regional MDS Nurse stated that MDS LVN completed their job correctly. The surveyor asked the Regional MDS Nurse when does the facility verify the correctness of the PL1 submitted to the facility and the Regional MDS Nurse stated that the facility would do a correction when a new qualifying diagnosis was presented or diagnosed. The surveyor asked the Regional MDS Nurse what happens if the referring entity's paperwork lists the qualifying diagnosis and was submitted to the facility before Resident #50's admission for review for admission to facility. The Regional MDS Nurse stated that they just enter what referring entity marks. The surveyor mentioned that the PASRR policy for the facility reflected that the facility will enter the PL1 Screening Form exactly as written except for corrections to identifying data and that the facility is required to review the submitted PL1 for accuracy per their policy. The Regional MDS Nurse stated that they would need to review the facility policy due to not being sure about 'correcting' the referring entities submitted PL1. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document, Documentation undated reflected: Goal 1. The facility will maintain complete and accurate documentation for each resident. Procedure 2. Review documents to determine need for follow-up monitoring. Review of PASRR Level 1 (PL1) Screening Form, June 2023, Version 4.0 reflected: Section C. C0090. Primary Diagnosis of Dementia.Is there evidence that dementia is the primary diagnosis for this individual? C0100. Mental Illness. Is there evidence or an indicator this is an individual that has a Mental Illness? C0200. Intellectual Disability. Is there evidence or an indicator this is an individual that has an intellectual Disability? C0300. Developmental Disability. Is there evidence or an indicator that this is an individual that has a Developmental Disability (Related Condition) other than an Intellectual Disability? Review of PASRR Level 1 Screening, July, 2021, V.3 form reflected: Section C C0100. Mental Illness. Is there evidence or an indicator this is an individual that has a Mental Illness? C0200. Intellectual Disability. Is there evidence or an indicator this is an individual that has an intellectual Disability? C0300. Developmental Disability.Is there evidence or an indicator that this is an individual that has a Developmental Disability (Related Condition) other than an Intellectual Disability? Review of the facility document, PASRR Level 1 Screen Policy and Procedure dated 3-6-2019 reflected: PASRR Program has 3 Goals: 1. To identify individuals with MI, ID, or DD/RC.3. The Facility will review the PL1 Screening Form for completion and correctness prior to admission and submit the PL1 form per regulations.

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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 observations, interviews, and record reviews the facility failed to provide pharmaceutical services which included procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident, for 2 of 8 residents (Residents #51 and #94) reviewed for administration and documentation of medications. On 3/24/2026 at 7:34 AM LVN C said she had administered Resident #51's medications but had not documented the administration.On 3/24/2026 at 7:34 AM LVN C said she had administered Resident #94's medications but had not documented the administration. These failures could place residents at risk for not receiving the therapeutic effects of their medications.The findings include: A record review of Resident #51's admission record dated 3/24/2026 revealed an admission date of 1/24/2026 with diagnoses which included chronic obstructive disease (a progressive, incurable lung disease-primarily caused by smoking-that obstructs airflow, causing severe breathing difficulties, persistent cough, and fatigue), Tracheostomy (a surgical procedure that creates an opening in the neck and directly into the trachea (windpipe) to create a secure, alternative airway), and a gastronomy tube (a medical device surgically inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications.) A record review of Resident #51's quarterly MDS assessment dated [DATE] revealed resident #51 was a [AGE] year-old female admitted for long term care related to her needs for a tracheotomy supported by a ventilator (This setup provides long-term, secure breathing support for patients unable to breathe adequately on their own due to chronic conditions, neuromuscular disorders, or severe injuries.) Resident #51 was assessed with unclear speech complicated by the tracheostomy and a BIMS score of 6 which indicated severe cognitive impairment. A record review of Resident #51's care plan dated 3/25/2026 revealed, The resident has congestive heart failure . Give cardiac medications as ordered . The resident has emphysema COPD chronic obstructive pulmonary disease . Give aerosol or bronchodilators as ordered . The resident has hypertension . give antihypertensive medications as ordered. The resident is on enhanced barrier precautions . gloves and gowns should be donned (to put on PPE) if any of the following activities are to occur: . Enteral feeding (tube feeding or enteral nutrition, is a method of delivering nutrients directly into the stomach or small intestine when a person cannot eat enough by mouth) care . tracheostomy care . high level contact . chronic pain syndrome osteoarthritis of the knee bilateral (both knees) . The resident uses anti-anxiety medications . administer anti-anxiety medications as prescribed by the physician. A record review of Resident #51's physicians' orders dated 3/25/2026 revealed Resident #51 was prescribed to receive the following medications, by her gastronomy tube, every morning:Cyanocobalamin 1000mgFurosemide 20mgEmpagliflozin 10mgMultivitaminPantoprazole 40 mgSpironolactone 25mgThiamine 100mgAspirin 81mgBuspirone 10mgMetoprolol 25mgQuetiapine 25mgCalcium carbonate 500mg A record review of Resident #94's admission record dated 3/25/2026 revealed an admission date of 3/9/2025 with diagnoses which included spastic quadriplegic cerebral palsy (a group of permanent movement disorders appearing in early childhood, caused by abnormal brain development or damage to the developing brain the most severe form of cerebral palsy, resulting from brain injury before, during, or shortly after birth), tracheostomy and gastronomy tube. A record review of Resident #94's quarterly MDS assessment dated [DATE] revealed resident #94 was a [AGE] year-old male admitted for long term care related to her needs for a tracheotomy supported by a ventilator (This setup provides long-term, secure breathing support for patients unable to breathe adequately on their own due to chronic conditions, neuromuscular disorders, or severe injuries.) Resident #94 was assessed with unclear speech complicated by the tracheostomy and a BIMS score of 99 which indicated Resident #94 could not complete the interview. A record review of Resident #94's care plan dated 3/25/2026 revealed, (Resident #94) has seizure disorder . Give medications as (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered . Resident #94 has Multiple sclerosis . give medications as ordered . Is fungal related skin condition . give medications as ordered . is on enhanced barrier precautions . gloves and gowns should be donned if any of the following activities are to occur: . Enteral feeding care . tracheostomy care . high level contact . A record review of Resident #94's physicians' orders dated 3/25/2026 revealed Resident #94 was prescribed to receive the following medications, by her gastronomy tube, every morning:Carbamazepine 100mg/ml give 10mlCholecalciferol 100 unitsFamotidine 40mgAscorbic acid 500mgClonazepam 1mgUTI stat 30mlLactulose 20g/ml give 30mlOxybutynin 5mg-And apply to face - Triamcinolone acetonide cream. During an observation and interview on 3/24/2026 at 7:34 AM revealed LVN C was at the end of the 400-hall at her medication cart documenting on her computer. LVN C stated she had arrived for work this morning at 6:00 AM, received report from the previous nurse, and had assumed resident care. LVN C stated she was assigned to care for 10 residents from room [ROOM NUMBER] to room [ROOM NUMBER] which included Resident #51 and Resident #94. LVN C stated she was finished with her morning medication administration. LVN C stated she had administered medications via gastronomy tubes to all 10 residents within an hour and a half. LVN C stated she was currently documenting her medication administration on residents' medication administration records. LVN C stated she had yet to document Residents #51 and #94. LVN C stated she had already assessed Resident #51's blood sugar, and administered her medications which included:FurosemideEmpagliflozinAspirinCalcium carbonatePantoprazoleAnd vitamins.LVN C stated she had assessed Resident #91's blood sugar and had administered Resident #94 medications via his gastronomy tube and had not yet documented the medication administration in Resident #94's medication administration record. LVN C stated Resident #94's medications included:ClonazepamOxybutyninFamotidineVitamin cCarbamazepineVitamin dUTI stat LVN C stated she had documented her medication administration for all of her 10 residents and stated the procedure was accepted by professional standards. LVN C stated she was fast and usually completed all her medication administration which included donning and doffing PPE, assessing residents for blood sugar levels, applying topical creams, flushing indwelling urinary catheters, and administering gastronomy tube medications in an hour and a half. During an interview on 3/25/2026 at 4:00 PM the Regional Clinical RN stated the policy, training, and professional standard for medication administration was for all nurses to follow physicians' orders and administer medications and treatments and then to immediately document the medication administration for each individual resident. The Regional Clinical RN stated the practice of signing for all residents after multiple medication administrations could be the residents may not receive the therapeutic effects of their prescribed medications. A record review of the facility's undated policy Medication Administration and General Guidelines revealed, Medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices and only by persons legally authorized to do so. procedure: . Medications are administered at the time they are prepared medications are not pre poured. This person then records the administration on the residence medication administration record at the time the medication is given at the end of each medication passed the person administering the medication reviews the medication administration record to ascertain that all necessary doses were administered and documented . If a dose of regularly scheduled medication is withheld, refused, forgiven at other than the scheduled time, the physician must be notified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews the facility failed to ensure all drugs and biologicals were locked in compartments under proper temperature controls and permitted only authorized personnel to have access to the keys, for 1 of 6 medication carts (the 400-hall medication cart) reviewed for security. LVN A left the 400-hall medication cart unsupervised, unattended, and unlocked for more than 9 minutes. This failure could place residents at risk for misappropriation of property and or not receiving the therapeutic effects of their medications.The findings include: During an observation on 3/22/2025 at 9:35 AM revealed the 400-hall medication cart stationed at the end of the 400-hall. The 400-hall was occupied by more than 14 residents. The medication cart was unattended, unsupervised, and unlocked and the drawers were facing out towards the hall. During an observation and interview on 3/22/2026 at 9:44 AM revealed LVN A returned with PPE supplies and recognized she had left her cart unlocked and proceeded to lock the cart. LVN A stated she went to the 200-hall supply room to retrieve PPE supplies and could not see her cart from the 200-hall. LVN A stated she left her cart unlocked and knew she should have locked her cart. LVN A stated medications, such as high blood pressure, insulins and others, could have been taken out of the cart by not locking the cart. During a joint interview on 3/25/2026 at 4:24 PM the Administrator and the Regional Clinical RN stated the policy, training, and expectations were for all nursing staff to secure their medication carts when not in use and whenever the nurse needed to be away from the cart. The Regional Clinic RN stated the potential negative outcome could be the loss of secured medications. A record review of the facility's undated Medication Administration and General Guidelines policy revealed, Medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices and only by persons legally authorized to do so. procedure: . when administering as needed medications at times other than medication pass, the dose may be prepared in the medication cart storage area and taken to the residence bedside, leaving the cart locked and secured.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 resident in the sample of 6 (Resident #4) reviewed for clinical records. The facility failed to ensure Resident #4's schizophrenia and bipolar disorder diagnosis was accurately documented in his medical diagnosis list and MDS Assessment. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records.The findings include:Review of Resident #4's admission record, dated 03/25/2026, reflected a [AGE] year-old male. He was admitted on [DATE] and re-admitted on [DATE].Review of Resident #4's diagnosis report dated 03/24/2026, reflected diagnoses which included schizophrenia, bipolar disorder, and vascular dementia. Further review of Resident #4's diagnosis report reflected 08/18/2018 bipolar disorder and Schizophrenia, unspecified onset, 04/25/2019, move-in dx [history] vascular dementia onset 9/23/2022, and primary of unspecified dementia, onset 09/23/2022. Review of Resident #4's quarterly Minimum Data Set (MDS) dated [DATE], reflected the resident had a BIMS score of 14, which indicated he was cognitively intact. Resident #4's active diagnoses included bipolar disorder and schizophrenia, and he was taking antianxiety, antidepressant, diuretic, and opioid medications.Review of Resident #4's current care plan dated 03/19/2026 revealed that the resident had an impaired cognitive function/dementia or impaired thought processes [related to] BIPOLAR DISORDER, UNSPECIFIED, VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE, SCHIZOPHRENIA, UNSPECIFIED. Further review of Resident #4's care plan revealed it did not include PASRR services. Review of Resident #4's initial PASRR Level I (PL1) dated 04/25/2019 reflected a positive determination that there was evidence or an indicator this is an individual that has a mental Illness. A second PL1 Screening dated 04/26/2019 reflected a negative determination that there was no evidence or an indicator this is an individual that has a mental illness. A change of ownership prompted PL1 Screening dated 08/24/2022 reflected a negative determination that there was no evidence or an indicator this is an individual that has a mental illness. The medical record did not contain PL1 Screening using the revised June 2023 pre-admission screening form. The medical record did not contain a PASRR level II evaluation prior to admission to the facility.During an interview on 03/24/2026 6:54 p.m., the Regional MDS Nurse revealed that in January of 2023 the facility underwent a transition and was required to have a thorough assessment for schizophrenia conducted by the Local Authority (LA) before it could be a valid diagnosis. He said once Resident #4's schizophrenia diagnosis was validated by the LA the diagnosis report was updated to include the valid diagnosis. He added that Resident #4's medical diagnosis report was inaccurate for a brief period (August 2024 - December 2025) but had since been corrected with the quarterly Minimum Data Set (MDS) dated [DATE] The Regional MDS Nurse said it was important for medical records to reflect accurate information including diagnosis to provide the best possible care for each resident.During an interview on 03/25/2026 at 6:30 p.m., the Administrator said he was working with the staff to ensure they were accurately documenting medical records as inaccurate records could cause concerns with the services provided to a resident. Review of the facility document, Documentation undated reflected: Documentation is the recording of all infom1ation, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident repo1ts, and summary sheets (daily, weekly, monthly, discharge). Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.

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F 0919 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that each resident room marked as available for new residents was adequately equipped to allow new residents to call for staff assistance through a communication system that would relay the call directly to a staff member or centralized staff work area for one room (215) of four observed that had a welcome sign and future resident listed outside of room.The facility failed on 3/22/2026 to ensure that the call light system was properly working for potential new resident rooms for room [ROOM NUMBER]. The call light box was hanging from the wall.This failure could place new residents at risk of not having a means of directly contacting staff in an emergency or when they needed support for daily living.Findings included:During an observation on 3/22/2026 at 10:23 am on the 200 hall revealed that the call light for room [ROOM NUMBER] was activated, as evidenced by the light flashing outside of the room door in the hallway. The surveyor did not hear the call light ringing at the nurse's station. The surveyor walked to nurses station and approached the nurse call light panel behind the nurses station to locate room [ROOM NUMBER] on the panel. The surveyor observed no light on the panel for room [ROOM NUMBER], as well as no ringing sound. A light for another room on 100 hall lit up and the panel began to ring. During an interview on 3/22/2026 at 10:25 am with LVN C, LVN C stated the nurse call light panel lit up and rang when a resident pushed their call light. The surveyor asked LVN C if the panel acknowledged that the call light in room [ROOM NUMBER] was activated. LVN C looked at the nurse call light panel and stated that the panel was not activated for that room. The surveyor asked LVN C why the light above the door to room [ROOM NUMBER] was lit and flashing if the call panel indicated that the call light was not activated. LVN C revealed that she did not have an answer.During an observation on 3/22/2026 at 10:26 am at the nurses station the surveyor witnessed LVN C leave the nurses station and walk to the200 hall. The surveyor observed that another LVN, LVN B, had started walking down the 200 hall when the surveyor was asking LVN C about the call light panel. At 10:30 am LVN B was exiting room [ROOM NUMBER] and called to LVN C that the room was empty and housekeeping was in there and had activated the light but now could not turn it off. LVN C proceeded to initiate a work order for the call light, expressing thankfulness that teh room was empty.During an observation on 3/22/2026 at 10:31 am the surveyor entered room [ROOM NUMBER] and observed the call light box hanging from the wall, connected by the wires only. Both call lights were plugged into the call light box. During an interview on 3/22/2026 at 10:32 am with Housekeeper K, Housekeeper K stated that she did clean the 200 hall. Housekeeper K stated that she was also responsible for cleaning the empty rooms, however housekeeper K had not entered room [ROOM NUMBER] on 3/22/2026 as of yet. When asked Housekeeper K stated that she was unaware that the light was going off as she had not heard the ringing to prompt her to look up at doorways.Interview on 3/22/2026 at 12:45 am with the Administrator revealed that the beds listed on Bed Classification report showed available beds.Record review of the 3740, Bed Classification form dated 3/22/2026 revealed that room [ROOM NUMBER], both bed A and bed B, were reported on form as ready for move-in.