STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676321	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Corpu	3030 Fig St Corpus Christi, TX 78404

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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 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 of eight residents (Resident #3) reviewed for medication errors. The facility failed to hold Resident #3's midodrine (blood pressure medication) when Resident #3's blood pressure was outside of physician's parameters on April 3rd, 9th, 10th, 15th, and 21st of 2026. This failure could place residents at risk for complications such as increased blood pressure, exacerbation of symptoms, and potential hospitalization.The findings include:Record review of Resident #3's face sheet dated 05/04/26 revealed a [AGE] year-old male with an original admission date of 12/15/21 and a current admission date of 07/12/24. Resident #3's pertinent diagnosis included heart failure, unspecified (a clinical condition where the heart cannot pump blood efficiently, but the medical documentation lacks sufficient detail to specify if it is systolic, diastolic, acute, or chronic). Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 indicating his cognition was intact. Record review of Resident #3's order summary on 05/04/26 revealed an active order for midodrine oral tablet 10 MG, give 1 tablet by mouth four times a day for BP, hold if BP is greater than 110/60, initiated on 12/26/25. Record review of Resident #3's MAR for April 2026 revealed midodrine was administered at nighttime on the following dates with associated blood pressures:April 3rd, 2026 - 127/76 by LVN EApril 9th, 2026 - 125/67 by LVN EApril 10th, 2026 - 115/73 by LVN BApril 15th, 2026 - 144/61 by LVN CApril 21st, 2026 - 124/87 by LVN E In an interview with the DON at 10:30 AM on 05/05/26, the DON stated the April 2026 MAR for Resident #3 indicated he was administered midodrine 10 MG outside of physician parameters on April 3rd, 9th, 10th, 15, and the 21st. The DON stated the medication should not have been administered on those nights with the blood pressures that were recorded. The DON stated it was important not to administer midodrine outside of parameters because it may lead to hypertension causing heart palpitations or excessive sweating in the resident. A phone interview was attempted with LVN E at 10:39 AM on 05/05/26, but she could not be reached and was left a message to call back. A phone interview was attempted with LVN B at 10:41 AM on 05/05/26, but she could not be reached and was left a message to call back. A phone interview was attempted with LVN C at 11:55 AM on 05/05/26, but she could not be reached and was left a message to call back. Record review of the facility's policy Medication Administration dated 10/24/22 revealed the following policy: .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide reasonable accommodation of resident needs and preferences, for 2 of 6 residents (Resident #35 and Resident #79) reviewed for call light placement. The facility failed to ensure Resident #35 and Resident #79's call lights were within reach.This failure could place residents at risk of needs and accommodations being unmet.Findings included: 1. Record review of Resident #35's face sheet, dated 05/03/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities), anxiety disorder (uncontrollable worry about everyday issues, affecting daily functioning and quality of life),), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and cerebral infarction (stroke). Record review of Resident #35's MDS, dated [DATE], reflected a BIMS was not conducted as Resident #35 was rarely/never understood. The MDS reflected Resident #35 was dependent for all activities of daily living. Resident #35 was dependent for roll left/right. Record review of Resident #35's care plan, dated 05/03/26, reflected [Resident #35] had an ADL self-care performance deficit related to cerebral infarction. Date initiated: 03/20/25. Interventions: [Resident #35] was dependent on staff for all ADLs. [Resident #35] was at high risk for falls. Date initiated: 03/20/25. Interventions: Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. 2. Record review of Resident #79's face sheet, dated 05/03/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: nontraumatic intracerebral hemorrhage (bleeding within the brain tissue, resulting from underlying health issues rather than external trauma), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), anxiety disorder (uncontrollable worry about everyday issues, affecting daily functioning and quality of life), major depressive disorder (mental health condition with persistent feelings of sadness, loss of interest, various emotional/physical problems), and encephalopathy (disorder that affects brain function). Record review of Resident #79's MDS, dated [DATE], reflected a BIMS score of 7, indicating severe cognitive impairment. The MDS reflected Resident #79 was dependent for toileting hygiene, shower/bathe self, and lower body dressing. Resident #79 required substantial/maximal assistance for personal hygiene and roll left/right. Record review of Resident #79's care plan, dated 05/03/26, reflected [Resident #79] had an ADL self-care performance deficit related to brain injury. Date initiated: 12/13/24. Interventions: [Resident #79] was dependent on staff or required assistance for all ADLs. [Resident #79] was at high risk for falls. Date initiated: 12/13/24. Interventions: Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. During an interview and observation, on 05/03/26 at 2:20 PM, Resident #35 was asked basic questions and she did not respond. Resident #35 was not interviewable. Resident #35 was lying in bed and not injured or in distress. The call light was hanging on the bed frame behind Resident #35's head and was not within reach. During an interview and observation, on 05/03/26 at 2:25 PM, CNA G stated Resident #35 was not able to reach the call light where it was hanging on the bed frame. CNA G moved the call light and placed it within reach of Resident #35. CNA G stated she was not sure who changed or repositioned Resident #35 last but perhaps they forgot to leave the call light within reach. CNA G stated Resident #35 was not able to use the call light so the staff rounded on her more frequently, but it was still the staff's responsibility to ensure Resident #35's call light was within reach at all times. During an interview and observation, on 05/03/26 at 2:45 PM, Resident #79 was asked basic questions, and she did not respond with coherent answers. Resident #79 was not interviewable. Resident #79 was lying in bed and not injured or in distress. The call light was hanging off the bed with the button hanging towards the floor and was not within reach of Resident #79. During an interview, on 05/03/26 at 2:55 PM, CNA G stated Resident #79 cannot move much but was (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to use the call light. CNA G stated Resident #79 was dependent for most needs. CNA G stated Resident #79 liked to be in bed but she did not know who checked on Resident #79 last. CNA G stated it was the staff's responsibility to ensure Resident #79's call light was within reach at all times. During an interview and observation, on 05/03/26 at 3:00 PM, LVN K stated Resident #79's knees were contracted so she does not get up from bed, but was able to move her arms, reposition herself in bed, and press the call light. LVN K stated Resident #79 was not able to reach the call light where it was hanging off the bed. LVN K moved the call light and placed it within reach of Resident #79. LVN K stated the CNAs and the nurses ensured the residents' call lights were left within reach as it was a team effort. LVN K stated Resident #35 was not able to use the call light as Resident #35 was very confused. LVN K stated regardless, staff had to ensure to leave the call light within reach no matter if the resident was able to use it or not, it had to be available and within reach at all times. During an interview, on 05/05/26 at 10:40 AM, the ADON stated staff were instructed to place the call lights within reach for residents at all times, even if the resident was unable to use the call light. The ADON stated Resident #35 had a soft touch pad call light but did not comprehend how to use it. During an interview, on 05/05/26 at 1:45 PM, the DON stated it was the staff's responsibility to ensure the call lights were within reach of the residents. The DON stated regardless of if the resident had the capability to use or press the call light, the call light should have been within reach and not hanging on the bed frame or hanging towards the floor. Record review of the facility's Call Lights: Accessibility and Timely Response policy, dated 10/13/22, reflected - Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. 5. Staff will ensure the call light is within reach of resident and secured, as needed.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 at time of admission, for 2 of 12 residents (Resident #48 and Resident #124) reviewed for physician admission orders. -The facility failed to ensure Resident #48's Morphine order had specific pain level parameters for administration. -The facility failed to have physician orders in place for Resident #124's indwelling catheter. These failures could place residents at risk of not receiving appropriate care.Findings included: 1. Record review of Resident #48's admission record reflected an [AGE] year-old male originally admitted to the facility on [DATE] and most recently admitted on [DATE]. His relevant diagnoses included Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), alcoholic polyneuropathy (nerve damage caused by years of heavy drinking and poor nutrition that can cause pain, numbness, weakness, balance issues and more), heart failure (when the heart does not pump blood as well as it should causing fluid to build up in the lungs), and chronic obstructive pulmonary disease (a progressive, incurable lung disease that causes inflammation and difficulty breathing). Record review of Resident #48's quarterly MDS dated [DATE] reflected a BIMS score of 1 which indicated he had severe cognitive impairment. Record review of Resident #48's care plan dated 07/12/25 reflected a focus of a terminal diagnosis related to Alzheimer's disease initiated 04/29/26. The focus was the resident's comfort would be maintained through the review date. Interventions included admit patient to routine hospice care with terminal diagnosis of Alzheimer's Disease by [Hospice RN] under the care of medical director [Hospice medical director's name], observe resident closely for signs of pain, administer pain medication as ordered, and notify physician immediately if there is breakthrough pain, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met, work with nursing staff to provide maximum comfort for the resident. Initiated on 04/29/26. Record review of Resident #48's order summary on 05/05/26 reflected the following orders: Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.25 ml by mouth every 2 hours as needed for Pain. Order date 04/16/26. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.5 ml by mouth every 2 hours as needed for Pain. Order date 04/16/26. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 0.75 ml by mouth every 2 hours as needed for Pain. Order date 04/16/26. Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML. Give 1 ml by mouth every 2 hours as needed for Pain. Order date 04/16/26. Record review of Resident #48's Morphine order details reflected: Order Summary: Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Pain AND Give 0.50 ml by mouth every 2 hours as needed for Pain AND Give 0.75 ml by mouth every 2 hours as needed for Pain AND Give 1 ml by mouth every 2 hours as needed for Pain. Created by LVN J on 04/16/26. 2. Record review of Resident #124's face sheet, dated 05/04/26, reflected an [AGE] year-old male, admitted on [DATE], diagnoses included: non-ST-segment elevation myocardial infarction (heart attack when a part of the heart is not getting enough oxygen), sepsis (condition caused by the body's extreme response to an infection), chronic kidney disease (kidneys gradually lose function), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and pneumonia (infection that inflames the lungs). Record review of Resident #124's MDS, dated [DATE], reflected MDS was in progress. Resident #124 had a BIMS score of 15, indicating intact cognition. Record review of Resident #124's baseline care plan, dated 04/27/26, reflected [Resident #124] used a catheter. Interventions: check tubing for kinks, monitor and document intake/output as ordered, monitor for signs/symptoms of discomfort, and monitor for signs/symptoms and report to MD for: pain, burning, blood tinged urine, cloudiness, no output, (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating patterns. The baseline care plan was completed by LVN K and reviewed/signed off by the DON. Record review of Resident #124's order summary report, dated 05/04/26, reflected there were no orders for Resident #124's indwelling catheter. Record review of Resident #124's order summary report, dated 05/05/26, reflected orders: indwelling urinary catheter care every shift and PRN, clean with soap and water/cleansing wipes every shift and as needed, indwelling urinary catheter: irrigate catheter with 30 MLS of NS as needed, indwelling urinary catheter: change 16 F with 30 ml bulb as needed for PRN plugged or out, check indwelling urinary catheter use securement device every shift use leg strap to secure foley in place, monitor for catheter privacy bag placement every shift, and monitor that collection bag is off the floor and hung below bladder level every shift with start date of: 05/05/26. During an observation and interview, on 05/04/26 at 10:00 AM, Resident #124 stated he was doing well as the staff took care of him. Resident #124 stated he had been at different hospitals and had the catheter placed during one of those visits. Resident #124 stated the facility staff emptied out the bag, checked the tubing, and cleaned it. Resident #124 stated there were no issues with the catheter. Resident #124's urinary bag was observed hanging below the bladder, off the floor with a privacy bag. During an interview, on 05/05/26 at 10:20 AM, LVN F stated Resident #124 had an indwelling catheter and she knew how to care for the catheter with training and following his orders. LVN F was asked what were Resident #124's catheter orders. LVN F reviewed Resident #124 physician's orders and verified there were no orders for the catheter. LVN F stated the admitting nurse was responsible for inputting the orders and the team reviewed/verified the orders. LVN F stated she inputted the orders for the catheter at this time. During an interview, on 05/05/26 at 10:40 AM, the ADON stated for new admissions, the admitting nurse input orders, and called the doctor for clarifications. The ADON stated it was a team effort to review and ensure all orders were in place appropriately. The ADON stated residents with a foley catheter had to have orders in place. The ADON stated Resident #124 had an indwelling foley catheter, but she was unsure if Resident #124 had orders for the catheter. The ADON stated she and LVN F provided catheter care today without issue and Resident #124 had not been injured or harmed. In an interview on 05/05/26 at 11:57 am, LVN J stated for the Morphine orders for Resident #48, the and was automatically put into the order due to the way it was entered into the computer. She stated if the orders were put in separately for each of the Morphine doses, each dose was on the MAR individually and a nurse could mistakenly give a resident too much Morphine. She stated she was not sure how to change the order so it did not put the AND in it. She stated the Morphine order for Resident #48 was a written hospice order that she put into the computer. LVN J stated the hospice orders went into the computer under the facility doctor's name because the hospice doctors could not get into the computerized medical record to electronically sign the order. She stated there was a progress note that said which doctor wrote the orders and the reason there were no pain level parameters was because it was not written that way by the hospice provider. LVN J stated it was important to have pain level parameters, so the nurses knew what amount of Morphine to give the resident based on his pain level. In an attempted interview, on 05/05/26 at 12:15 PM, LVN K was not working. A phone call was attempted and a voicemail was left requesting a callback. During an interview, on 05/05/26 at 1:35 PM, the ADM stated there was no policy for admission orders. During an interview, on 05/05/26 at 1:45 PM, the DON stated Resident #124 was admitted on [DATE] and had the indwelling catheter present on admission. The DON stated Resident #124 should have had orders for the catheter since his admission. The DON stated the admitting nurse inputted the orders and the team verified to ensure all orders were in place and appropriate. The DON stated she reviewed Resident #124's orders and verified he did not have catheter orders until today. The DON stated there was no negative outcome or risk of harm for Resident #124 as staff knew how to care for him and the catheter. The DON stated the CNAs knew to call the nurse for any changes related to the catheter and the nurses knew how to care for the catheter as that was part of their (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	competency checks. The DON stated it was important for orders to be accurate to ensure all staff were aware of how to care for the resident and to provide appropriate care. In an interview on 05/05/26 at 2:26 pm, the DON stated it was important to have parameters for Morphine orders, so the resident was medicated appropriately. She stated it was important to not have the and in the order so that residents were not overmedicated. The DON stated if a resident was overmedicated with Morphine, it could cause decreased respirations and death.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the assessment accurately reflected the resident's status, for 1 of 6 (Resident #124) residents reviewed for accuracy of assessments. The facility failed to ensure Resident #124's baseline care plan was accurate. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #124's face sheet, dated 05/04/26, reflected an [AGE] year-old male, admitted on [DATE], diagnoses included: non-ST-segment elevation myocardial infarction (heart attack when a part of the heart is not getting enough oxygen), sepsis (condition caused by the body's extreme response to an infection), chronic kidney disease (kidneys gradually lose function), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and pneumonia (infection that inflames the lungs). Record review of Resident #124's MDS, dated [DATE], reflected the MDS was in progress. Resident #124 had a BIMS score of 15, indicating intact cognition. Record review of Resident #124's baseline care plan, dated 04/27/26, reflected [Resident #124] used an external catheter. There was an option to check off indwelling catheter which was not selected. The baseline care plan was completed by LVN K and reviewed/signed off by the DON. During an observation and interview, on 05/04/26 at 10:00 AM, Resident #124 stated he was doing well as the staff took care of him. Resident #124 stated he had been at different hospitals and had the catheter placed during one of those visits. Resident #124 stated the facility staff emptied out the bag, checked the tubing, and cleaned it. Resident #124 stated there were no issues with the catheter. Resident #124's urinary bag was observed hanging below the bladder, off the floor with a privacy bag. During an interview, on 05/05/26 at 10:40 AM, the ADON stated the initial baseline care plan was completed by the admitting nurse and reviewed/signed off by an RN. During an interview, on 05/05/26 at 11:55 AM, the DON stated there was no policy for resident assessments. In an attempted interview, on 05/05/26 at 12:15 PM, LVN K was not working. A phone call was attempted and a voicemail was left requesting a callback. During an interview, on 05/05/26 at 1:45 PM, the DON stated Resident #124 was admitted on [DATE] and had the indwelling catheter present on admission. The DON stated Resident #124's baseline care plan reflected the use of a catheter, however, it was marked as an external catheter instead of an indwelling catheter. The DON stated the admitting nurse, LVN K, completed the baseline care plan, and the DON was the RN that signed off on the assessment. The DON stated she was supposed to review the information and ensure it was accurate, however, she had been very busy so she only signed off. The DON stated there was no negative outcome or risk of harm for Resident #124 as staff knew how to care for him and the indwelling catheter. The DON stated it was important for the assessments, including the baseline care plan, to be accurate to provide appropriate care for the resident. Record review of the facility's Baseline Care Plan policy, dated 06/06/25, reflected - Policy: The facility will develop and implement a baseline 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. 1. The baseline care plan will: b. include the minimum healthcare information necessary to properly are for a resident. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident or resident representative, as applicable. b. interventions shall be initiated that address the resident's current needs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, for 2 (Resident #106 and Resident #68) of 16 residents reviewed for care plans. - The facility failed to develop Resident #106's care plan in that his oxygen use was not identified and planned for. - The facility failed to ensure Resident #68's care plan reflected the need for enhanced barrier precautions. These failures could place residents at an increased risk of needs going unmet or harm. Findings included: 1. Record review of Resident #106's face sheet dated 05/04/26 revealed a [AGE] year-old male with an admission date of 04/02/26. Resident #106's pertinent diagnosis included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrients). Record review of Resident #106's Comprehensive MDS assessment dated [DATE] revealed a BIMS score could not be obtained because the resident is rarely understood. Further review revealed Resident #106 had not received oxygen within 14 days of the MDS Assessment. Record review of Resident #106's Comprehensive Care Plan dated 05/04/26 revealed oxygen use had not been care planned. 2. Record review of Resident #68's face sheet, dated 05/03/26, reflected a [AGE] year-old female, admitted on [DATE], diagnoses included: acute embolism and thrombosis of deep veins (formation of a blood clot in blood vessels) of left upper extremity, lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues), heart failure (heart muscle unable to pump enough blood), chronic kidney disease (condition that affects the kidneys' ability to filter waste from the blood), muscle wasting and atrophy (reduction in muscle mass and strength), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), anxiety disorder (uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and unspecified dementia (decline in cognitive function severe enough to interfere with daily life affecting memory loss, language, problem solving, and other cognitive abilities). Record review of Resident #68's MDS, dated [DATE], reflected a BIMS score of 13, indicating intact cognition. Record review of Resident #68's care plan, dated 05/03/26, reflected [Resident #68] had potential/actual impairment to skin integrity. [Resident #68] had an alteration in skin integrity related the presence of pressure ulcer/injury. The care plan did not reflect enhanced barrier precautions. During an interview and observation, on 05/03/26 at 3:45 PM, Resident #68 stated she was doing well. Resident #68 stated she had wounds on her legs and feet. Resident #68 stated the staff wore yellow gowns and gloves to provide her care. Resident #68 stated the nurses cleaned the areas and changed the bandages every day. Resident #68 stated she did not remember how long she had the wounds but it has been months. Resident #68 was covered with a blanket, her legs/feet were not visible, and she did not allow to move the blanket. During an interview and observation, on 05/03/26 at 4:27 PM, LVN H was observed donning gown and gloves to enter Resident #68's room. LVN H exited the room at 4:30 PM. LVN H stated Resident #6 was on EBP for wounds that she had since admission. LVN H stated staff knew to wear appropriate PPE by following the signs, having the supplies at the door, and getting updates on residents during shift change. During an observation of Resident #106 in his room at 9:38 AM on 05/04/26, Resident #106 was laying in bed with nasal canula flowing 2 L/M of oxygen. An interview was attempted at this time but Resident #106 was not interviewable. During an interview, on 05/05/26 at 10:40 AM, the ADON stated Resident #68 had wounds and required EBP. The ADON stated Resident #68's need for EBP should have been care planned. During an interview, on 05/05/26 at 1:45 PM, the DON stated Resident #68 had wounds on her feet, toes, knee, and shin which were present since admission on [DATE]. The DON stated Resident #68 required EBP since admission and the EBP should have been care planned. The DON (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she reviewed Resident #68's care plan and verified EBP was not in her care plan. The DON stated there was no negative outcome for Resident #68 and no risk of harm or injury because staff had the supplies and were aware to don PPE for those residents with wounds. The DON stated it was important to develop care plans accurately so everyone knew how to care for the resident. In an interview on 05/05/26 at 1:48 PM, the MDS Nurse stated she was the care management specialist at the facility. The MDS Nurse stated she completed the MDS assessments and completed comprehensive care plans. The MDS Nurse stated it was her fault that oxygen had not been care planned in Resident #106's comprehensive care plan. The MDS Nurse stated she did not have a good reason for why it was not done in a timely manner. The MDS Nurse stated it was important for the care plan to be completed on time so everyone could refer back to it for the resident's care. In an interview with the DON at 2:05 PM on 05/05/26, the DON stated the MDS Nurse was responsible for updating the residents comprehensive care plans. The DON stated Resident #106's oxygen use should have been care planned. The DON stated any time there was a change of condition she expected the comprehensive care plan to be updated no later than 2 business days. The DON stated it was important to update the care plans in a timely manner, so all nurses knew how to properly care for the residents. Record review of the facility policy Comprehensive Care Plans dated 10/24/22 revealed the following policy: .3. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, physicians orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 residents (Resident #106) reviewed for respiratory care. The facility failed to ensure LVN C transcribed a physician's order during her shift for oxygen at 2 Lpm as needed into PCC for Resident #9. This deficient practice could place residents at-risk for insufficient or inappropriate care due to other staff not being aware the physician's order existed.The findings include:Record review of Resident #106's face sheet dated 05/04/26 revealed a [AGE] year-old male with an admission date of 04/02/26. Resident #106's pertinent diagnosis included vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrients). Record review of Resident #106's Comprehensive MDS assessment dated [DATE] revealed a BIMS score could not be obtained because the resident is rarely understood. Further review revealed Resident #106 had not received oxygen within 14 days of the MDS Assessment. Record review of Resident #106's Comprehensive Care Plan dated 05/04/26 revealed oxygen use had not been care planned. Record review of Resident #106's order summary dated 05/04/26 revealed no orders for oxygen use. Record review of nurse progress notes on 05/04/26 revealed a progress note with an effective date of 04/20/26 at 10:28 PM written by LVN C stated Resident noted to be coughing up think white to clear Phlegm. Pale in color. O2 sating at 84%, resident was afebrile (no fever). Called [Nurse Practitioner] at this time. Order for [Chest X-Ray] STAT given and resident to be placed on oxygen at 3L/M per nasal canula. O2 was given as ordered at this time and resident O2 level at 92%. Resident has PRN order for Duoneb (medication to increase oxygen intake) to be given Q 6 hours PRN. Which was given at this time, Resident noted to relax, breathing normal after neb[ulizer] [treatment] given. During an observation of Resident #106 in his room at 9:38 AM on 05/04/26, Resident #106 was laying in bed with nasal canula flowing 2 L/M of oxygen. An interview was attempted at this time but Resident #106 was not interviewable. In an interview with LVN D at 3:07 PM on 05/04/26, LVN D stated she was the floor nurse for Resident #106 for her shift. LVN D stated she was not sure what the correct L/M of oxygen flow for Resident #106 was. LVN D stated if she needed to look up the correct oxygen flow she would check the orders for Resident #106. LVN D stated she could not find any orders for oxygen use in Resident #106's EHR. LVN D stated it was important to put orders into the EHR for residents so everyone knew how to properly care for them. In an interview with the DON at 2:05 PM on 05/05/26, the DON stated there should have been an order for oxygen for Resident #106 in his EHR. The DON stated the resident went to the hospital about 2 weeks ago, and when he came back he was on oxygen. The DON stated the admitting nurse should have put the new order for oxygen into his EHR. The DON stated the admitting nurse in this case was LVN C. The DON stated it was important to have accurate orders so every nurse could properly care for the residents. A phone interview was attempted with LVN C at 11:55 AM on 05/05/26, but she could not be reached and was left a message to call back. Record review of the undated facility guidelines titled When you are writing/ obtaining orders for one of the following please use the following suggestions for writing orders to have complete and accurate orders revealed the following: .Write prn orders for oxygen if resident uses oxygen.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs, for 1 of 6 (Resident #76) residents reviewed for unnecessary medications. The facility failed to ensure Resident #76's Xanax (psychotropic medication for anxiety) medication was not used for an excessive duration. This failure could put residents at risk of harm from adverse reactions or harmful side effects. Findings included: Record review of Resident #76's face sheet, dated 05/04/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: syncope and collapse (temporary loss of consciousness due to reduced blood flow to the brain), malignant neoplasm of the temporal lobe (cancerous tumor in the brain's temporal lobe), sepsis (condition caused by the body's extreme response to an infection), chronic obstructive pulmonary disease (progressive lung disease), muscle wasting and atrophy (reduction in muscle mass and strength), and pneumonia (infection that inflames the lungs). Record review of Resident #76's MDS, dated [DATE], reflected Resident #76 had a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #76's care plan, dated 05/04/26, reflected [Resident #76] used anti-anxiety medications (Xanax) related to anxiety disorder. Date initiated: 04/15/26. Interventions: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness. Record review of Resident #76's order summary report, dated 05/04/26, reflected an active order: Xanax oral tablet 0.25 MG (Alprazolam), give 1 tablet by mouth every 24 hours as needed for anxiety with start date of: 04/04/26 and no stop date. Recor review of Resident #76's MAR, dated April-May 2026, reflected Resident #76 was administered Xanax oral tablet 0.25 MG on 04/04/26 at 11:57 AM and 04/07/26 at 6:31 AM.During an interview and observation, on 05/04/26 at 8:05 AM, Resident #76 was asked basic questions and he did not respond. Resident #76 was not interviewable. Resident #76 was lying in bed and not injured or in distress. During an interview, on 05/05/26 at 10:40 AM, the ADON stated PRN psychotropic medications were ordered for 14 days. The ADON stated a new order was obtained to continue to use the medication. The ADON stated Resident #76 had been admitted under hospice services recently as he had declined, and that was the family's decision. The ADON stated there were days when Resident #76 did not respond or interact. During an interview, on 05/05/26 at 1:45 PM, the DON stated Resident #76 had an order for Xanax to be used as needed for anxiety with start date of 04/04/26. The DON stated the order had no stop date. The DON stated Resident #76's order should have had a stop date of 14 days. The DON stated when the order was inputted, the nurse should have ensured the order had a stop date. The DON stated she was not sure who input the order. The DON stated the medication was not being used to sedate Resident #76 or for the staff's convenience. The DON stated there was no negative outcome for Resident #76 and no risk of injury or harm because the medication was only administered as needed. Record review of the facility's Medication Management policy, dated 10/01/19, reflected - Policy: In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. F. As needed (PRN) orders include an indication for use. a. If the PRN medication is used to modify behavior, the indication for use is clearly defined in objective terms (what specific symptom is being addressed). c. PRN orders for psychotropic drugs are limited to 14 days.

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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 that drugs and biologicals were stored in locked compartments for 1 of 8 medication carts observed for compliance. The facility failed to ensure the 400-hall medication cart was not left unlocked and unattended by LVN I.This failure could place residents at risk of access and ingestion of medications and risk of drug diversion.Observation on 5/3/26, at 10:30 a.m., the 400-hall medication cart was unlocked and no staff member within view of the cart. During an interview on 5/3/2026 at 10:35 a.m., LVN I verbalized the cart was hers and she had stepped into a room to assist a resident. LVN I verbalized she thought she locked the cart before walking away. LVN I stated it is her responsibility and expected of her to lock the cart. LVN I also stated a resident could have accessed the medications in the drawers that were accessible (all non-narcotics).During an interview on 5/5/2026 at 1:30 p.m., the DON stated it is her expectation for all medication carts to be locked when staff are not in sight of the cart. The DON stated residents on the 400 hall could have accessed the medication in the cart. The DON stated, LVN I has been re-educated regarding leaving the medication cart unlocked. Record review of a facility policy titled, Medication Carts and Supplies for Administering Meds reviewed 10/01/2019, reflected, 2. The medication cart is locked at all times when not in use. and 4. Wheel the medication cart to the resident's room when passing medications or park the medication cart in the doorway of the room with drawers facing the Nurse as she/he stands in the room. The cart must remain in your line of sight when it is not locked. The medication cart is not to be wheeled into a resident group setting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 1 (Resident #64) of 5 residents reviewed for infection control practices. The facility failed to ensure RN A washed her hands prior to beginning wound care, performed hand hygiene and changed gloves between removing soiled dressings and placing clean dressings, and washed her hands after performing wound care for Resident #64. The facility failed to ensure RN A did not place clean wound care supplies on a surface that had not been disinfected. The facility failed to ensure RN A placed a barrier between Resident #64's buttocks and brief during wound care. These failures could place residents at risk of cross-contamination and development or spread of infection. The findings included: Record review of Resident #64's admission record reflected a [AGE] year-old male resident admitted to the facility on [DATE]. His pertinent diagnoses included pressure ulcer of the right buttock- unstageable (localized skin and soft tissue injuries that develop due to prolonged pressure exerted over specific areas of the body with full thickness tissue loss where the wound base is covered by thick, leathery, or sloughy (dead) tissue, making it impossible to see the wound bed), pressure ulcer of the sacrum (the triangular bone at the base of the spine)- unstageable, sepsis- unspecified organism (damage to vital organs caused by an infection), and lymphedema wounds of the right and left arms (fluid buildup and swelling that occurs when your lymphatic system is blocked somewhere in your body, preventing lymph fluid from draining properly). Record review of Resident #64's admission MDS dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #64's order summary report on 05/04/26 reflected the following orders: Lymphedema wounds to left arm: Clean with NS and dry. Apply [name of a sterile, non-adherent, petrolatum-based wound dressing impregnated with 3% Bismuth Tribromophenate (an antimicrobial), designed for treating light- draining wounds, burns, and surgical sites by providing a moist healing environment, preventing stickiness to the wound, and acting as an antiseptic agent to prevent infection] and wrap with [name of a sterile roll of bulky gauze] daily, one time a day. Lymphedema wounds to right arm: Clean with NS and dry. Apply [name of a sterile, non-adherent, petrolatum-based wound dressing impregnated with 3% Bismuth Tribromophenate (an antimicrobial), designed for treating light- draining wounds, burns, and surgical sites by providing a moist healing environment, preventing stickiness to the wound, and acting as an antiseptic agent to prevent infection] and wrap with [name of a sterile roll of bulky gauze] daily, one time a day. Unstageable pressure injury to right gluteus (cheek of buttocks): clean with NS and dry. Apply [name of water-soluble gel used for wound care], calcium alginate and cover with bordered foam dressing daily, one time a day. Unstageable pressure injury to sacrum: clean with NS and dry. Apply [name of water-soluble gel used for wound care], calcium alginate and cover with bordered foam dressing daily, one time a day. All ordered on 04/15/26. During an observation of Resident #64's wound care on 05/04/2026 beginning at 8:39 am, RN A picked up the wound care supplies (several 4 inch by 4 inch gauze pads, 2 packages of petrolatum gauze, 2 packages of rolled bulky dressing, and a 15ml vial of 0.9% saline), walked into Resident #64's room and set the supplies down on his rolling overbed table which had numerous other personal items on it. RN A did not wash or sanitize her hands prior to putting on gloves and beginning wound care on Resident #64. RN A took her bandage scissors out of her scrub shirt pocket and cut Resident #64's soiled dressings off of his right forearm, then laid the scissors on top of his blanket on his lap. RN A threw away the soiled dressings then picked up the vial of saline, squirted some on Resident #64's wounds on his right arm, put the vial back on the table, picked up a piece of gauze, wiped off one of the wounds, threw the gauze away, and repeated this for the rest of the wounds on his right arm. RN A picked up one of the unopened packages of petrolatum gauze, opened it, removed the dressing from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the package, threw the package in the trash, and applied the dressing to Resident #64's right forearm. RN A then picked up one of the unopened packages of rolled gauze, opened it, removed the roll, threw away the package, then applied the rolled gauze to Resident #64's right forearm over the petrolatum gauze. RN A removed her gloves, did not perform hand hygiene, put on a clean pair of gloves, and repeated the same steps for Resident #64's left forearm. After RN A finished Resident #64's wound care on his arms, she removed her gloves, picked up her bandage scissors, and walked out of the room. RN A did not wash her hands after she finished with Resident #64's wound care on his arms. RN A stepped out of the room to get assistance for the rest of Resident #64's wound care to his buttocks and sacral areas. RN A gathered her supplies for Resident #64's wound care with the assistance of the ADON and the DON. RN A washed her hands but put her hands under the water several times while scrubbing. After she washed her hands, RN A touched the doorknob in bathroom, the rolling table, and the bed controls. RN A did not perform hand hygiene, put on gloves, then took off Resident #64's blankets, pillow under his side/bottom, and unfastened the right side of his brief. The ADON and the DON helped and turned Resident #64 on his left side then RN A moved the unsecured side of Resident #64's brief part way down, did not place a barrier between his brief and his buttocks, took off the bordered gauze on his sacrum and right gluteus, threw them in the trash, then touched clean gauze pads with dirty gloves. RN A took off her gloves and washed her hands with soap and water, put on clean gloves and finished with Resident #64's wound care. In an interview on 05/04/26 at 9:21 am, RN A stated she should have gotten a table and wiped it with disinfectant wipes before getting supplies for Resident #64's wound care. She stated she washed her hands before she got to her cart, but she should have washed them again before she started wound care. RN A stated she scrubbed her hands for one minute and got a little more water when she scrubbed because she felt she did not have enough lather. She stated she normally put her supplies on top of the inside of the dressing package but forgot to this time. RN A stated it was important to wash hands before and after wound care to prevent the spread of infection. She stated it was important not to put clean or sterile supplies or dressings on a dirty surface to prevent contamination of the wounds. RN A stated she did not normally do wound care but was filling in for the treatment nurse who was on vacation. RN A stated she had only been at the facility for a couple of months and only worked weekends as needed. In an interview on 05/05/26 at 10:56 am, the WCN stated it was important to wash hands to keep infection down, reduce bacteria, and ensure bacteria were not transferred to residents. She stated it was important to have a clean surface for supplies, so infection or organisms were not transferred from the surface to the resident. The WCN stated it was important to change gloves and clean hands between dirty and clean procedures to ensure bacteria were not transferred back to the resident after the wounds were cleaned. She stated she had competency check offs done once a year which was done about 4 months ago, and she just completed her wound care certification within the last 3 months. The WCN stated RN A had been at the facility for a couple of months, and she had not taught RN A to do wound care. She stated she thought wound care was part of the onboarding paperwork, but she did not know. The WCN stated when she was not at the facility, the floor nurses did wound care and on weekends the usual RN supervisor did it. She stated she thought all the nurses had wound care in their annual skills check offs. The WCN stated in-services on handwashing was part of their online training, and they demonstrated it about every quarter. In an interview on 05/05/26 at 1:51 pm, the DON stated staff did competency checkoffs when hired and annually. She stated she thought at least the basics of wound care were on the check-off. The DON stated she did not know if RN A had a check-off done. The DON stated RN A was hired not that long ago, maybe a month ago, and she only worked weekends. The DON stated staff was in-serviced on infection prevention and hand washing when hired and at least annually. She stated staff also had online education that included hand washing and infection prevention. The DON stated it was very important for hand hygiene to be done properly because it was the first line of defense against spreading germs or bacteria to residents. She stated supplies needed to be put on a clean surface to prevent contamination. The DON stated hand washing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was done when the nurse walked into the room, then hand hygiene was done and gloves changed after the soiled dressing was removed and after the wound was cleaned before putting on clean the clean dressing. She stated when wound care was completed for all wounds, the nurse washed her hands before exiting the room. The DON stated it was important to place a barrier under the resident's wound to protect the wound area from the brief or other surface and to prevent potential bacteria from entering the wound. The facility did not provide a completed Wound Treatment Competency Assessment for RN A. Record review of the facility's Hand Hygiene Policy dated 10/24/22 reflected in part: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: 1. Staff will perform band hygiene when indicated, using proper technique consistent with accepted standards of practice. 4. Hand hygiene technique when using soap and water: a. Wet hands with water. Avoid using hot water to prevent drying of skin. b. Apply to hands the amount of soap recommended by the manufacturer. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. 5. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Record review of the facility's undated Wound Treatment Competency Assessment reflected in part: 4. Performs hand hygiene and puts on gloves/ appropriate PPE as indicated. 5. Places supplies on barrier and clean surface. Open supplies without contaminating. 6. Position the area to be treated. Place a clean barrier next to the resident to protect the bed linen. 7. Remove soiled dressings and discards into appropriate receptacle. 8. Removes gloves, performs hand hygiene, and dons clean gloves. 9. Cleanse the wound as ordered, using gauze once and discard in the appropriate receptacle. 10. Removes gloves, performs hand hygiene, and dons clean gloves. 12. Applies and secures dressing as ordered. 13. Discard all disposable items to the designated receptacle and remove gloves. Take receptacle to cart for disposal. 14. Wash hands.