STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676308	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Rehabilitation and Care Center	4100 College Park Dr Round Rock, TX 78665

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 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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 10 residents (Resident #44, and Resident #68) reviewed for rights. The facility failed to ensure LVN A and CNA B knocked on Resident #44, and Resident #68's doors when going into the residents' rooms. The deficient practice could place residents at risk of feeling like their privacy was being invaded or the facility was not their home. Findings included: Resident #44 Review of Resident #44's Face Sheet dated 07/16/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #44's diagnoses included chronic pain, constipation, depression, insomnia (difficulty sleeping), hypertension (high blood pressure), muscle weakness, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), lack of coordination, and anxiety (feeling of uneasiness or worry), cognitive communication deficit problems with communication), abnormalities of gait and mobility, pain in left hand, metabolic encephalopathy (brain disease), nausea with vomiting, hemiplegia (paralyzed on one side) and protein-calorie malnutrition (inadequate intake of both protein and calories). Record review of Resident #44's Quarterly MDS assessment dated [DATE] revealed Resident #36 had a BIMS score of 11 indicating moderate impairment. Resident #68 Review of Resident #68's Face Sheet dated 07/16/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #68's diagnoses included dysuria (painful or uncomfortable urination), anxiety (feeling of uneasiness or worry), hyperlipidemia (high cholesterol), muscle wasting, obesity, muscle weakness, obstructive pulmonary disease (chronic progressive lung disease), gastroesophageal reflux disease without esophagitis (reflux), and dementia (memory, thinking, difficulty). Record review of Resident #68's Quarterly MDS assessment dated [DATE] revealed Resident #68 had a BIMS score of 12 indicating moderate impairment. Observation of the 100-hall meal tray pass on 07/15/2025 at 11:59 a.m., revealed that CNA G did not knock on Resident #44's door before entering the room. Observation of the 100-hall meal tray pass on 07/15/2025 at 12:03 p.m., revealed that CNA G did not knock on Resident #68's door before entering the room. During an interview with Resident #68 on 07/15/2025 at 2:14 p.m., revealed sometimes staff did knock and sometimes staff did not knock. She said that she would like for the staff to knock all the time. She said that she did get upset when staff did not knock because there were times, she was doing something that she did not want staff to see. She also said that she got upset when staff did not knock, and she was not properly dressed. During an attempted interview with Resident #44 on 07/17/2025 at 10:24 a.m., revealed that he did not want to talk to the surveyor. During an interview with LVN A on 04/30/2025 at 10:57 a.m., she said she had been trained on residents' rights. She said the policy for knocking was that staff were supposed to always knock before entering, introduce themselves and explain to the resident what they were going to do. She said that all staff were required to knock before entering the resident's room. She said that there was no time that the staff should not knock before entering. She said if staff did not knock, the resident may feel like staff do not respect them. She said that all staff monitored to ensure staff were knocking on the residents' doors. She said that staff monitored by observations. She said she was not aware that CNA G was not knocking on the resident's room. During an interview with CNA G on 07/16/2025 at 1:34pm revealed that she had been trained on residents' rights. She said the policy for knocking on the resident's door was to knock, introduce themselves and tell the resident what they were there for. She said staff were supposed to knock all the time before entering the resident's room. She said that the residents may feel uncomfortable if staff did not knock. She said knocking was something that should always be done. She said there was not any time that staff did not have to knock before entering. She said the nurses were responsible for ensuring staff were knocking. She the nurses watch and listen and if the staff are not doing something correctly, the nurse will correct the staff. She said she did not realize that she did not knock on Resident #44 and Resident #68's doors. During an interview on 07/17/2025 at 2:20pm with LVN B revealed that she had been trained on residents' rights. She said that the policy for knocking on the door was staff should knock before entering. She also said that staff were to let the resident know that staff were coming into their home. She said everyone should always knock before entering the room. She said that the resident may feel like staff were not respecting their home. She said the only time staff did not have to knock was in an emergency. She said all staff should be monitoring each other through observations. She said she thought staff did not knock because they were not reminded to knock

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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 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for 2 of 10 residents (Resident #49 and Resident #67) reviewed for environment. The facility failed to ensure Resident #49 and Resident #67's room was in good repair and free of holes in the walls. This failure could affect any resident and place them at risk for not having a sanitary homelike environment. Findings included: Resident #49 Review of Resident #49's Face Sheet dated 07/16//2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #49's diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental function), breast cancer, swimmers ear (infection in the outer ear canal), urinary tract infection, hyperlipidemia (high cholesterol), protein-calorie malnutrition (inadequate intake of both protein and calories), anxiety (feeling of uneasiness or worry), hypothyroidism (excessive production of thyroid hormones), chronic pain, dry eye, glaucoma (eye disease), and gastroesophageal reflux disease without esophagitis (reflux). Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed Resident #49 had a BIMS score of 07 indicating severe cognitive impairment. Resident #67 Review of Resident #67's Face Sheet dated 07/16//2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #67's diagnoses included glaucoma (eye disease), hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), vision loss, anemia (not enough healthy red blood cells), muscle weakness, depression, cognitive communication deficit (problems with communication), hypothyroidism (excessive production of thyroid hormones), hyperlipidemia (high cholesterol), hypertension (high blood pressure), Record review of Resident #67's Quarterly MDS assessment dated [DATE] revealed Resident #67 had a BIMS score of 12 indicating moderate impairment. Observation on Resident #67's room on 07/15/2025 at 2:19 p.m., revealed the walls in the room were a bluish gray color. On the wall behind Resident #67's head of the bed there were two parallel holes in the wall (like from moving the bed up and down). The wall across from Resident #67's bed had white paint spots. Observation of Resident #49's room on 07/16/2025 at 10:41 a.m., revealed the walls in the room were a bluish gray color. On the wall by the bathroom door appeared to have been repaired from a hole in the wall. The wall was still white and not the same color as the rest of the wall. The wall next to Resident #49's dresser had eight areas that had white paint spots on the wall. On the wall on the other side of the bathroom had five areas that had white paint spots. During an interview with Resident #67 on 7/16/2025 at 8:27 a.m., revealed that his walls had been with paint spots on them since he moved in. He said it did not feel homelike and that he wish they would fix it. During an interview with Resident #49 on 07/16/2025 at 10:41am revealed that her wall had been patched up without being repainted since she had gotten to the facility. She said that she was losing her eyesight and was not able to see the walls. During an interview with MAIN on 07/16/2025 at 4:21pm revealed he had been trained on residents' rights and homelike environment. He said he was responsible for repairing residents' rooms. He said if a resident's room needed repairs, he could move the resident into a different room. He said when the repairs were done, he could move the resident back into the room. He said the repairs usually took a day. He said that he would consider the room homelike if the room had holes in the wall or paint spots. He said he never had a complaint about the walls. He said that he may have started on the room and then the facility must have gotten a new admit. He said after seeing the way the walls were in Resident #49 and Resident #67's rooms, that he would not consider the rooms to be homelike. He said that the guardian angels (management) did rounds every day and put in a work order if rooms needed to be repaired. He said no one had put in a work order for Resident #49 and Resident #67's room. He said the residents may feel like their room was not completed. He said some residents don't want to move for the repairs to be done. He also said if a resident did not want to move it would be documented. He said he could not recall if anyone was in the room or if he told the ADM that the room was not done before the residents were moved in. He also said that he will get to Resident #49 and Resident #67's rooms one day. During an interview with CNA G on 07/17/2025 at 1:42pm revealed that she had been trained on residents' rights. She said that the policy was that residents' rooms were to feel like home and in good repair. She said everyone played a part in making a resident's room homelike. She said if something was broken or messed up in the room staff were to report it to the nurse, and DON and they would get with MAIN. She said that MAIN was responsible for making sure there were no holes in the wall and that the paint was not spotty

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from any physical restraints imposed for purposes of convenience and not required to treat the resident's medical symptoms for 3 (Residents #7, Residents #12, and Resident #95) of 5 residents reviewed for restraints. The facility failed to ensure that restraints were not used on Residents #7, Residents #12, and Resident #95's bed. This failure could result in residents having physical restraints used that limited their movement without being evaluated for the medical need. Findings include: Resident #7 Record review of Resident #7's face sheet dated 07/16/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental function), metabolic encephalopathy (brain disease), dementia (memory, thinking, difficulty), dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), urinary tract infection, altered mental status, cognitive communication deficit (problems with communication), repeated falls, muscle weakness, abnormalities of gait and mobility, functional quadriplegia (paralyzed not due to spine or brain injury), cerebral infraction (stroke), and breast cancer. Record review of Resident #7's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 05 indicating severe cognitive impairment. The MDS also indicated Resident #7 was dependent for bed mobility and marked as not applicable for transfers. The MDS did not have anything regarding restraints or bed rails. Record review of Resident #7's Care Plan dated 02/19/2025 revealed that Resident #7 was at risk for falls due to significant deficits in both functional ability and cognition. Approaches were encourage use of environmental devices such as hand grips, handrails, and safe transfer techniques. Bed rails were not on the care plan. Observation of Resident #7 on 07/16/2025 at 4:00 p.m., revealed Resident #7 was in her bed with her bed in the low position and the 1/2 bed rails were in use on both sides of the bed. During an interview with Resident #7 on 07/16/2025 at 4:02 p.m., revealed that she did not know why staff were using the side rails on her bed. The resident asked the surveyor why they were using the rails. She said that she could not get out of bed when the side rails were in use on her bed. She said that she might fall if she tried to get up with the rails in use. She also said she did not know how long the facility had been using the rails on her bed. When asked how she felt about the side rails being used, the resident said she wanted a peanut butter sandwich. Record review of Resident #7's Orders dated 07/10/2025 revealed that there were no orders for the 1/2 bed rails. Record review of Resident #7's Side Rail assessment dated [DATE] revealed that Resident #7 was total dependent on bed mobility and transfers. The assessment also said that the side rails posed a risk of depression, incontinence, agitation, and confusion. The box next to Resident requires/requests the use of siderails. Monitor every 30 minutes and release and reposition every two hours and PRN for toileting and/or repositing was not checked. The side rail type was marked for 1/2. The assessment also revealed that the reason for side rails was for bed mobility. Resident #12 Record review of Resident #12's face sheet dated 07/16/2025 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including anxiety (feeling of uneasiness or worry), constipation, shortness of breath, nausea with vomiting, fever, and disturbances of salivary secretion (issue with production or flow of saliva). Record review of Resident #12's Quarterly MDS assessment dated [DATE] reflected a BIMS score was not entered. The MDS also indicated Resident #12's bed mobility and transfers were not indicated. Staff revealed that Resident #12 was unable to communicate, and bed bound. The MDS did not have anything about bed rails or restraints. Record Review of Resident #12's Care Plan dated 07/11/2025 revealed that Resident #12 was at risk for falls due to significant deficits in both functional ability and cognition. Approaches were encourage use of call light, orient to room and safety devices. Bed rails were not on the care plan. Observation of Resident #12 on 07/16/2025 11:25 a.m., revealed Resident #12 was in his bed with both 1/2 side rails in use on both sides of his bed. Observation of Resident #12 on 07/16/2025 1:22 p.m., revealed Resident #12 was in his bed with both side rails in use on both sides of his bed. An interview was attempted with Resident #12 on 07/16/2025 at 1:23 p.m., but the resident was not able to communicate with the surveyor. Record review of Resident #12's Orders dated 07/16/2025 revealed that there were no orders for the 1/2 bed rails. Record review of Resident #12's Side Rail assessment dated [DATE] revealed that Resident #12 was total dependent for n bed mobility and transfers. The assessment also reflected the side rails posed a risk of incontinence, decreased mobility, constipation, and agitation. The box next to Resident requires/requests the use of siderails. Monitor every 30 minutes and release and

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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 on interview and record review, the facility failed to provide accurate PASRR screenings for individuals with a mental disorder for 1 (Resident #4) of 2 residents reviewed for PASRR. The facility failed to complete an accurate PASRR level one screening after Resident #4 was admitted with a negative PASRR Level 1 screening but had a mental illness. This failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included: Record review of Resident #4's quarterly MDS assessment, dated June 05, 2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses of Psychotic disorder with hallucinations due to known physiological condition (mental disorder where hallucinations are directly caused by a medical condition affecting the brain) and Depression. Her BIMS score was a 14 which indicated intact cognitive response. Record review of Resident #4's care plan dated last revised 06/19/2025 reflected the resident was on a psychotropic drug due to receiving antipsychotic medication for treatment of psychotic disorder with hallucinations. Record review of Resident #4's PASRR Level 1 screening, dated 08/31/2023 conducted by the hospital doctor, reflected Resident #4 was negative for mental illness, intellectual disability, and developmental disability. Interview on 07/17/25 at 12:45PM with the ADM revealed that she had been the ADM for the facility for 7 months. The ADM stated that a positive Level 1 PASRR could be from intellectual disability and mental illness. ADM reviewed Resident #4's diagnoses and reported that the resident should have a PASRR 2 screening completed. ADM stated that the resident could be negatively impacted by the resident not receiving the services she was eligible for. Interview on 07/17/25 at 1:00PM, with MDS Coordinator A revealed she had been the MDS coordinator for the facility for 2 years. MDSC A stated that a mental illness, intellectual disability and developmental disability would result in a positive Level 1 PASRR screening. If a resident had a positive Level 1 PASRR screening, it would lead to a screening of a Level 2 PASRR screening. MDSC A stated that Resident #4's diagnoses of behavioral issues and depression, should have resulted in a positive Level 1 PASRR. MDSC A stated that Resident #1's primary diagnosis was Vascular Dementia but had been changed due to readmittance into the facility. Interview on 07/17/2025 at 3:30PM with the DON revealed that she had been the DON at the facility for 7 years. The DON stated that positive Level 1 PASRR could be from intellectual disabilities and a diagnosis like schizophrenia. The DON stated Resident #4 having a diagnosis of psychotic disorder would result in a Positive Level 1 PASRR. The DON stated that could negatively impact the resident by the resident not receiving the services that she was eligible for. Review of the facility's PASRR policy dated last revised 11/01/2017 revealed This policy is intended as a general guide for the PASRR process. Each facility develops a process for completion of the PASRR requirements as indicated by state specific policy and procedures. This document revealed the following:1. If the Level 1 PASRR screening indicates the individual may have an ID, DD or MI diagnosis, follow the state-specific process for completion of the Level II evaluation. 2. Mental Disorder: is the equivalent to Mental illness, which states an individual is considered to have a serious mental illness if the individual meets the following requirements on diagnosis, level of impairment and duration of illness.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for two (Resident #53 and Resident #67) of ten residents reviewed for ADL care. The facility failed provide Resident #53 and Resident #67 with showers and brushing their teeth. This deficient practice could place residents at risk of a decline in their sense of well-being and level of satisfaction with life. Resident #53 Review of Resident #53's face sheet reflected a [AGE] year-old male re-admitted on [DATE] with initial admission date of 09/26/2024 with diagnoses of Neurocognitive disorder with Lewy bodies (is a medical condition that leads to a progressive decline in cognitive function, affecting memory, attention, and visual perception, need for assistance with personal care, acute respiratory (medical condition that can significantly impact breathing and overall health), muscle weakness (generalized), cognitive communication deficit (medical condition referring to difficulties in communication that arise from impaired cognitive functions, such as attention, memory, reasoning, and problem-solving), depressive episodes (medical condition characterized by persistent sadness, fatigue, and a loss of interest in activities), and Parkinson's disease (is a movement disorder of the nervous system that worsens over time). Review of Resident #53's MDS dated [DATE] reflected a BIMS of 09 and had an active diagnosis of hemiplegia (a medical condition that involves weakness or reduced strength on one side of the body) or hemiparesis (a medical condition characterized by complete paralysis on one side of the body) and Parkinson's disease (is a movement disorder of the nervous system that worsens over time) and requires extensive assistance with Activities of Daily Living (ADL). Review of Resident #53's Care Plan dated 05/14/2025 reflected Resident #53 has impaired functional mobility and requires assistance with ADLs. Further review reflected the goal for Resident #53 is to be clean, dressed appropriately to weather, participate to preferred activities, and stable weight for 90 days. The approach to meeting Care Plan goal was to assess Resident #53's degree of functional impairment and assist with ADLs based on the current level of mobility. Review of Resident #53's Point of Care History Report dated 6/20/2025 - 7/17/2025 reflected staff enter Showers in this system when giving showers. No documented evidence the resident received showers for the following days: 6/28/2025 Activity did not occur. 6/29/2025 Activity did not occur.6/30/2025 Activity did not occur.7/01/2025 Activity did not occur.7/08/2025 Activity did not occur.7/09/2025 Activity did not occur.7/10/2025 Activity did not occur Resident #67 Review of Resident #67's face sheet reflected a [AGE] year-old male with admission date of 03/11/2025 with diagnoses of Unspecified glaucoma (a medical eye condition that can lead to optic nerve damage, resulting in vision loss or blindness) Hypertensive heart disease with heart failure (a medical condition that arise due to chronic high blood pressure), Unqualified visual loss, both eyes, depression, unspecified, muscle weakness, age-related osteoporosis without current pathological fracture, shortness of breath, cognitive communication deficit (refers to difficulties in communication that arise from impaired cognitive functions, such as attention, memory, reasoning, and problem-solving), type 2 diabetes mellitus without complications. Review of Resident #67's MDS dated [DATE] reflected a BIMS of 12 with active diagnoses of medically complex conditions, heart failure, hypertension, rental insufficiency (poor kidney function), renal failure, or End-Stage Rental Disease (ESRD), Diabetes Mellitus (DM), and hyperlipidemia. Further review reflected Resident #67 required substantial/maximal assistance for toilet transfer and tub/shower transfer, oral hygiene, and personal hygiene. There was no documentation of oral hygiene in the Review of Resident #67's Care Plan dated 07/02/2025 reflected Resident #67 has impaired functional mobility and vision impairment and requires assistance with ADL's. The care plan goal was Resident #67's will be clean, dressed appropriately to weather, participate to preferred activities, and stable weight for 90 days. To approach goal facility would assess Resident #67's degree of functional impairment. There was no documentation of oral hygiene in the care plan. Review of Resident #67's Point of Care History Report dated 6/20/2025 - 7/17/ staff enter Showers in this system when giving showers reflected no documented evidence the resident received showers for the following days: 6/20/2025 Activity did not occur. 6/21/2025 Activity did not occur.6/22/2025 Activity did not occur.6/23/2025 Activity did not occur.6/24/2025 Activity did not occur.6/25/2025 Activity did not occur.6/26/2025 Activity did not occur.6/27/2025 Activity did not occur.6/28/2025 Activity did not occurDuring an interview on 07/15/2025 at 2:19 PM Resident #67 stated that he was not getting his showers. He appeared to have food on his clothing. During an interview on 07/16/2025 at 8:33 AM Resident #67 He

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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	676308	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Rehabilitation and Care Center	4100 College Park Dr Round Rock, TX 78665

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance with 4 (Residents #28, #33, #68, and #93) of 4 residents reviewed for sufficient staffing.The facility failed to ensure that the facility had sufficient staffing to meet the needs of Residents #28, #33, #68, and #93. This failure could affect and diminish the resident's quality of life by potentially placing the residents at risk of not receiving timely care or receiving nursing interventions to meet the resident's needs, risk of injury, risk of safety, and or it can make the resident feel neglected affecting their mental health and overall psychosocial well-being not being met by facility staff. Findings include: Record review of Resident #28's Face Sheet dated 07/17/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses that included fracture of right lower leg (break in the continuity of a bone to left leg), Depression (a common mental disorder that involves a depressed mood or loss of interest in activities for long periods of time), Chest pain (discomfort or pain that you feel anywhere along the front of your body between your neck and upper abdomen), Muscle weakness (lack of muscle strength), Diabetes Mellitus with Diabetic Polyneuropathy (multiple peripheral nerves malfunction throughout the body) Hypertensive Chronic Kidney Disease with stage 1 through stage 4 (persistent kidney disease that reduces the rate at which kidneys filter waste and fluids), and Atherosclerotic Heart Disease (condition that causes arteries to narrow, restricting healthy blood flow to organs and other parts of the body).Record review of Resident #28's quarterly Minimum Data Set, dated [DATE] reflected a Brief Interview for Mental Status Score of 15, which indicated to be cognitively intact.Record review of Resident #28's Care Plan dated 05/30/2025 reflected Resident #28 required assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs while encouraging independence. The goals were for Resident #28 to maintain current level of function with assistance in his daily living care needs. Record review of Resident #33's Face Sheet dated 07/17/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses that included Chronic Atrial Fibrillation (type of heart arrhythmia that causes the top chambers of your heart, the atria, to quiver and beat irregularly), Glaucoma (eye condition that damages the optic nerve), Heart Failure (chronic progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs), and Chronic KidneyDisease (gradual loss of kidney function).Record review of Resident #33's quarterly Minimum Data Set, dated [DATE] reflected a Brief Interview for Mental Status Score of 15, which indicated to be cognitively intact.Record review of Resident #33's Care Plan dated 07/11/2025 reflected Resident #33 required assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #33 to maintain current level of function with assistance in his daily living care needs.Record review of Resident #68's Face Sheet dated 07/17/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses that included Iron Deficiency Anemia (include decreased iron intake, increased iron loss, and increased iron requirements), Polyneuropathy (type of neuropathy, or nerve disease, that affects many nerves), Dysuria (pain or a burning sensation during urination), Shortness of Breath (unable to get enough air to lungs), Anxiety Disorder (mental health condition characterized by excessive fear that interferes with daily activities), Hypertensive Heart Disease with Heart Failure (group of disorders that includes heart failure, ischemic heart disease, and left ventricular hypertrophy), Muscle weakness (lack of muscle strength), Respiratory Disorder (disease or condition that affects the lungs and the ability to breathe), Depression (a common mental disorder that involves a depressed mood or loss of interest in activities for long periods of time), and Dementia (group of symptoms affecting memory, thinking and social abilities). Record review of Resident #68's quarterly Minimum Data Set, dated [DATE] reflected a Brief Interview for Mental Status Score of 12, which indicated to be cognitively intact.Record review of Resident #68's Care Plan dated 04/28/2025 reflected Resident #68 required assistance with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #68 to maintain current level of function with assistance in her daily living care needs.Record review of Resident #93's Face Sheet dated 07/17/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included Chronic Kidney Disease (gradual loss of kidney function), Pulmonary

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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 ensure that all drugs and biologicals used in the facility were labeled in accordance with professional standards, including expiration dates for 1 of 4 medication carts reviewed. During observation of MC A, Resident #28's box of Novolin 70/30 had been opened on 05/29/25 and according to the manufacturing instructions should be disposed after 42 days of opening which would be on or before 07/10/25. This failure could lead to medication not being effective, and therefore impacting residents' health. Findings included: Record review of Resident #28's undated face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #28 had diagnosis which included diabetes mellitus type 2. Record review of Resident #28's Active Physician's Orders, dated 07/17/25, reflected he had been prescribed Humulin 70/30 U-100 Kwik Pen 100 unit/mL and to receive 28 units subcutaneous once daily. An observation on 7/17/25 at 9:40 AM of a medication cart revealed an expired medication Novolin (Humulin same and both names can be used interchangeably) 70/30. The box of Novolin 70/30 had been opened on 05/29/25. An interview on 7/17/25 at 9:40 AM with RN L who administered the medications stored on the medication cart stated that the medication was prescribed for Resident #28 and the medication should have been removed before the expiration date 07/10/25., or 42 days. RN L was aware of the policy for monitoring medications on the med cart for expiration dates and prompt removal the expired medications. She stated that the resident had non-expired medication already available for administration on the cart. An interview on 07/17/25 at 2:40 PM with the DON, who stated the charge nurse should be checking the medication carts for expiration dates before administering medications, and the Pharmacist checked all medications and carts monthly. The DON further stated that she and the Pharmacist were responsible for ensuring there were no expired medications on the medication carts. The DON further stated an expired medication might not be therapeutic to a resident if the medication was past the expiration date. Review of Novolin 70/30: Package Insert/Prescribing Info dated 08/24/23 reflected:Table 2: Storage Conditions and Expiration Dates for NOVOLIN 70/30 for the 10 mL multiple-dose vial reflected once in use/opened the medication was to be kept at room temperature for up to 42 days and up to 77 degrees Fahrenheit, and not to refrigerate.Review of an undated Policy and Procedure for Medication Labeling and Storage reflected, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.4. For over the counter (OTC) medications in bulk containers the label contains:a. the medication name.b. strength. c. quantity.d. accessory instructions.e. lot number; andf. expiration date (if applicable).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Resident #2, Resident #63 and Resident #57) reviewed for infection control. 1. CNA H, CNA C, and CNA K did not sanitize their hands between glove changes during peri-care for Resident #2 and Resident #57. 2. CNA H did not sanitize their hands between glove changes during Foley catheter care for Resident #63. These failures could place the residents at risk of infection transmission, sepsis (a systemic infection), and hospitalization. Findings included: An observation on 7/16/25 at 11:32 AM revealed CNA H did not sanitize her hands between changing gloves during peri-care for Resident #2. More specifically, CNA H did not sanitize hands when changing gloves when going from the peri-area to the bottom. Record review of Resident #2's face sheet revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included dementia, cerebral infarction (stroke), pressure ulcer sacral region (the sacral bone can endure a lot of pressure and motion. Along with the coccyx (tailbone), the sacrum provides a stable platform to help you sit upright.), dysphagia (difficulty swallowing), and muscle weakness. Record review of Resident #2's Quarterly MDS assessment, dated 06/07/25 did not reveal a BIMS score. Further review of the MDS revealed Resident #2 had a Stage 4 pressure injury, and had a pressure reducing device for the bed, nutrition or hydration interventions to manage skin problems, and was receiving pressure ulcer/injury care Record review of Resident #2's Care Plan dated 06/11/25 reflected: [Resident #2] had Enhanced Barrier Precautions in place related to wounds. The goal was for prevention of transferring infection within the next 90 days. Approach included staff to wear gloves and a gown for high-contact resident care/activities. [Resident #2] had a pressure ulcer to sacrum with a wound vac in place. The goal was for [Resident #2's] ulcer to heal without complications. The approach was to limit sitting up in wheelchair to 2 hours, use therapeutic air cushion for pressure reduction when resident is in chair, apply dressings per physician order. Review of Active Orders dated 07/17/25 for Resident #2 reflected to cleanse the sacral wound with Dakin's solution, apply skin prep and ostomy (artificial surgical opening created by a surgeon) border. Place black foam cut to fit wound, cover with draping, attach to suction at 125mm/hg once daily on Monday, Wednesday and Friday. An observation on 7/16/25 at 11:32 AM revealed CNA H did not sanitize her hands between changing gloves during peri-care for Resident #2. More specifically, CNA H did not sanitize hands when changing gloves when going from the peri-area to the bottom. Record review of Resident #63's face sheet revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included sepsis (systemic infection), nontraumatic acute subdural hemorrhage (bleeding in the brain), urinary tract infection, chronic kidney disease, hypertension, dysphagia (difficulty swallowing), muscle weakness, benign neoplasm of prostate (cancer of the prostate gland), and chronic pain. Record review of Resident #63's Comprehensive MDS assessment dated [DATE] revealed a BIMS Score of 2, which reflected severe cognitive impairment. Further review of Resident #63's assessment revealed he had an indwelling catheter device for a diagnosis of neurogenic bladder (injury or disease interrupts the electrical signals between nervous system and bladder function). Record review of Resident #63's Care Plan dated 06/11/25 reflected: [Resident #63] had Enhanced Barrier Precautions in place related to a Foley catheter. The goal was for prevention of transferring infection within the next 90 days. Approach included staff to wear gloves and a gown for high-contact resident care/activities. Review of Active Orders dated 07/17/25 for Resident #63 reflected Foley catheter care may be completed by nursing assistant every shift. An observation on 07/17/25 at 09:58 AM of peri-care for Resident #63 revealed CNA H cleansed his peri-area and changed gloves without conducting hand hygiene. CNA H then did not change gloves before cleansing the Foley catheter tubing. CNA H changed gloves but did not conduct hand hygiene before applying the new brief. Interview on 07/17/25 at 10:21 AM with CNA H revealed they were provided with Foley catheter care training, which was provided every 6 months. CNA H stated nurses changed Foley and tubing once a week and the CNAs cleaned only 5 inches of the tubing from meatus (the opening of the urethra to the exterior of the body). CNA H stated they needed to sanitize their hands every time they changed gloves. Record review of Resident #57's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), urinary tract infection, dysuria (difficulty with urination), hypertension, diabetes mellitus type 2, chronic pain, muscle weakness, and need for assistance with