STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676319	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have Physician Orders for the resident's immediate care for one of two (Resident #1) reviewed for resident assessments. The facility failed to have Physician orders for the care and treatment for Resident #1's foley catheter, colostomy, and wound care orders upon his readmission to the facility on [DATE]. This failure could place resident at risk for not receiving appropriate care and treatment services. Findings included: Record review of Resident #1's undated Face Sheet reflected a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Record review of Resident #1's 5-day MDS assessment dated [DATE] reflected a BIMS of 15 which indicated he was cognitively intact, had a urinary catheter, colostomy (surgical procedure that creates an opening in the abdomen to the colon) and abscess (collection of pus and dead tissue) to the groin (junction area between the lower abdomen and inner thigh) and perineum (area between the anus and the genitals) Record review of Resident #1's care plan completed on 03/19/26 reflected the resident was a new admission post sepsis. Goals were to identify the residents' immediate health and safety needs. Approaches included Catheter use for wound management. Turn and reposition. Treatments- see Physician orders. The colostomy was not identified. Record Review of Resident #1's hospital discharge orders dated 04/09/26 did not contain orders for wound care, foley catheter or colostomy care. Instructions indicated, Please send detailed wound care instructions with the patient. Continue wound vac in the skilled nursing facility. Recommend frequent repositioning and pressure offloading to prevent pressure ulcer in the back . Record review of Resident #1's Physician Order Summary for April 2026 reflected no orders for the urinary catheter or colostomy care. Wound care orders were added on 04/15/26 and reflected, Daily wound treatment: Cleanse peri/medial lower buttock with Dakin's (antiseptic) solution, pat dry, apply calcium alginate (absorbent dressing with particles of silver) with silver, top with abdominal pads (absorbent dressing) and secure with mesh underwear daily. Sacrum: continue wound vac to sacrum 125 mmhg (pressure) continuous medium negative pressure. To be changed Monday-Wednesday-Friday. Record review of Resident #1's progress note by RN B on 04/10/26 at 5:49 p.m. reflected, Resident returned from hospital admission at this time. He was accompanied by his [Family member] and two transport personnel who transferred him to bed via manual lift. Diagnosis: Perineal Abscess wound complication. He is alert and oriented x 4, on a regular diet and requires assistance with ambulation.NP [name] was notified of patient's arrival. His wound vac (negative pressures wound therapy device) was assembled and connected to the machine and power source was plugged. Suction pressure was set to intermittent 125 mmHg of pressure. The skin and all system assessment was deferred at this time. Record review of Resident #1's progress note by RN D on 04/10/26 at 10:00 p.m. reflected, The skin assessment done- Surgical wound site to coccyx (base of spine) area. Another wound noted on perineum and scrotum, Wound vac noted.skin grafted site on right upper leg- Reddened area noted. Suture marking on both upper legs on inner aspects of thigh.Last foley changed on 04/09/26. Last colostomy bag changed on 04/09/26. Record review of Resident #1' progress note by RN B on 4/12/26 at 3:46 p.m. reflected, Resident informed this RN at this time that he wishes to defer wound care treatment until 4/13.The bandage were clean, dry and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact at this time upon assessment. Colostomy is also intact, indwelling catheter intact, no kinking and urine color is pale yellow. Record review of Resident #1 progress noted dated 04/13/26 at 4:51 p.m. by the Treatment nurse (recorded as Late entry on 04/15/26 5:00 p.m.) reflected, Writer rounded on resident today for weekly wound care rounds. Wound vac in place to sacrum. Currently set to 125 mmhg. Suctioning noted. MD also assessed peri/groin incisions intact. No open areas noted lower extremities. MD to reinstate previous orders. During an interview and observation on 04/15/26 at 2:40 p.m., Resident #1 and his family member revealed he had returned to the facility late on 04/10/26 after a short stay in the hospital for re-evaluation of his wounds. Resident was observed with a urinary catheter and a wound vac at the bedside set to 125 mmhg. Resident #1's family member stated all of this started with the Resident #1 having the flu back in January 2026. She stated he ended up with a severe infection that was diagnosed as gangrene to his buttocks. She stated he had multiple surgeries and skin grafts, and they had to do a reversable colostomy to help with the healing of the wounds as well as the urinary catheter. She stated the hospital sent him to this facility around the middle of March 2026 but did not send him here with any antibiotics. Resident #1 stated he was getting wound care daily, but started to have increased drainage and they sent him out to the hospital for evaluation. He stated he did not have a wound vac prior to going to the hospital. Resident #1's family member stated since his return, he had been receiving wound care, but the facility contacted her and asked if the hospital had sent any wound care orders with her, and she stated she got the same copy the facility got. She stated she had brought her copy of his discharge orders yesterday (04/14/26). She stated his wound vac dressing was changed last Friday (04/10/26) at the hospital and stated it was changed twice a week at the hospital. Resident #1 and his family member did not have concerns about his wound care. During an interview on 04/15/26 at 3:32 p.m. with the Treatment Nurse, she stated Resident #1 re-admitted to the facility on the evening of 04/10/26 and the hospital had not sent any wound care orders. She stated she had obtained wound care orders on Monday 04/13/26 from the facility's wound care physician which was to resume the previous wound care orders, with the exception of the wound vac and she was still trying to verify with the hospital the orders. She stated she obtained the orders for the wound vac on 04/14/26. She stated she should had restarted the orders she had on 04/13/26 and then added the wound vac orders. She stated the nurse doing the admission should have reached out to the hospital, or herself, and she could have reached out to the wound care physician for the facility, or the weekend supervisor could had reached out as well. She stated Resident #1 did get wound care on 04/13/26 and 04/14/26, it just was not documented. She stated the risk of not having orders upon admission were wounds could not receive treatment and could decline and become worse or infected or colotomy care and urinary catheter care could be missed which increased the risk of infections. During an interview on 04/15/26 at 3:36 p.m. RN B revealed he started Resident #1's re-admission to the facility. He stated Resident #1 did not come with any wound care orders from the hospital. He stated he did not think to call the MD and ask if he could re-start the previous wound care orders, urinary catheter orders, or colostomy care orders. He stated he was not sure who the wound care physician was since their most recent wound care physician had passed away. He stated he did not think about calling the Treatment Nurse, and stated that was what he should have done, or attempted to contact the hospital to obtain the orders. He stated RN D completed the skin assessment and dressing change on 04/11/26, and the resident declined to have wound care on 04/12/26. He stated it was the admitting nurse's responsibility to input the admission orders, and the DON and the ADONs would review the orders the next day or on Monday if it was a weekend admission. He stated they had to have orders to meet the needs of the resident. During an interview on 04/16/26 at 10:50 a.m. with the Clinical Service Director she stated the previous DON had been gone since the end of March 2026 and both the ADONs were new to their roles. She stated it was the expectation any resident admitted to the facility had to have orders to provide the necessary care the resident needed, which would include wound care orders, urinary catheter care orders and colostomy care orders. She stated new admissions would be reviewed in the (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	morning clinical meetings, but the DON and ADON would be responsible for reviewing hospital discharge orders to ensure all the orders were captured. She stated if the hospital discharge orders did not have wound care orders, they had to clarify it with the physician to determine the treatment needed. She stated daily orders would need to be clarified immediately in order to provide the residents with the necessary care they needed. She stated not having admission orders could delay resident treatments which could result in a decline in the residents' overall well-being and recovery. She stated they identified the facility had documentation issues and had a mobile DON who was to start on 04/20/26 along with Cooperate support for training needs. Record review of the facility's policy Physician Orders, dated May 2023, reflected, .The qualified licensed nurse completed an admission medication regimen review from the transfer record from an acute care hospital, home, or other entity.A call is placed to the physician to confirm the orders and request any additional orders as needed.Upon admission, the Facility has physician orders for the resident's immediate care to include not limited to.Routine care orders to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an appropriate care plan.Facilities with paper medical records will transcribe the order on the Medication Administration record (MAR) or Treatment Record as appropriate. Initial and date the entry on the MAR/Treatment Record. Medication Administration or Treatment Records are generated electronically in facilities with electronic medical records.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for two of six (Residents #1 and #2) reviewed for comprehensive care plans. 1. The facility failed to include, in the care plan for Resident #1 created on 03/18/26, and revised on 04/15/26, the colostomy and the necessary care and interventions. 2. The facility failed to include, in the care plan for Resident #2 last revised on 04/06/26, the midline catheter inserted on 03/27/26, and the necessary care and interventions. These failures could place residents at risk of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: 1. Record review of Resident #1's undated Face Sheet reflected a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Record review of Resident #1's 5-day MDS assessment dated [DATE] reflected a BIMS score of 15 which indicated his cognition was intact, he had a urinary catheter, colostomy (surgical procedure that creates an opening in the abdomen to the colon) and abscess (collection of pus and dead tissue) to the groin (junction area between the lower abdomen and inner thigh) and perineum (area between the anus and the genitals) Record review of Resident #1's care plan completed on 03/19/26 reflected the resident was a new admission post sepsis. Goals were to identify the residents' immediate health and safety needs. Approaches included Catheter use for wound management. Turn and reposition. Treatments-see Physician orders. There was no care plan addressing Resident #1's colostomy, goals, or interventions. Record review of Resident #1' progress note on 03/18/26 at 2:59 a.m. by Agency LVN K, reflected, Resident admitted to facility from [hospital name] .Resident has a colostomy that is intact and draining semi solid waste material.Foley catheter put in today at hospital with about 500 ml clear amber urine output.Had a number of surgeries in the hospital including colostomy. During an interview and observation on 04/15/26 at 2:40 p.m., Resident #1 and his family member revealed he had returned to the facility late on 04/10/26 after a short stay in the hospital for re-evaluation of his wounds. Resident was observed with a urinary catheter and a wound vac at the bedside set to 125 mmhg (pressure). Resident #1's family member stated he had multiple surgeries and skin grafts, and they had to do a reversable colostomy to help with the healing of the wounds as well as the urinary catheter. She stated the hospital sent him to this facility around the middle of March 2026. Resident #1's family member stated since his return, he had been receiving colostomy care and catheter care. 2. Record review of Resident #2's undated Face sheet reflected a [AGE] year-old-femle admitted [DATE]. Diagnosis included encephalopathy (disturbance of brain function) cellulitis (bacterial infection of the skin), urinary tract infection, and pressure ulcers. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderately impaired cognition. She had a foley catheter, was always incontinent of bowel, and had not received intravenous therapy while a resident. Record review of Resident #2's Physician order history report from 03/21/26 through 04/17/26 reflected: 3/27-26-OK to start midline (8-12 cm peripheral venous access device inserted into upper arm veins) for long term IV fluids infusion . No discontinuation date noted 03/27/26-Sodium chloride 0.9% parenteral solution- amt: 3 liters at 80 ml/hr. continuous-Discontinued on 03/31/26. 03/27/26-when Peripheral line catheter not in use: flush every 12 hours with 10 ml NS.start date 03/27/26 and discontinued date of 04/07/26. Scheduled at 12 midnight and 12 noon each day. 04/10/26- OK to start PICC/midline for intravenous infusion- one time orderRecord review of Resident #2's Care plan date 4/15/26 did not address the resident's mid-line catheter. An interview with RN B on 04/15/26 at 3:36 p.m. revealed he worked 12-hour shifts from 6 a.m. to 6 pm. He stated he and RN D, who worked the 6 p.m. to 6 a.m. shift, worked the same rotation. He stated (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was admitted to the facility with very poor nutrition, failure to thrive, and wounds. He stated her oral intake was poor and the NP ordered a midline catheter to be placed and for Resident #2 to receive 3 liters of normal saline. He stated they were to leave the midline in after completion of the fluids and flush every 12 hours to keep it patent (open) in case she needed some additional fluids. He stated his last shift on 04/03/26, Resident #2's midline was patent and flushing well. He stated when he returned to work on 04/06/26, he was told by RN D when she came to work for the 6 p.m. to 6 a.m. shift (which begins on 04/05/26 and ended 04/06/26) the midline was not present. He stated they had re-inserted another midline on 04/10/26 for additional fluids and he was waiting for orders to discontinue the midline. During an observation and interview on 04/16/26 2:25 p.m. with Resident #2, she stated she was trying her best to eat and drink more. Resident #2 was observed with a midline in place in her right upper left arm. Dressing was intact, clean and dry. During an interview with MDS Nurse G on 04/17/26 at 2:39 p.m., She stated that she and MDS Nurse P were responsible for completing and updating the comprehensive care plans when they completed the initial, quarterly, significant change assessment and annual assessments. She stated the DON and ADONs updated the care plans when there were changes. She stated the nurses, and usually the ADONs, did the baseline care plan upon admission of a resident, and would need to keep it updated until the comprehensive care plan was completed. She stated urinary catheters, midline catheters, colostomies all should be care planned to ensure they addressed the interventions, and needs of the resident. She stated the care plan was the tool that provided an overall plan as to the needs and wishes of the resident. An Interview on 04/17/26 at 4:10 p.m. with the Clinical Service Director revealed the MDS Coordinators, the DON, and the ADONs were all responsible for updating the care plans. She stated the floor nurses were responsible for starting the care plan upon admission and should include all aspects of the resident's immediate care needs, which would include, colostomies, catheters and midline catheters. She stated the care plan was a comprehensive look at all the residents' needs and what the facility was doing to address those needs. She stated failing to have the care plan completed and updated could result in unmet needs. Record review of the facility's policy, Care Plan Process, Person-Centered Care, revised May 2023, reflected, The facility will develop and implement a .comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, will meet professional standards of quality.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for one of two residents (Resident #2) reviewed for peripheral intravenous care. 1. The facility failed to ensure Agency LVN K obtained physician's orders for the removal of Resident #2's midline intravenous catheter on 04/04/26. 2. The facility failed to document the removal of Resident #2's midline catheter on 04/04/26. These failures placed the resident at risk of ensuring the midline was removed properly and intact which could lead to infection and embolism, and communicated with oncoming staff for further monitoring.Findings included: Record review of Resident #2's undated Face sheet reflected a [AGE] year-old-femle admitted [DATE]. Diagnosis included encephalopathy (disturbance of brain function) cellulitis (bacterial infection of the skin), urinary tract infection, and pressure ulcers. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 12 indicating resident was moderately cognitively impaired. She had a foley catheter, was always incontinent of bowel, and had not received intravenous therapy while a resident. Record review of Resident #2's Physician order history report from 03/21/26 through 04/17/26 reflected: 3/27-26-OK to start midline (8-12 cm peripheral venous access device inserted into upper arm veins) for long term IV fluids infusion .No discontinuation date noted 03/27/26-Sodium chloride 0.9% parenteral solution- amt: 3 liters at 80 ml/hr. continuous Discontinued on 03/31/26. 03/27/26- when Peripheral line catheter not in use: flush every 12 hours with 10 ml NS.start date 03/27/26 and discontinued date of 04/07/26. Scheduled at 12 midnight and 12 noon each day. Record review of Resident #2's April 2026 MAR/TAR revealed the midline was flushed every 12 hours from 04/01/26 through 12 noon 04/03/26 by RN B 6 a.m.-6 p.m. shift, and by RN D 6p.m. to 6 a.m. shift. On 04/04/26, Agency LVN K signed off the midline was flushed at 7:13 a.m. (for the midnight flush time). Record review of Nursing progress notes for Resident #2 reflected: 04/04/26 6:21 a.m. recorded as Late Entry on 04/05/26 at 6:23 a.m. by Agency LVN M-No midline is noted 04/06/26 at 3:42 p.m. by RN B reflected.Midline to Right upper arm is no longer present.She [Resident #2] completed her course of ABT (antibiotics) on 04/03.NP was contacted for notification of condition and who ordered DC (discontinuation) of midline. No further orders at this time. 04/07/26-10:17 a.m. by RN B reflected Resident is eating better today.dark amber urine with noted sedimentation.NP was notified and this RN inquired whether she wants to order IV fluids for resident.No IV fluids midline ordered at this time . An interview with RN B on 04/15/26 at 3:36 p.m. revealed he worked 12-hour shifts on 6 a.m. to 6 pm. He stated he and RN D, who worked the 6 p.m. to 6 a.m. shift worked the same rotation. He stated Resident #2 was admitted to the facility with very poor nutrition, failure to thrive and wounds. He stated her oral intake was poor and the NP ordered a midline catheter to be placed for Resident #2 to receive 3 liters of normal saline. He stated they were to leave the midline in after completion of the fluids and flush every 12 hours to keep it patent (open), in case she needed some additional fluids. He stated his last shift on 04/03/26, Resident #2's midline was patent and flushing well. He stated when he returned to work on 04/06/26, he was told by Agency LVN N, when she came to work for the 6 p.m. to 6 a.m. shift (which begins on 04/05/26 and ended 04/06/26), the midline was not present. He stated he notified the Interim DON and the NP who declined to have another midline placed at that time, but she later re-ordered another midline on 04/10/26 for additional round of IV fluids. He stated he thought they determined it was Agency LVN K who possibly had discontinued the midline on 04/04/26, but he could not be sure. He stated they were required to have a physician's order to discontinue a midline catheter, and they had to document the procedure, which included if the catheter came out intact, or showed any signs of damage. He stated in addition they had to assess the insertion site for signs of infection, and cover the insertion site with a dressing to prevent risk of infection. He stated he was currently waiting for orders to discontinue the midline. During an (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 04/16/26 2:25 p.m. with Resident #2, she stated she did not remember what happened to her midline catheter in her right arm. She stated she was so out of it, at that time, she did not remember if someone took it out, or if it came out. She stated she was feeling a little better, but she still did not have an appetite. She stated she was trying her best to eat and drink more. During an interview on 04/16/26 at 7:12 p.m. with RN D she stated when she returned to work, on her 6 p.m. to 6 a.m. shift on 04/06/26, she received report from RN B that someone had discontinued the midline catheter on Resident #2, and he was following up with the doctor to determine if they needed to have it re-inserted. She stated she was unable to locate an order to have the midline discontinued. She stated they had to have an order to discontinue a midline catheter and had to document the procedure, describe the condition of the catheter and the insertion site. Attempts were made to reach Agency LVN K on 04/17/26 at 12:50 p.m. with no answer and no return call. An interview on 04/17/26 at 4:10 p.m. with the Clinical Service Director revealed her expectation was for the nurses to check the midlines every shift and follow physician orders for flushing, and document once the procedure had been completed. She stated they had to have a physician order to discontinue a midline, and the staff should be documenting the procedure and documenting the condition of the line upon removal and assessing the insertion site and how the resident tolerated the procedure. She stated they needed an overall re-education for the nurses on documentation requirement. She stated they had a book of protocol and procedures at the nursing station for the Agency staff as well. She stated failure to obtain an order could result in a midline being removed when it shouldn't and failing to document the removal the oncoming staff would not know what to assess for if there had been complications during the removal. Record review of the facility's undated procedure, Removing PICC, reflected, .Verify the practitioners orders to discontinue catheter.After successful removal of the catheter, apply manual pressure to the site and just above the site with a sterile gauze pad for a minimum of 30 seconds or until hemostasis is achieved. Cover the site with a petroleum-based ointment and sterile dressing for at least 24 hours.Assess the integrity of the removed catheter. Compare the length of the catheter with the original insertion length.If you note any damage, notify the practitioner immediately.Document the procedure.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one of four (Residents #4) reviewed for pharmacy services. 1.The facility failed to ensure Resident #4 was free from abuse when ADON E knowingly placed the following medications on hold without a physician's order: Resident #4's Latanoprost 0.005% eye drops prescribed for once per day, on hold from [DATE] until [DATE], 25 doses were missed.2. Resident #4's Dorzolamide 2% eye drops prescribed for two time a day, on hold from [DATE] until [DATE], 47 doses were missed. 3.The facility failed to ensure MA H cleared Resident #4's nasal passages before the administration of Fluticasone Nasal Spray. This failure placed residents at risk of not receiving therapeutic dosage of medication. Findings included: 1. Review of a Face Sheet for Resident #4 dated [DATE] revealed Resident #4 was an [AGE] year-old female who was admitted to the facility originally on [DATE] and readmitted on [DATE]. Resident #4 was diagnosed with Bilateral Primary Open-Angle Glaucoma (chronic, progressive eye disease-and the most common form of glaucoma-characterized by slow, asymptomatic damage to the optic nerve, often associated with high eye pressure. It causes irreversible peripheral vision loss, leading to blindness if untreated), multiple sclerosis (autoimmune disease of the central nervous system) and allergic rhinitis (inflammation of the mucous membranes of the nose).Review of Resident #4's MDS dated [DATE] revealed Resident #4 was coded to have moderately impaired vision .limited vision; not able to see newspaper headlines but can identify objects. Resident #4 wears corrective lenses .contacts, glasses, or magnifying glasses. Resident #4 was noted to score an 11 on the BIMS indicating Resident #4 had moderate cognitive impairment.Section I-Active Diagnoses.Other.Additional active diagnoses.B. Unspecified open-angle glaucoma, stage unspecified. Review of Resident #4's Care Plan dated [DATE] revealed Problem.Problem Start Date: [DATE] Category: Visual Function [Resident #4] has impaired vision related to Glaucoma.Goal.Pain will be relieved or minimized related to ocular pressure through next review.Approach.Administer drugs as ordered at appropriate times and in appropriate order.If more than one type of eye drops are ordered at same time, wait 5 minutes between administering each type of eye drop.Keep eye appointment as scheduled.Plan activities that do not place straining on the eyes.Teach resident to avoid activities that may increase intraocular pressure (URIs, emotional upset-worry, fear, anger). Record review of Resident #4's Active Physician Order for [DATE] reflected, Dorzolamide drops: 2% amt: 1 drop.each eye twice a day.latanoprost drops:0.005%; amt 1 drop.each eye once a day.with a start date of [DATE] .Fluticasone propionate spray suspension; 50 mcg (corticosteroids to treat allergies); amt: 1 spray; nasal twice a day . with a start date of [DATE]. There was no order indicating when the Dorzolamide and Latanoprost eye drops were placed on hold or restarted. Review of Medication Administration Record for Resident #4 dated [DATE] revealed Resident #4 was prescribed Dorzolamide ophthalmic drops 2% two times per day. Resident #4's Dorzolamide was on hold from [DATE] until the evening dose on [DATE]. Resident #4 missed a total of 47 doses of Dorzolamide. Resident #4 was prescribed Latanoprost ophthalmic drops 0.005% one-time per day. Resident #4's Latanoprost was put on hold from [DATE]-[DATE]. Resident #4 missed 25 total doses of Latanoprost.Review of Resident #4's Progress Notes by ADON E dated [DATE] revealed .XXX[DATE] at 22:33 [10:33 PM] .Patients eye drops out of date. Hospice RN CM contacted to refill: Lantaprost [sic] gtts and Dorzolamide HCL gtts. Medication placed [sic] on hold until arrival. Charge nurse to reactivate order and take off hold when arrives from hospice pharmacy.signed by [ADON E] .Review of Resident #4's Progress Notes by LVN Q dated [DATE] at 13:39 [1:39 p.m.] .During this shift, it was identified 2 prescribed ophthalmic medication ([sic] eye drops); Latanoprost 0.005%, and Dorzolamide 2% had been placed on hold by another nurse without (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notification to family, or follow-up with hospice or pharmacy. The resident's family contacted the facility requesting clarification regarding the reason for holding the medications and expressed concern about the lack of communication. This nurse reviewed the patient's chart and confirmed the absence of follow up with either hospice or facility pharmacy after documented the reason for hold was awaiting for delivery. [Hospice Agency] were contacted and verified that the prescribed glaucoma eye- [sic] drops are not covered under the hospice. [NP] was notified of the situation, including the medication hold, Dx: B/L open-angle glaucoma, and family concerns, new order to resume both Latanoprost 0.005%, and Dorzolamide2% [sic] as previously prescribed. Pharmacy was contacted promptly to process and dispense medications. confirmation was received to ensure timely delivery and continuation of therapy. The resident's family was called back, and was updated regarding the situation, including the reason for the interruption, action taken to resolve the issue, and plan to resume treatment. The family reports lack of communication between facility staff, hospice services and them.signed by LVN Q.Review of Resident #4's Progress Notes by ADON E dated [DATE] by ADON E at 9:45 a.m.Pharmacy contacted regarding status of Latanoprost 0.005%, and Dorzolamide 2% eye gtts, as orders taken off hold per EMAR. Pharmacy confirmed Dorzolamide gtts were delivered at 1800 (6pm) on [DATE]. Pharmacy also stated that Lantaprost [sic] eye gtts had not been requested for refill since [DATE]. Refill request for Lantanoprost [sic] completed both verbally with pharmacy and electronic EMAR request at this time. Ongoing follow up completed to ensure availability of medications and continuity of care. Awaiting call back from nursing to confirm that Dorzolamide gtts are on medication cart .signed by ADON E.XXX[DATE] at 10:18 AM. Dorzolamide gtts verified present on medication cart.signed ADON E.XXX[DATE] 10:20 AM.Lantaprost gtt [sic] hold order continues until delivery of medication by pharmacy.signed ADON E.XXX[DATE] at 10:37 AM.[NP] notified that Lantaprost [sic] eye gtts are awaiting pharmacy delivery. Medication was placed back on hold until delivery. Pharmacy states ETA for medication will be on PM med run.signed by ADON E.Review of Resident #4's Progress Notes by ADON F [DATE] at 18:31 [6:31 p.m.] .nurse called [Family Member] to inquire if the family would like to family to set up an appointment for the eye doctor, [family member] declined facility setting up appointment stated that she would follow up with personal eye doctor.signed by ADON F.Review of Resident#4's Progress Notes revealed there was no documentation or follow-up by ADON E documented from [DATE] until [DATE].Review of a Pharmacy Manifest dated [DATE] revealed Resident #4's Dorzolamide Ophthalmic Solution was delivered to the facility on [DATE].Review of a Pharmacy Manifest dated [DATE] at 8:18 PM, revealed Resident #4's Latanoprost Ophthalmic Solution was delivered to the facility on [DATE].Review of Investigation Statements documented by Administrator dated [DATE] revealed On [DATE] [ADON E] and [Resident #4's Family Member] came to admin office. [ADON E] began to explain that the {Family Member] is upset she was not notified of [Resident #4's] eye drops being placed on hold. Admin stated that it is regarding clinical matters and she needed to be a part of it. [Interim DON] arrived shortly afterwards, and [Family Member] expressed her concerns again. At this time [ADON E] admit that she was the one the placed the orders on hold and told the nurses to follow up. Admin reported this allegation to HHSC on 4.13.26 [Interim DON] & HR Suspended [ADON E] pending investigation Notified Physician, Medical Director, Family, Ombudsman. Abuse & Neglect Inservice. Admin reached out to [ADON] to further interview, but the calf [sic]was not answered. [ADON F] Reached out to the [Family Member] to schedule an ophthalmologist appointment. [Family Member] declined and stated she has an outside one and can schedule one if she needs too but she has had glaucoma for years and is not sure she needs an appointment. Review of an Investigation Statement with LVN R dated [DATE] revealed On 4.14.26 Admin spoke with [LVN R].[LVN R] stated that on that night [ADON E] was doing an Audit she found the expired medication and she told [LVN R] that she had put it on hold that I just had to put it on the 24hr report that the nurse is to take it off hold once received from the pharmacy. I was not directed to do anything else and for me I did not think to follow up on the medication because it is not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given at night, so I am not triggered to remember. As a nurse when you put a medication on hold you have to get doctors' orders first, so I assumed she had done that since she told me she had already put it on hold. Additionally, I want to state that when I get orders to put a medication on hold, I get a time frame from the physician like 3-7 days that way triggers me to review. [ADON E] put it in as an open-ended hold. Review of an Investigation Statement with LVN Q dated [DATE] revealed On 4.14.26 Admin spoke with LVN Q. [LVN Q] stated that on 3.19.26 [LVN R] reported to her on her oncoming shift that the medication was put on hold and when it comes in to take if off hold, that was all that was directed to me. It did not arrive on my shift, so I did not take the medication off hold. We nurse usually call the Doctor/Family/Hospice before we put the medication on hold because we have to get orders to do that in the first place, so I thought it was done because it had been put on hold during the previous shift. On 4.11.26 the [Family Member] had taken [Resident #4] to the park and called me while they were down there and had asked when the last time was, she had received her eye drops, so I looked in the chart and gave her the dates, and the [Family Member] said that no one had notified her so I told her that I would look into this. So, I called hospice and they said they did not do that medication, then I called the pharmacy to see if they had it, next I called [NP] and told her what was going on and that the pharmacy had the med and asked if it was ok to take it off hold and order, [NP] told me it was ok so I did that and I documented in the chart. [ADON E] was on call and aware.Review of an Investigation Statement with RN C dated [DATE] revealed [DATE] 1:45 p.m.Interview with RN C] .I asked this employee what her knowledge was of the eye drops for [Resident #4]. [RN C] stated last weekend she heard the charge nurse talking about [Resident #4's] eye drops being on hold and not in the facility. [LVN Q] said they had been ordered but were not in the facility. [RN C] stated she contacted the person on call which was [ADON E]. [ADON E] informed her she had placed the med on hold and ordered the medication. [RN C] stated she had looked for it, and it was not in the facility. [RN C] then stated she initiated an incident report that she then passed onto [LVN Q] to complete as she was the nurse who identified the issue. The report was then placed under the administrator's door. [RN C] went on to say all parties were notified including the physician, family, Administrator, [Interim DON]. Finally, [RN C] confirmed with [ADON E] that the med had been ordered. She said because she only works weekends she was not aware when the med arrived.During an interview with the Administrator on [DATE] at 8:53 a.m., it was revealed that ADON E was suspended as a result of a self-report the facility called in. During the investigation it was learned ADON E placed Resident #4's eye drops on hold for almost a month so Resident #4 went without her eye drops for almost a month. ADON E admitted to placing Resident #4's eye drops on hold and did not get a physician's order to do so. During an interview with the Interim DON on [DATE] at 8:53 a.m., it was revealed an assessment was conducted on Resident #4 and the physician and family were notified about the medication being placed on hold. Interim DON stated ADON E removed the eye drops from the medication cart while ADON E was doing an audit on a medication cart. ADON E discarded the medication and decided to put the medication on hold and told the nurse to not restart the medication until the medication was back in the building. Interim DON stated ADON E failed to get a physician's order and/or notify the physician. ADON E failed to follow through with ensuring the medication was properly reordered or obtained from a pharmacy. Interim DON stated that ADON E practiced outside the scope of nursing by placing Resident #4's eye drops on hold and giving directions to nurses without a physician's order.During an interview with a Family Member on [DATE] at 10:45 a.m., it was revealed she was mostly upset with ADON E and stated ADON E blamed the nurses on the floor for not following up on the eye drops. Family Member stated ADON E needed to be held accountable as she was the supervisor who stopped the eye drops for Resident #4 and placed them on hold. Family Member stated she was not contacted by ADON E regarding the eye drops being placed on hold.During an interview with the MD on [DATE] at 11:40 a.m., it was revealed she learned approximately a week ago that Resident #4 had not been receiving her glaucoma medications (eye drops). MD stated she was not notified about the eye drops being place on hold. MD stated a resident (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failing to receive prescribed eye drops for glaucoma could cause a worsening condition, but the condition varies per patient. MD stated no changes had been reported to her regarding Resident #4. MD stated there was confusion with Resident #4 being on hospice and whether hospice would cover the cost of the medication. MD stated hospice did not cover eye drops or order those medications ordinarily as they did not pertain to the admitting diagnosis. During an interview with ADON E on [DATE] at 2:12 p.m., it was revealed she was hired as an ADON in [DATE] but had been PRN since [DATE]. ADON E explained she was not currently active in the building and did not confirm she was suspended pending investigation. ADON E stated she was doing a medication audit on the night shift when she noted Resident #4's eye drops expired. ADON E stated she removed the eye drops from the medication cart. ADON E stated she documented the information, communicated with the oncoming charge nurse, and reported it to the DON. ADON E stated she attempted to contact the hospice but only got a busy signal so she communicated with the oncoming charge nurse, and a note was left in the hospice binder. ADON E stated she asked the oncoming to communicate the medications being placed on hold and to the hospice nurse. ADON E was asked if she followed up on the eye drops being on hold and ADON E stated she documented the issues, communicated to the staff and the DON. When ADON E was asked if she communicated with the NP or the physician she stated, I'm pretty sure the doctor was aware. ADON E explained the workflow for medications not available were to place them on hold. ADON E stated she did not specifically call the physician at 3:00 AM when she was working but stated she thought she would have talked with the physician. ADON E stated in stand up during the clinical meeting she followed up and stated the eye drops for Resident #4 were discussed. ADON E stated she communicated the eye drops being on hold and stated she requested clarification. ADON E stated she sent emails to the previous DON and Administrator. ADON E stated the eye drops expired were identified as ADON and ADON E stated her job was to make sure the need for the medication was addressed and that appropriate steps were taken to get the needed medication in the building. ADON E stated she was only hearing that the medication had not been delivered by the hospice and that hospice was working on it. When asked what she could have done as ADON, ADON E stated she identified the eye drops were expired, documented the information, reported it to the Administrator and DON and followed up on what information she was receiving from the charge nurses which was that the medication was still on hold. ADON E stated she did not call the hospice again after calling on [DATE] and the phone was busy. ADON E stated she did not call Resident #4's physician, she only spoke with the administration and charge nurses. ADON E stated she did not call Resident #4's family. When asked what could have been done differently on part of her job as an ADON, ADON E repeated she identified the eye drops were expired, documented the information, reported it to the Administrator and DON. ADON E stated Resident #4 not receiving eye drops could lead to increased pressure and progression of glaucoma including loss of vision over time.During an interview with Administrator on [DATE] at 2:39 p.m., revealed in the morning clinical meeting the nurses would go over each resident, anything new coming up, behaviors, any resident appointments, IVs, and if a resident had not had a BM in 72 hours. The Administrator stated she did not remember hearing that Resident #4 was without her eye drops or that the eye drops were on hold except one time when ADON E said something. The Administrator the eye drops being on hold did not come up in the clinical meeting daily. The Administrator stated there was information from the charge nurse reports a few times that they had not received the medication from the pharmacy or hospice. The Administrator stated that ADON E was assigned the task of ensuring follow-up was conducted regarding any pharmacy issues like medications not being available or received from the pharmacy. The Administrator stated she had not seen a medication stay on hold for a long period of time. The Administrator stated as the ADON/Supervisor it was up to ADON E to address problems that she may see, follow up and find out how to fix the issues. ADONs were to help the nurses on the floor with guiding and assisting and ensuring clinical issues were being addressed. During an interview with ADON F on [DATE] at 3:41 p.m., revealed she started as an ADON on [DATE]. ADON F stated when (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she was put on eye drops twice per day, Latanoprost and Dorzolamide. Resident #4 denied experiencing vision loss, blurry vision or pain because of the glaucoma. Resident #4 stated she utilized two separate pairs of glasses for her near- and far-sighted vision. Resident #4 stated she recently went without her eye drops for a period, so she reported to her Family Member. Resident #4 stated she complained to her Family Member the eye drops had been restarted. Resident #4 stated that while she knew she was not getting the eye drops she stated she could not think of any side effects she experienced.During an interview with MA T on [DATE] at 10:25 a.m., revealed Resident #4 was previously receiving eye drops (latanoprost and dorzolamide) and then they were stopped because the eye drops were put on hold. MA T stated she would ask the nurse depending on who worked. If it was agency they could not have assisted her because the agency nurses were not familiar with the residents. MA T reported to her charge nurses when the eye drops were originally placed on hold. MA T stated she did not have the ability to get the eye drops or fix the order. MA T stated she would ask about the eye drops she was only told the eye drops were on hold. MA T stated she was told ADON E put them on hold. MA T stated when medications were placed on hold, they usually had a stop date, but the eye drops did not.During an interview with Clinical Services Director (CSD) on [DATE] at 10:39 a.m., it was revealed that ADONs were expected to report to the DON and act in the place of a DON if there was no DON or if the DON was not in the building. ADONs were to be involved in the daily clinical meeting including going over charting from the day before, admissions, reviewing physician's orders, reviewing incident/accidents amongst other things. CSD stated the Latanoprost and Dorzolamide being on hold for almost a month was not reported to her. CSD stated these medications being placed on hold should have been discussed in the morning clinical meeting. CSD stated any medication that needed to be placed on hold a nurse should be getting physician's order and usually the physician would provide a stop and start date for the hold time. CSD stated when she became aware of the eye drops being on hold when she reviewed ADON E had not put a stop date and there was no information about the physician being contacted. CSD stated she was informed of the medication error on Monday [DATE]. CSD stated ADON E was the clinical management on call over the past weekend. CSD stated if ADON E and/or Weekend Supervisor learned of Resident #4's family's concern over the weekend the Interim DON and Administrator should have been contacted. CSD stated she would consider this a form of neglect. CSD stated ADON E was new in her position. ADON E was described by CSD as someone who was very heightened about everything that came up as a concern, but ADON E lacked the ability to follow up and fix concerns. ADON E could identify concern but no accountability to fix issues.During an interview with Ophthalmologist Assistant on [DATE] at 11:54 a.m., revealed Resident #4 was diagnosed with Severe Stage Bilateral Glaucoma. Ophthalmologist Assistant explained glaucoma caused high pressure in the eye that would damage the optic nerve resulting in permanent blindness. The eye drops (Latanoprost and Dorzolamide) were prescribed to keep eye pressure down and prevent further damage. Ophthalmologist Assistant stated Resident #4 would not feel pain as a person could not feel the eye pressure increasing which was why it was important for a patient to be followed by an Ophthalmologist. Once there was vision loss it was permanent and could not be reversed. Ophthalmologist Assistant stated it was very important to continue the eye drops and if needed the eye drops could be sent to the facility. Ophthalmologist Assistant stated they had not seen Resident #4 since August so she could not speak to whether going for almost a month without the eye drops caused further damage to Resident #4's eyes.During an interview with Administrator on [DATE] at 12:38 a.m., revealed on Monday afternoon, [DATE], Resident #4's Family Member came in and notified her and ADON E of a complaint, part of which was the concern of Latanoprost and Dorzolamide eye drops being withheld for almost a month, and no one told Family Member. Due to the concerns Interim DON was brought in to hear Family Member concerns. As a result, ADON E reported that she in fact placed the eye drops on hold in March without a physician order. ADON E was placed on suspension pending investigation on [DATE] around 3:00 PM. ADON E did not report calling the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician but there were no physician's orders in the EHR. Administrator explained that the investigation started, safe surveys were started, Abuse Neglect Exploitation in-service was started, a skin and pain assessment were conducted with Resident #4 due to Family Member's other complaints. Family Member, Medical Director and Ombudsman were all notified and then a report was made to HHSC. Administrator stated she spoke with LVN R who reported she was working the night ADON E was completing the medication cart audits. ADON E reported to LVN R the Latanoprost and Dorzolamide were expired and that she put them on hold. ADON E asked LVN R to report to the oncoming nurse that they were on hold until the medications came from the pharmacy. Administrator to place a medication on hold she understood there should have been a call to the physician to receive a physician's order first. Administrator stated she spoke with LVN Q who stated LVN R reported to her the medication was on hold and LVN Q needed to take the medication off hold when the medications arrived from the pharmacy. Both LVN Q and LVN R thought everything was taken care of because ADON E was the one who placed the eye drops on hold. Administrator denied every hearing LVN Q bring up Resident #4's eye drops being unavailable and/or on hold. During an interview with the Interim DON on [DATE] at 1:00 p.m., it was revealed she had only been supporting the facility for just over a week. Interim DON explained that ADON and DON should be running a report before the clinical meeting to determine if there are unavailable medications or on hold medications. Then the ADON and DON should be discussing the medications and follow up for any clarification, making sure the physician, family and residents are notified. Interim DON stated it was important to ensure medications that were unavailable or on hold should be trouble shot to get a root cause and then ensure that no harm occurred because of the resident not having the medication. Interim DON stated the significance of a resident not receiving glaucoma medications was dependent on the individual resident as each person responded differently but glaucoma was a slowing moving illness. Glaucoma caused eye pressure to build up in the eye and eventually lead to blindness if left untreated. Interim DON stated she was not familiar with Resident #4 and what stage her glaucoma was. Interim DON denied receiving a call about the medication error involving Resident #4's eye drops. Interim DON stated she felt she and Administrator should have received a call in Saturday when the family complained due to the length of the medication error. Interim DON stated ADON E acted outside her scope as a LVN by telling nurses to not restart the Latanoprost and Dorzolamide eye drops for Resident #4. During an interview with Hospice Nurse on [DATE] at 1:19 p.m., it was revealed she had received a call around 6:00 AM from Family Member of Resident #4 regarding Resident #4's Latanoprost and Dorzolamide being discontinued. Hospice Nurse stated she had not previously been notified of a change with these medications. Hospice Nurse stated hospice did not cover the cost of glaucoma medications and did not order the medications as it was not part of the admitting diagnosis to hospice. Hospice Nurse the glaucoma medications would be ordered through the facility's pharmacy. Hospice Nurse due to their concern about Resident #4 going without the Latanoprost and Dorzolamide Hospice Nurse wrote a telephone order for the Latanoprost and Dorzolamide eye drops because they were included in the original list of medications at the time Resident #4 admitted to hospice, so the facility had an active prescription to be able to obtain the medications from the pharmacy. Hospice Nurse stated ADON E told her the eye drops had been removed from their original box with label and expiration date, so ADON E placed the eye drops on hold and stated she forgot to follow-up. Therefore, Resident #4 went without her Latano

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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 interview and record review, the facility failed to ensure residents were free from any significant medication errors for one (Resident #4) of 13 residents reviewed for significant medication errors. The facility failed to ensure Resident #4 was free from significant medication errors when the following were placed on hold:-Latanoprost 0.005% eye drops prescribed for once per day on hold without physician's order on [DATE] until [DATE], 25 doses were missed.-Dorzolamide 2% eye drops prescribed for two times a day on hold without physician's order on [DATE] until [DATE], 47 doses were missed. This failure had the potential to place residents at risk for not receiving the therapeutic benefits from their medication.Findings Included:Review of a Face Sheet for Resident #4 dated [DATE] revealed Resident #4 was an [AGE] year-old female who was admitted to the facility originally on [DATE] and readmitted on [DATE]. Resident #4 was diagnosed with Bilateral Primary Open-Angle Glaucoma (chronic, progressive eye disease-and the most common form of glaucoma-characterized by slow, asymptomatic damage to the optic nerve, often associated with high eye pressure. It causes irreversible peripheral vision loss, leading to blindness if untreated.)Review of Resident #4's MDS dated [DATE] revealed Resident #4 was coded to have moderately impaired vision .limited vision; not able to see newspaper headlines but can identify objects. Resident #4 wears corrective lenses .contacts, glasses, or magnifying glasses. Resident #4 was noted to score an 11 on the BIMS indicating Resident #4 had moderate cognitive impairment.Section I-Active Diagnoses.Other.Additional active diagnoses.B. Unspecified open-angle glaucoma, stage unspecified.Review of Resident #4's Care Plan dated [DATE] revealed Problem.Problem Start Date: [DATE] Category: Visual Function [Resident #4] has impaired vision related to Glaucoma.Goal.Pain will be relieved or minimized related to ocular pressure through next review.Approach.Administer drugs as ordered at appropriate times and in appropriate order.If more than one type of eye drops are ordered at same time, wait 5 minutes between administering each type of eye drop.Keep eye appointment as scheduled.Plan activities that do not place straining on the eyes.Teach resident to avoid activities that may increase intraocular pressure (URIs, emotional upset-worry, fear, anger).Review of Medication Administration Record for Resident #4 dated [DATE] revealed Resident #4 was prescribed Dorzolamide ophthalmic drops 2% two times per day. Resident #4's Dorzolamide was on hold from [DATE] until the evening dose on [DATE]. Resident #4 missed a total of 47 doses of Dorzolamide. Resident #4 was prescribed Latanoprost ophthalmic drops 0.005% one-time per day. Resident #4's Latanoprost was put on hold from [DATE]-[DATE]. Resident #4 missed 25 total doses of Latanoprost.Review of Resident #4's Progress Notes by ADON E dated [DATE] revealed .XXX[DATE] at 22:33 [10:33 PM].Patients eye drops out of date. Hospice RN CM contacted to refill: Lantaprost [sic] gtts and Dorzolamide HCL gtts. Medication placed [sic] on hold until arrival. Charge nurse to reactivate order and take off hold when arrives from hospice pharmacy.esigned by [ADON E].Review of Resident #4's Progress Notes by LVN Q dated [DATE] at 13:39 [1:39 PM].During this shift, it was identified 2 prescribed ophthalmic medication ([sic] eye drops); Latanoprost 0.005%, and Dorzolamide 2% had been placed on hold by another nurse without notification to family, or follow-up with hospice or pharmacy. The resident's family contacted the facility requesting clarification regarding the reason for holding the medications and expressed concern about the lack of communication. This nurse reviewed the patient's chart and confirmed the absence of follow up with either hospice or facility pharmacy after documented the reason for hold was awaiting for delivery. [Hospice Agency] were contacted and verified that the prescribed glaucoma eye- [sic] drops are not covered under the hospice. [NP] was notified of the situation, including the medication hold, Dx: B/L open-angle glaucoma, and family concerns, new order to resume both Latanoprost 0.005%, and Dorzolamide2% [sic] as previously prescribed. Pharmacy was contacted promptly to process and dispense medications. confirmation was received to ensure timely delivery and continuation of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	therapy. The resident's family was called back, and was updated regarding the situation, including the reason for the interruption, action taken to resolve the issue, and plan to resume treatment. The family reports lack of communication between facility staff, hospice services and them.esigned by LVN Q.Review of Resident #4's Progress Notes by ADON E dated [DATE] by ADON E at 9:45 AM.Pharmacy contacted regarding status of Latanoprost 0.005%, and Dorzolamide 2% eye gtts, as orders taken off hold per EMAR. Pharmacy confirmed Dorzolamide gtts were delivered at 1800 (6pm) on [DATE]. Pharmacy also stated that Lantaprost [sic] eye gtts had not been requested for refill since [DATE]. Refill request for Lantanoprost [sic] completed both verbally with pharmacy and electronic EMAR request at this time. Ongoing follow up completed to ensure availability of medications and continuity of care. Awaiting call back from nursing to confirm that Dorzolamide gtts are on medication cart .esigned by ADON E.XXX[DATE] at 10:18 AM. Dorzolamide gtts verified present on medication cart.esigned ADON E.XXX[DATE] 10:20 AM.Lantaprost gtt [sic] hold order continues until delivery of medication by pharmacy.esigned ADON E.XXX[DATE] at 10:37 AM.[NP] notified that Lantaprost [sic] eye gtts are awaiting pharmacy delivery. Medication placed back on hold until delivery. Pharmacy states ETA for medication will be on PM med run.esigned by ADON E.Review of Resident #4's Progress Notes by ADON F [DATE] at 18:31 [6:31 PM].nurse called [Family Member] to inquire if the family would like to family to set up an appointment for the eye doctor, [family member] declined facility setting up appointment stated that she would follow up with personal eye doctor.esigned by ADON F.Review of Resident#4's Progress Notes revealed there was no documentation or follow-up by ADON E documented from [DATE] until [DATE].Review of a Pharmacy Manifest dated [DATE] revealed Resident #4's Dorzolamide Ophthalmic Solution was delivered to the facility on [DATE].Review of a Pharmacy Manifest dated [DATE] at 8:18 PM, revealed Resident #4's Latanoprost Ophthalmic Solution was delivered to the facility on [DATE].Review of Investigation Statements documented by Administrator dated [DATE] revealed On [DATE] [ADON E] and [Resident #4's Family Member] came to admin office. [ADON E] began to explain that the {Family Member] is upset she was not notified of [Resident #4's] eye drops being placed on hold. Admin stated that it is regarding clinical matters and she needed to be a part of it. [Interim DON] arrived shortly afterwards and [Family Member] expressed her concerns again. At this time [ADON E] admit that she was the one the placed the orders on hold and told the nurses to follow up. Admin reported this allegation to HHSC on 4.13.26 [Interim DON] & HR Suspended [ADON E] pending investigation Notified Physician, Medical Director, Family, Ombudsman. Abuse & Neglect Inservice. Admin reached out to [ADON] to further interview but the calf [sic]was not answered. [ADON F] Reached out to the [Family Member] to schedule an ophthalmologist appointment. [Family Member] declined and stated she has an outside one and can schedule one if she needs too but she has had glaucoma for years and is not sure she needs an appointment. Review of an Investigation Statement with LVN R dated [DATE] revealed On 4.14.26 Admin spoke with [LVN R].[LVN R] stated that on that night [ADON E] was doing an Audit she found the expired medication and she told [LVN R] that she had put it on hold that I just had to put it on the 24hr report that the nurse is to take it off hold once received from the pharmacy. I was not directed to do anything else and for me I did not think to follow up on the medication because it is not given at night so I am not triggered to remember. As a nurse when you put a medication on hold you have to get doctors' orders first, so I assumed she had done that since she told me she had already put it on hold. Additionally, I want to state that when I get orders to put a medication on hold, I get a time frame from the physician like 3-7 days that way it triggers me to review. [ADON E] put it in as an open-ended hold. Review of an Investigation Statement with LVN Q dated [DATE] revealed On 4.14.26 Admin spoke with LVN Q.[LVN Q] stated that on 3.19.26 [LVN R] reported to her on her oncoming shift that the medication was put on hold and when it comes in to take if off hold, that was all that was directed to me. It did not arrive on my shift so I did not take the medication off hold. We nurse usually call the Doctor/Family/Hospice before we put the medication on hold because we have to get orders to do that in the first place so I (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thought it was done because it had been put on hold during the previous shift. On 4.11.26 the [Family Member] had taken [Resident #4] to the park and called me while they were down there and had asked when was the last time, she had received her eye drops, so I looked in the chart and gave her the dates and the [Family Member] said that no one had notified her so I told her that I would look into this. So, I called hospice and they said they did not do that medication, then I called the pharmacy to see if they had it, next I called [NP] and told her what was going on and that the pharmacy had the med and asked if it was ok to take it off hold and order, [NP] told me it was ok so I did that and I documented in the chart. [ADON E] was on call and aware.Review of an Investigation Statement with RN C dated [DATE] revealed [DATE] 1:45 PM.Interview with RN C].I asked this employee what her knowledge was of the eye drops for [Resident #4]. [RN C] stated last weekend she heard the charge nurse talking about [Resident #4's] eye drops being on hold and not in the facility. [LVN Q] said they had been ordered but were not in the facility. [RN C] stated she contacted the person on call which was [ADON E]. [ADON E] informed her she had placed the med on hold and ordered the medication. [RN C] stated she had looked for it and it was not in the facility. [RN C] then stated she initiated an incident report that she then passed onto [LVN Q] to complete as she was the nurse who identified the issue. The report was then placed under the administrator's door. [RN C] went on to say all parties were notified including the physician, family, Administrator, [Interim DON]. Finally, [RN C] confirmed with [ADON E] that the med had been ordered. She said because she only works weekends she was not aware when the med arrived.During an interview with the Administrator on [DATE] at 8:53 AM, it was revealed that ADON E was suspended as a result of a self-report the facility called in. During the investigation it was learned ADON E placed Resident #4's eye drops on hold for almost a month so Resident #4 went without her eye drops for almost a month. ADON E admitted to placing Resident #4's eye drops on hold and did not get a physician's order to do so. During an interview with the Interim DON on [DATE] at 8:53 AM, it was revealed an assessment was conducted on Resident #4 and the physician and family were notified about the medication being placed on hold. Interim DON stated ADON E removed the eye drops from the medication cart while ADON E was doing an audit on a medication cart. ADON E discarded the medication and decided to put the medication on hold and told the nurse to not restart the medication until the medication was back in the building. Interim DON stated ADON E failed to get a physician's order and/or notify the physician. ADON E failed to follow through with ensuring the medication was properly reordered or obtained from a pharmacy. Interim DON stated that ADON E practiced outside the scope of nursing by placing Resident #4's eye drops on hold and giving directions to nurses without a physician's order.During an interview with a Family Member on [DATE] at 10:45 AM, it was revealed she was mostly upset with ADON E and stated ADON E blamed the nurses on the floor for not following up on the eye drops. Family Member stated ADON E needed to be held accountable as she was the supervisor who stopped the eye drops for Resident #4 and placed them on hold. Family Member stated she was not contacted by ADON E regarding the eye drops being placed on hold.During an interview with the MD on [DATE] at 11:40 AM, it was revealed she learned approximately a week ago that Resident #4 had not been receiving her glaucoma medications (eye drops). MD stated she was not notified about the eye drops being place on hold. MD stated a resident failing to receive prescribed eye drops for glaucoma could cause a worsening condition, but the condition varies per patient. MD stated no changes had been reported to her regarding Resident #4. MD stated there was confusion with Resident #4 being on hospice and whether hospice would cover the cost of the medication. MD stated hospice did not cover eye drops or order those medications ordinarily as they did not pertain to the admitting diagnosis. During an interview with ADON E on [DATE] at 2:12 PM, it was revealed she was hired as an ADON in [DATE] but had been PRN since [DATE]. ADON E explained she was not currently active in the building and did not confirm she was suspended pending investigation. ADON E stated she was doing a medication audit on the night shift when she noted Resident #4's eye drops expired. ADON E stated she removed the eye drops from the medication cart. ADON E stated she documented the information, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communicated with the oncoming charge nurse, and reported it to the DON. ADON E stated she attempted to contact the hospice but only got a busy signal so she communicated with the oncoming charge nurse, and a note was left in the hospice binder. ADON E stated she asked the oncoming to communicate the medications being placed on hold and to the hospice nurse. ADON E was asked if she followed up on the eye drops being on hold and ADON E stated she documented the issues, communicated to the staff and the DON. When ADON E was asked if she communicated with the NP or the physician she stated, I'm pretty sure the doctor was aware. ADON E explained the workflow for medications not available were to place them on hold. ADON E stated she did not specifically call the physician at 3:00 AM when she was working but stated she thought she would have talked with the physician. ADON E stated in stand up during the clinical meeting she followed up and stated the eye drops for Resident #4 were discussed. ADON E stated she communicated the eye drops being on hold and stated she requested clarification. ADON E stated she sent emails to the previous DON and Administrator. ADON E stated the eye drops expired were identified as ADON and ADON E stated her job was to make sure the need for the medication was addressed and that appropriate steps were taken to get the needed medication in the building. ADON E stated she was only hearing that the medication had not been delivered by the hospice and that hospice was working on it. When asked what she could have done as ADON, ADON E stated she identified the eye drops were expired, documented the information, reported it to the Administrator and DON and followed up on what information she was receiving from the charge nurses which was that the medication was still on hold. ADON E stated she did not call the hospice again after calling on [DATE] and the phone was busy. ADON E stated she did not call Resident #4's physician, she only spoke with the administration and charge nurses. ADON E stated she did not call Resident #4's family. When asked what could have been done differently on part of her job as an ADON, ADON E repeated she identified the eye drops were expired, documented the information, reported it to the Administrator and DON. ADON E stated Resident #4 not receiving eye drops could lead to increased pressure and progression of glaucoma including loss of vision over time.During an interview with Administrator on [DATE] at 2:39 PM, revealed in the morning clinical meeting the nurses would go over each resident, anything new coming up, behaviors, any resident appointments, IVs, and if a resident had not had a BM in 72 hours. The Administrator stated she did not remember hearing that Resident #4 was without her eye drops or that the eye drops were on hold except one time when ADON E said something. The Administrator the eye drops being on hold did not come up in the clinical meeting daily. The Administrator stated there was information from the charge nurse reports a few times that they had not received the medication from the pharmacy or hospice. The Administrator stated that ADON E was assigned the task of ensuring follow-up was conducted regarding any pharmacy issues like medications not being available or received from the pharmacy. The Administrator stated she had not seen a medication stay on hold for a long period of time. The Administrator stated as the ADON/Supervisor it was up to ADON E to address problems that she may see, follow-up and find out how to fix the issues. ADONs were to help the nurses on the floor with guiding and assisting and ensuring clinical issues were being addressed. During an interview with ADON F on [DATE] at 3:41 PM, revealed she started as an ADON on [DATE]. ADON F stated when she started, she was assigned to the infection control system and ADON E was over the pharmacy systems. ADON F stated that she did not recall Resident #4's medications being brought up in the clinical meeting. ADON F stated she knew it was not discussed daily. ADON F stated she found out there was a concern with Resident #4's eye drops on Monday, [DATE] when the hospice nurse came to her about the family calling her upset about ADON E putting the eye drops for Resident #4 being placed on hold. ADON F stated the hospice nurse went ahead and ordered the eye drops because the family was upset.During an interview with Interim DON on [DATE] at 3:45 PM, revealed ADON E was assigned the pharmacy system meaning anything regarding medication, physician's orders, entering and auditing physician's orders and making sure medications were in the building with physician's being notified and Responsible Parties being notified. Interim (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON heard on Monday, [DATE] when Resident #4's family complained. ADON E reported the medication was on hold. Interim DON stated she understood the nurses were going directly to ADON E because she placed the eye drops for Resident #4 on hold, originally. Interim DON stated as ADON, ADON E should have followed up to see what was going on with getting the eye drops but instead ADON E delegated everything to other people and never followed up. During an interview with Administrator on [DATE] at 8:50 AM, it was revealed she did not remember any calls related to Resident #4's eye drops over the weekend. The Administrator stated she found out about the medication error on Monday, [DATE]. The Administrator stated ADON E was the on-call nurse over the weekend and was suspended pending investigation on the afternoon of [DATE]. The Administrator stated Resident #4's family member came to see her on the afternoon of [DATE] regarding the concerns with the eye drops and some other concerns.An attempt was made to interview the former DON on [DATE] at 9:08 AM. A message was left for a return call.During an interview with the Pharmacy Consultant on [DATE] at 9:09 AM, revealed Latanoprost and Dorzolamide are used to treat glaucoma. The Pharmacy Consultant explained that a resident not receiving the eye drops could cause the eye pressure to increase but would not cause physical pain. The Pharmacy Consultant stated she did not know if the resident's vision could get blurry. The Pharmacy Consultant stated that glaucoma was silent and did not have a lot of symptoms but over years could cause the vision of a resident to lessen due to the eye not being able to take in much light. The Pharmacy Consultant stated glaucoma was a slow progression. The Pharmacy Consultant stated the most important thing for Resident #4 was to ensure the medication was restarted as soon as possible.During an interview with LVN Q on [DATE] at 9:20 AM, revealed stated that he had been working at the facility as an LVN for two years. LVN Q explained that Resident #4's eye drops were placed on hold on the night shift on [DATE]. LVN Q stated she worked the following day and was told they were waiting on the eye drops to arrive from the pharmacy. LVN Q stated on Saturday, [DATE] the family called about Resident #4's eye drops. LVN Q stated when she worked since [DATE] she would report in the morning meeting that the eye drops had not been received. ADON E was giving her the information that the medications were still on hold. LVN Q stated she was not able to unhold a medication because she did not receive the physician's order to take the medication off hold. LVN Q stated normally when a medication was placed on hold there was a stop date for when the medication was to be restarted. LVN Q stated she was not able to take an order from ADON E because she was a nurse and not a physician. LVN Q explained ADON E was the nurse to put the medication on hold. LVN Q reported to the former DON and ADON E and she would only get the response that the eye drops were still on hold. LVN Q stated she did not call hospice nor the pharmacy as a follow up. LVN Q stated ADON E should have taken care of the eye drops, called pharmacy and hospice because she executed the order. LVN Q stated there was no physician's order associated with this medication being put on hold. LVN Q stated physician's orders that were not actually physician's orders could not be passed along. An attempt was made to interview LVN R on [DATE] at 9:28 AM. A message was left for a return call.An attempt was made to interview LVN S on [DATE] at 9:38 AM. A message was left for a return call.During an interview with Resident #4 on [DATE] at 9:50 AM, revealed she was diagnosed with glaucoma some time in her 30's. Resident #4 stated she was put on eye drops twice per day, Latanoprost and Dorzolamide. Resident #4 denied experiencing vision loss, blurry vision or pain because of the glaucoma. Resident #4 stated she utilized two separate pairs of glasses for her near- and far-sighted vision. Resident #4 stated she recently went without her eye drops for a period, so she reported to her Family Member. Resident #4 stated she complained to her Family Member the eye drops had been restarted. Resident #4 stated that while she knew she was not getting the eye drops she stated she could not think of any side effects she experienced.During an interview with MA T on [DATE] at 10:25 AM, revealed Resident #4 was previously receiving eye drops (latanoprost and dorzolamide) and then they were stopped because the eye drops were put on hold. MA T stated she would ask the nurse depending on who worked. If it was agency they could not have assisted her (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because the agency nurses were not familiar with the residents. MA T reported to her charge nurses when the eye drops were originally placed on hold. MA T stated she did not have the ability to get the eye drops or fix the order. MA T stated she would ask about the eye drops she was only told the eye drops were on hold. MA T stated she was told ADON E put them on hold. MA T stated when medications were placed on hold, they usually had a stop date, but the eye drops did not.During an interview with Clinical Services Director (CSD) on [DATE] at 10:39 AM, it was revealed that ADONs were expected to report to the DON and act in the place of a DON if there was no DON or if the DON was not in the building. ADONs were to be involved in the daily clinical meeting including going over charting from the day before, admissions, reviewing physician's orders, reviewing incident/accidents amongst other things. CSD stated the Latanoprost and Dorzolamide being on hold for almost a month was not reported to her. CSD stated these medications being placed on hold should have been discussed in the morning clinical meeting. CSD stated any medication that needed to be placed on hold a nurse should be getting physician's order and usually the physician would provide a stop and start date for the hold time. CSD stated when she became aware of the eye drops being on hold when she reviewed ADON E had not put a stop date and there was no information about the physician being contacted. CSD stated she was informed of the medication error on Monday [DATE]. CSD stated ADON E was the clinical management on call over the past weekend. CSD stated if ADON E and/or Weekend Supervisor learned of Resident #4's family's concern over the weekend the Interim DON and Administrator should have been contacted. CSD stated she would consider this a form of neglect. CSD stated ADON E was new in her position. ADON E was described by CSD as someone who was very heightened about everything that came up as a concern, but ADON E lacked the ability to follow up and fix concerns. ADON E could identify concern but no accountability to fix issues.During an interview with Ophthalmologist Assistant on [DATE] at 11:54 AM, revealed Resident #4 was diagnosed with Severe Stage Bilateral Glaucoma. Ophthalmologist Assistant explained glaucoma caused high pressure in the eye that would damage the optic nerve resulting in permanent blindness. The eye drops (Latanoprost and Dorzolamide) were prescribed to keep eye pressure down and prevent further damage. Ophthalmologist Assistant stated Resident #4 would not feel pain as a person could not feel the eye pressure increasing which was why it was important for a patient to be followed by an Ophthalmologist. Once there was vision loss it was permanent and could not be reversed. Ophthalmologist Assistant stated it was very important to continue the eye drops and if needed the eye drops could be sent to the facility. Ophthalmologist Assistant stated they had not seen Resident #4 since August so she could not speak to whether going for almost a month without the eye drops caused further damage to Resident #4's eyes.During an interview with Administrator on [DATE] at 12:38 PM, revealed on Monday afternoon, [DATE], Resident #4's Family Member came in and notified her and ADON E of a complaint, part of which was the concern of Latanoprost and Dorzolamide eye drops being withheld for almost a month, and no one told Family Member. Due to the concerns Interim DON was brought in to hear Family Member concerns. As a result, ADON E reported that she in fact placed the eye drops on hold in March without a physician order. ADON E was placed on suspension pending investigation on [DATE] around 3:00 PM. ADON E did not report calling the physician but there were no physician's orders in the EHR. Administrator explained that the investigation started, safe surveys were started, Abuse Neglect Exploitation in-service was started, a skin and pain assessment were conducted with Resident #4 due to Family Member's other complaints. Family Member, Medical Director and Ombudsman were all notified and then a report was made to HHSC. Administrator stated she spoke with LVN R who reported she was working the night ADON E was completing the medication cart audits. ADON E reported to LVN R the Latanoprost and Dorzolamide were expired and that she put them on hold. ADON E asked LVN R to report to the oncoming nurse that they were on hold until the medications came from the pharmacy. Administrator to place a medication on hold she understood there should have been a call to the physician to receive a physician's order first. Administrator stated she spoke with LVN Q who stated LVN R reported to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her the medication was on hold and LVN Q needed to take the medication off hold when the medications arrived from the pharmacy. Both LVN Q and LVN R thought everything was taken care of because ADON E was the one who placed the eye drops on hold. Administrator denied every hearing LVN Q bring up Resident #4's eye drops being unavailable and/or on hold. During an interview with the Interim DON on [DATE] at 1:00 PM, it was revealed she had only been supporting the facility for just over a week. Interim DON explained that ADON and DON should be running a report before the clinical meeting to determine if there are unavailable medications or on hold medications. Then the ADON and DON should be discussing the medications and follow up for any clarification, making sure the physician, family and residents are notified. Interim DON stated it was important to ensure medications that were unavailable or on hold should be trouble shot to get a root cause and then ensure that no harm occurred because of the resident not having the medication. Interim DON stated the significance of a resident not receiving glaucoma medications was dependent on the individual resident as each person responded differently but glaucoma was a slowing moving illness. Glaucoma caused eye pressure to build up in the eye and eventually lead to blindness if left untreated. Interim DON stated she was not familiar with Resident #4 and what stage her glaucoma was. Interim DON denied receiving a call about the medication error involving Resident #4's eye drops. Interim DON stated she felt she and Administrator should have received a call in Saturday when the family complained due to the length of the medication error. Interim DON stated ADON E acted outside her scope as a LVN by telling nurses to not restart the Latanoprost and Dorzolamide eye drops for Resident #4. During an interview with Hospice Nurse on [DATE] at 1:19 PM, it was revealed she had received a call around 6:00 AM from Family Member of Resident #4 regarding Resident #4's Latanoprost and Dorzolamide being discontinued. Hospice Nurse stated she had not previously been notified of a change with these medications. Hospice Nurse stated hospice did not cover the cost of glaucoma medications and did not order the medications as it was not part of the admitting diagnosis to hospice. Hospice Nurse the glaucoma medications would be ordered through the facility's pharmacy. Hospice Nurse due to their concern about Resident #4 going without the Latanoprost and Dorzolamide Hospice Nurse wrote a telephone order for the Latanoprost and Dorzolamide eye drops because they were included in the original list of medications at the time Resident #4 admitted to hospice, so the facility had an active prescription to be able to obtain the medications from the pharmacy. Hospice Nurse stated ADON E told her the eye drops had been removed from their original box with label and expiration date, so ADON E placed the eye drops on hold and stated she forgot to follow-up. Therefore, Resident #4 went without her Latanoprost and Dorzolamide eye drops for a period.During an interview with Administrator and CSD on [DATE] at 2:30 PM, it revealed ADON E was terminated from the facility effective [DATE]. ADON E was not excepting any calls from the facility or Administrator at the time, but Human Resources would be mailing her termination notice through certified mail.During an interview with RN C on [DATE] at 3:14 PM, revealed she was the Weekend RN Supervisor. RN C stated over the weekend it was brought to her attention Resident #4 had not had her Latanoprost or Dorzolamide in almost a month. LVN Q stated both were put on hold. RN C stated she checked the medication cart and medication refrigerator and could not locate the eye drops for Resident #4. RN C stated she called the on call clinical manager who was ADON E. ADON E confirmed the Latanoprost and Dorzolamide were on hold and explained they were both expired. RN

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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 observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 5 (100 Hall nurse medication cart) medication carts reviewed for medication storage:The facility failed to ensure all medication including insulin pen were not left unsecure and unattended on the 100 hall nurse medication cart. This failure could place residents at risk of having access to unauthorized medications and/or lead to adverse drug reactions or drug diversions. Findings included:During an observation on 04/15/2026 at 12:02 PM, the Hall 100 nurses medication cart was observed to have an insulin pen, lancets and glucometer strips sitting out on top of the medication cart. The medication cart was locked and there was no nurse or staff member at the medication cart, four different staff members were observed to walk past the medication cart . During an observation and interview on 04/15/2026 at 12:09 PM, revealed RN B was walking from down the hallway from a resident room. RN B walked up to the 100 Hall nurse medication cart, unlocked the medication cart and placed the insulin pen, lancets and glucometer strips in the top drawer. RN B stated it was the facility policy to make sure the medication cart was locked and secured 100% of the time when he walked away. RN B stated he never left medications out on top of the cart. Investigator pointed out the insulin and RN B stated he neglected to place the insulin pen back in the medication cart. RN B stated failing to put away medications could result in someone having access to the medication. During an interview with the CSD on 04/16/2026 at 10:39 AM, it was revealed that it was the policy of the facility for all medications to be locked inside of a medication cart or in the medication room when it was unattended. The CSD stated no medication should be left out on the top of the medication cart due to concerns for resident, visitor, and staff safety if the medication was to be picked up by someone. The CSD stated it was up to nursing management to do walking rounds to ensure medications were secured at all times.Review of Medication Storage policy dated 04/17/2024 revealed .POLICY: 1. Medication and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. In accordance with State Federal laws, the facility store all drugs and biologicals in locked compartments under proper temperatures and other appropriate environmental controls to preserve their integrity. 2. The medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members. PROCEDURES: 1. The LTC Pharmacy Provider dispenses medication and biologics in packaging/containers that meet regulatory requirements. Medications and biologicals shall be kept and stored in these packages/containers. Transfer of medications and biologicals from one container to another is not permitted, except by a licensed pharmacist. 2. The medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented and systematically organized for two of four (Resident #1 and Resident #2) reviewed for clinical documentation. 1. The facility failed to ensure staff documented Resident # 1's wound care on the MAR/TAR, that was provided or declined, from 04/11/26 through 04/14/26.2. The facility failed to ensure Resident #2's foley catheter physician order reflected the foley catheter size, the amount required for the [NAME], and the rationale for its use. This failure could place residents at risk of not receiving treatments as ordered which could impact the residents' health and recovery. Findings included:Record review of Resident #1's undated Face Sheet reflected a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Record review of Resident #1's 5-day MDS assessment dated [DATE] reflected a BIMS of 15 which indicated he was cognitively intact, had a urinary catheter, colostomy (surgical procedure that creates an opening in the abdomen to the colon) and abscess (collection of pus and dead tissue) to the groin (junction area between the lower abdomen and inner thigh) and perineum (area between the anus and the genitals) Record review of Resident #1's care plan completed on 03/19/26 and revised on 04/15/26 did not address Resident #1's colostomy. Record review of Resident #1 progress note by RN B on 04/10/26 at 5:49 p.m. reflected, Resident returned from hospital admission at this time. He was accompanied by his [family member] and two transport personnel who transferred him to bed via manual lift. Diagnosis: Perineal (area between genitals and rectum) Abscess wound complication. He is alert and oriented x 4, on a regular diet and requires assistance with ambulation. NP [name] was notified of patient's arrival. His wound vac (negative pressure wound therapy device) was assembled and connected to the machine and power source was plugged. Suction pressure was set to intermittent 125 mmHg of pressure. The skin and all system assessment was deferred at this time. Record review of Resident #1's progress note by RN D on 04/10/26 at 10:00 p.m. reflected, The skin assessment done- Surgical wound site to coccyx (base of the spine) area. Another wound noted on perineum and scrotum, Wound vac noted.skin grafted site on right upper leg- Reddened area noted. Suture marking on both upper legs on inner aspects of thigh.Last foley changed on 04/09/26. Last colostomy bag changed on 04/09/26. There was no documentation to reflect what treatment to the wounds was provided. Record review of Resident #1's Electronic Record reflected no evidence that wound care was provided or declined on 04/11/26. Record review of Resident #1' progress note by RN B on 4/12/26 at 3:46 p.m. reflected, Resident informed this RN at this time that he wishes to defer wound care treatment until 4/13. Record review of Resident #1 progress noted dated 04/13/26 at 4:51 p.m. by the Treatment nurse (recorded as Late entry on 04/15/26 5:00 p.m.) reflected, Writer rounded on resident today for weekly wound care rounds. Wound vac in place to sacrum. Currently set to 125 mmhg. Suctioning noted. MD also assessed peri/groin incisions intact. No open areas noted lower extremities. MD to reinstate previous orders. Record review of Resident #1's Electronic Record reflected no evidence that wound care was provided or declined on 04/14/26. During an interview and observation on 04/15/26 at 2:40 p.m., Resident #1 was observed in bed with a wound vac in place and a urinary catheter. Interview with Resident #1 and his family member revealed he had returned to the facility late on 04/10/26 after a short stay in the hospital for re-evaluation of his wounds. Resident #1 stated he was getting wound care daily but had started to have increased drainage and they sent him out to the hospital for evaluation on 04/06/26. He stated he did not have a wound vac prior to going to the hospital. Resident #1's family member stated since his return on 04/10/26 he had been receiving wound care. During an interview on 04/15/26 at 3:32 p.m. with the Treatment Nurse she stated Resident #1 re-admitted to the facility on the evening of 04/10/26 and the hospital had not sent any wound care orders. She (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she had obtained wound care orders on Monday 04/13/26 from the facility's wound care physician which was to resume the previous wound care orders, with the exception of the wound vac and she was still trying to verify with the hospital the orders. She stated she obtained the orders for the wound vac on 04/14/26. She stated she should had restarted the orders she had on 04/13/26 and then added the wound vac orders. She stated the nurse doing the admission should had reached out to the hospital, or herself and she could had reached out to the wound care physician for the facility or the weekend supervisor could had reached out as well. She stated she provided Resident #1 wound care on 04/13/26 and 04/14/26, it just was not documented. She stated the risk of not having orders upon admission were wounds could not receive treatment and could decline and become worse or infected. She stated it was the expectation any treatment provided needed to be documented on the MAR/TAR, so it was clear what treatment were provided and by whom. During an interview on 04/15/26 at 3:36 p.m. RN B revealed he had started Resident #1's re-admission to the facility. He stated Resident #1 did not come from the hospital with wound care orders. He stated RN D completed the skin assessment and dressing change on 04/11/26 and the resident declined to have wound care on 04/12/26. He stated it was the admitting nurse's responsibility to input the admission orders, and the DON and the ADONs would review the orders the next day or on Monday if it was a weekend admission. He stated they had to have orders to meet the needs of the resident. He stated it was the expectation to document any treatment provided on the MAR/TAR to show a treatment was completed or if it was declined. He stated he documented in the progress note about the Resident's refusal but stated there was nothing on the MAR/TAR since no orders had been put in the system. 2. Record review of Resident #2's undated Face sheet reflected a [AGE] year-old-femle admitted [DATE]. Diagnosis included encephalopathy (disturbance of brain function) cellulitis (bacterial infection of the skin), urinary tract infection, and pressure ulcers. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 12 indicating resident was moderately cognitively impaired. She had a foley catheter, was always incontinent of bowel, and had not received intravenous therapy while a resident. Record Review of Resident #2's care plan initiated on 04/02/26 reflected, [Resident #2] requires an indwelling urinary catheter related to urinary retention and urinary tract infections.Interventions.Change catheter per MD order. Record review of Resident #2's Physician order history report from 03/21/26 through 04/17/26 reflected: Indwelling foley catheter ___Fr (unit of measurement), ____cc's for_____ Diagnosis____ continuous, with a start date 03/16/26. No size of the catheter, the bulb size or rationale for use was identified May change foley catheter for obstruction or dislodging as needed, with a start date of 03/16/26 During an observation and interview on 04/16/26 2:25 p.m., Resident #2 was observed to have a urinary catheter. Resident #2 stated she was not sure how long she had the catheter and was not certain why she had it. She stated she did have a wound on her bottom, the facility was treating. During an interview on 04/16/26 at 10:50 a.m. with the Clinical Service Director, she stated the previous DON had been gone since the end of March 2026, and both the ADONs were new to their roles. She stated it was the expectation, any resident admitted to the facility, had to have orders to provide the necessary care the resident needed, which would include wound care orders, urinary catheter care orders, and depicting the size of the catheter and bulb size. She stated daily orders would need to be clarified immediately in order to provide the residents with the necessary care they needed. She stated any treatment provided was expected to be documented on the MAR/TAR, and reflect what treatment was provided. She stated not having a clear and concise clinical record could delay resident treatments which could result in a decline in the residents' overall well-being and recovery. She stated they identified the facility had documentation issues and had a mobile DON who was to start on 04/20/26 along with corporate support for training needs. Review of the facility's policy, Documentation guidelines dated January 2024, reflected, Documentation guidelines pertinent to good clinical record practice will be followed by all individuals who document in the patient's/resident record. A complete health pictures of the patient/resident must be available to all disciplines (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contributing to patient/resident care. Documentation in the electronic medical record (EMR) and paper versions comply with professional standards.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of seven (Resident #5 and Resident #6) residents observed for infection control. 1. The facility failed to ensure the Treatment Nurse performed hand hygiene during wound care for Resident #5 on 04/15/26. 2. The facility failed to ensure LVN L utilized Enhanced Barrier Precautions while transferring Resident #6 from bed to wheelchair and wheelchair to toilet on 04/16/26 and failed to perform hand hygiene before leaving the room. These failures could place residents at risk for infection and cross contamination.Findings included:1. Record review of Resident #5's undated face sheet reflected a [AGE] year-old female admitted [DATE], diagnosis included acute embolism and thrombosis of right tibial vein (blood clot lower leg).During an interview on 04/15/26 at 10:30 a.m., Resident #5 stated she had been admitted to the facility with bruises on her abdomen from the lovenox injections (anticoagulant) she was receiving due to a blood clot in her leg. Resident #5 stated she was glad they had recently stopped the lovenox, stating she was tired of getting stuck so much. Resident #5 stated she had a wound on the back of her right leg which the facility was treating every day. During an observation and interview on 04/15/26 at 10:55 a.m., the Treatment Nurse was observed at the treatment cart preparing wound care supplies for Resident #5. The Treatment Nurse stated Resident #5 had a small lesion on the back of her right calf the doctor thinks might be skin cancer. The Treatment Nurse gathered her supplies, performed hand hygiene, put on a gown and then put on 3 pairs of gloves one on top of the other, on both hands. The Treatment Nurse entered Resident #5's room and removed the old dressing from the wound. The wound had moderate amount of blood-tinged drainage. The Treatment Nurse then removed the top pair of gloves and proceed to clean the wound with normal saline. The Treatment Nurse then removed the second pair of gloves and applied a small piece of calcium alginate (absorbent type of dressing) to the wound and covered with a dry dressing. The Treatment Nurse then removed the final pair of gloves, her gown and performed hand hygiene. During an interview with the Treatment Nurse on 04/15/26 at 11:10 a.m., she stated she was supposed to perform hand hygiene before and after wound care. She stated she had put on 3 pairs of gloves as convivence for her. She stated she was supposed to perform hand hygiene after gloves changes and stated she should not had triple gloved. She stated the risk to the resident was spread of infection. 2. Record review of Resident #6's undated face sheet reflected a [AGE] year-old male, admitted [DATE]. Diagnoses included type 2 diabetes mellitus (chronic condition where high blood sugar results from insufficient insulin production), chronic viral hepatis C (virus that cause liver inflammation) and hemiparesis unspecified side (weakness affecting one side of the body).During an observation and interview on 04/16/26 at 8:05 a.m., Resident #6 was heard yelling I need help to get up, I need help. The call light was illuminated but no audible sound was heard. An Enhanced Barrier sign was posted outside of Resident #6's room and a cart containing gloves and gowns were also outside of the door. LVN L was observed walking down the hallway and entered Resident #6's room. LVN L then proceeded to transfer Resident #6 from his bed to his wheelchair without putting on gloves or gown. Resident #6 was observed with a dressing on his lower left leg. LVN L then pushed Resident #6 into the bathroom and assisted him to the toilet and told him to call when he was finished. LVN L then checked the bed and determined it was not raising up to chair level which was why Resident #6 was unable to get out of bed. She stated she would notify maintenance to see what was wrong with the bed. LVN L then left the room without performing hand hygiene, walked down the hall and used the hand sanitizer from the hall dispenser. During an interview with LVN L on 04/16/26 at 8:10 a.m., LVN L stated she was not sure if Resident # 6 was on Enhanced Barrier precautions, but stated she guessed he would be since had had a bandage on his leg. She stated she knew when a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was on enhanced barrier precautions they were to wear gloves during direct care but stated she was not sure about the gown. She stated Enhanced Barrier precautions was new to her and stated she guessed she needed some more training related to what to wear and when to wear it. She stated she used the hand sanitizer in the hallway and thought that was acceptable. During an interview on 04/17/26 at 8:00 a.m., Resident #6 stated he was usually able to get out of the bed by himself but stated yesterday (04/16/26) he could not get his bed to rise up where he could slide over into his wheelchair. Resident #6 stated he had asked the staff why they were wearing gowns when they helped him and they told him it was to protect him. He stated not all of the staff wore the gowns. He stated he did have a wound on his leg the staff was treating every day. During an interview on 04/17/26 at 4:06 p.m., the Clinical Service Director stated staff were to change their gloves and perform hand hygiene during wound care. She stated they were to remove their gloves after removing the dressing and cleaning the wound, prior to applying the treatment for the wound. She stated they were never taught to double or triple glove. She stated by not following proper glove changes and hand hygiene it placed residents at risk of cross contamination. She stated they had done extensive in-services with the staff on infection control, especially hand hygiene and the use of Enhanced barrier precautions. She stated any resident with a wound, a catheter, or a G-tube required the use of gown and gloves during any high contact care. Record review of the facility's undated policy titled, Performing A Dressing Change, reflected, .Wash hands before and after donning gloves.Don gloves.Remove old dressing.change gloves.Cleanse the wound of drainage, debris, or dressing/filler residue.change gloves.Apply a cover dressing-date and initial cover dressing.remove gloves. Record review of the facility's policy titled, Transmission Based/Standard Precautions, and Enhanced Barrier Precautions, dated May 2023, reflected, Enhanced Barrier Precautions expand the use of PPE (gowns and gloves) during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.EBP will be implemented for All resident with the following.Wounds and/or indwelling medical devices (urinary catheter, feeding tube.)regardless of MDRO colonization status.EBP will be implemented during the following high-contact resident care activities.Transferring.Providing hygiene.changing briefs or assisting with toilet.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and record review, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 1 centralized staff work area reviewed for resident call system.The facility failed to ensure they had a working call light system that was audible at the centralized staff work area (nurses' station).This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency.During an observation and interview on 04/16/26 at 8:05 a.m., Resident # 6 was heard yelling I need help to get up, I need help. The call light was illuminated but no audible sound was heard. LVN L was observed walking down the hallway and entered Resident #6's room and asked him to stop yelling. Resident #6 stated he was sorry but stated he had been waiting for 45 minutes for someone to come and help him. LVN L stated it had not been 45 minutes. LVN L assisted the resident from his bed to his wheelchair into the bathroom and told him to call when he was finished. LVN L then checked the bed and determined it was not raising up to chair level which was why Resident #6 was unable to get out of bed. She stated she would notify maintenance to see what was wrong with the bed. During an interview with RN B on 04/16/26 at 8:30 a.m., he stated he will answer call lights when he noticed them on. He stated it would be very helpful if they were audible. He stated the lights only illuminate and do not ring so they might go unnoticed for a while. He stated sometimes the lights were audible and other times they were not. He stated he was not sure why they were not audible. RN B was not able to state how long the call light system had not be audible.During an observation and interview on 04/16/2026 at 11:07 AM, the call light notification center (phone with screen identifying the room numbers of residents who requested assistance) was located at the nurses' station directly looking down Hall 200. The Administrator stated the call light system should be sounding as she pointed down Hall 200 at call lights illuminating above resident doors, but no audible sound could be heard. When the Administrator and this Investigator walked up to the call light notification center there was a cord plugging in the phone, the cord was not pushed all the way into the phone, once the phone was plugged in it began to be heard audibly and show the room numbers. The Administrator explained that the staff could not answer the call lights at the nurse's station but had to walk to the residents' rooms, respond, then reset the call lights in the resident rooms. The Administrator stated she was not aware the call light notification center had been unplugged previously.During an interview with the Maintenance Director on 04/16/2026 at 11:15 AM, he said the call light system was obsolete, and was no longer able to purchase parts to keep the call light system fully operational. The Maintenance Director stated he was in the process of getting bids turned into corporate for approval to have the call light system replaced. The Maintenance Director stated there was a supply of cow bells available to pass out to residents in the event the call light system went completely down. He stated it was not uncommon to find the call light system unplugged. The Maintenance Director stated he went to the former DON several times about this concern, he stated that the call light system shows error messages and continually beeps audibly requiring the staff to pick up the phone and set it back down to reset the light, which was why he thought the staff would unplug the phone.During an interview with the CSD on 04/16/2026 at 12:28 PM, it was revealed the call light system was functioning again where the lights were able to be seen and heard audibly. The CSD stated the Administrator was going around doing a one-on-one in-service education with the staff. The CSD stated the unplugging of the call light system was previously an issue around February 2026 and education was conducted at that time. The CSD denied receiving additional complaints. Observation on 04/16/2026 at 12:37 PM, revealed two call lights sounding at the call light notification center but there were no actual light illuminating and the message at the notification center showed failed.During an interview on 04/17/26 at 8:00 a.m., Resident #6 stated he was thankful for the assistance on 04/16/26. He stated he usually was able to get out of the bed by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676319	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corinth Rehabilitation Suites on the Parkway	3511 Corinth Parkway Corinth, TX 76208

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	himself but stated he could not get his bed to rise up where he could slide over into his wheelchair. He stated he does not have to call for help very often, but when he did call for help it would take the staff a while to answer his light. He stated it was not always, but sometimes it was over an hour for them to come. Observation on 04/17/2026 at 8:15 AM, revealed a call light on 200 hall was illuminated both red and white lights were flashing. The call light notification center showed call lights on 100 hall and 300 halls but no information regarding 200 hall.During an interview with CSD on 04/17/2026 at 4:06 PM, it was revealed that the call light system should be maintained and in working order. The CSD stated this meant the call lights should be able to be seen illuminated when looking down the hallway as well as audible at the nurses' station at the call light notification center. Any issues with the call light system should be reported to the Maintenance Director to address and fix any malfunction. The CSD stated that management should be making rounds in the facility at varying times to ensure the call light system was working during rounds. The CSD stated the call light system was utilized to notify staff of a resident needing assistance. The call light system not working could cause a delay in assistance to the residents.Review of Call Lights Policy dated 05/05/2023 revealed .POLICY: The staff will respond to call lights or other requests for assistance to meet the patient's/resident's needs. PROCEDURES: 1. Respond to call lights and requests for assistance as quickly as practicable. 3. Staff respond to emergency light immediately.4. Staff will cancel the call light to notify others that the residents is being assisted. 5. If unable to complete the requested task, inform the patient/resident/family and notify the appropriate discipline. Call lights should not be canceled until the resident's need has been addressed.