STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676327	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Healthcare and Rehabilitation	1500 Cottonwood Creek Trail Cedar Park, TX 78613

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 3 of 8 residents (Resident #84, Resident #108, and Resident #99) reviewed for ADL care. The facility failed to ensure Resident #84's incontinent brief was changed timely on 04/21/2026. The facility failed to ensure Resident #108 received scheduled showers/bed baths and linens changed after each shower. The facility failed to ensure that Resident #99 had his hair and beard groomed, fingernails trimmed and cleaned. This failure could place residents at an increased risk of not receiving services or care, diminishing quality of life, and decreased self-esteem. Findings included: 1.Record review of Resident #84's face sheet, dated 04/21/2026, reflected an [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included pneumonitis (inflammation of the lung), acute respiratory failure with hypoxia (a critical condition where the lungs fail to transfer enough oxygen into the bloodstream, resulting in low arterial blood oxygen levels), dysphasia (a language disorder caused by brain damage-commonly from stroke, tumor, or injury-that results in partial loss of the ability to produce or comprehend language), and hemiplegia (a severe or total paralysis affecting one side of the body caused by brain or spinal cord injuries) following cerebral infarction (a medical emergency caused by a blockage in a brain artery, cutting off blood flow and causing tissue death) effecting right dominant side. Record review of Resident #84's admission MDS Assessment, dated 02/01/2026, reflected Resident #84's triggered care areas: Urinary incontinence and pressure ulcer. Record review of Resident #84's Comprehensive Care Plan, dated 01/30/2026, reflected focus: ADL self-care performance deficit related to activity intolerance, fatigue, hemiplegia, and impaired balance with interventions: Toilet use: The resident requires 2 staff assist for toileting and focus: Skin impairment related to fragile skin, incontinence with interventions: Reposition resident on CNA rounds. Cleanse resident after incontinent episodes as needed. Record review of Resident #84's Nursing progress notes, dated 04/03/2026, reflected Resident is one person assist with ADL's and brief changes. Resident is incontinent of bowel and bladder. Observation and interview on 04/21/2026 at 10:00 a.m. revealed Resident #84 was sitting at the edge of his bed with Resident #84's family member (FM) changing his incontinent brief, clothing and bedding due to being wet with urine. Resident #84's FM stated that this is not first time she had to change him due to being wet with urine and his clothes smelled of urine. Resident #84's FM demonstrated video recordings on her phone with prolonged waiting time (45mins or longer) for nursing staff to come and assist Resident #84 with incontinent care during the night shifts. Resident #84's FM stated that it was not her job to change Resident #84 and provide care for him at the facility, but she did it because nursing staff at the facility did not do their job. She stated that it made her upset to see Resident #84 wet and she reported it to CNAs and charge nurses, but nothing changed. Observation of Resident #84's skin in his perineum area (around genitals and anus area) on 04/21/2026 at 1:28 p.m. did not reveal any skin issues like skin breakdown or redness. During an interview on 04/21/2026 at 10:10 a.m. Resident #84 had difficulties to communicate clearly regarding how long he had to wait to be changed just nodding and said yes to long time waiting to be changed. 2.Record review of Resident #108's face sheet, dated (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/21/2026, reflected an [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included inclusion body myositis (a progressive, inflammatory muscle disease, typically affecting adults over age [AGE]), dementia (a progressive syndrome, characterized by cognitive decline, including memory loss, confusion, and behavioral changes, permanent atrial fibrillation (normal heart rhythm cannot be restored or maintained), and need for assistance with personal care. Record review of Resident #108's MDS Assessment, dated 04/02/2026, reflected Resident #108's BIMS score of 12 - moderate cognitive impairment and required substantial/maximal assistance when helper does more than half the effort for toileting hygiene and shower/bath. Record review of Resident #108's Comprehensive Care Plan, dated 02/20/2026, reflected focus: ADL self-care performance deficit related to activity intolerance, fatigue, and impaired balance with interventions: Bathing: The resident requires 1 staff assist with bathing/showers. Toileting use: The resident requires 1 staff assist for toileting. During interview on 04/20/2026 at 11:05 a.m., Resident #108 stated he wanted to have showers and not bed baths, but CNAs were too busy to take him to take a shower as he required two people and a mechanical lift to assist him with transfers to the wheelchair. Resident #108 stated that he asked CNAs to be showered multiple times and waited for a while before getting bed baths instead. Resident #108 stated that sometimes CNAs were too busy and were not available to provide him with showers or bed baths at all. He stated that nursing staff did not change bed linens after giving him a bed bath for a couple of weeks. Resident #108 stated that he talked to Social Worker and other staff at the facility regarding not getting showers and his bed linens not being changed after each bathing. Record review of Resident #108's shower sheets revealed only four shower sheets with documented bed baths provided on 04/20/2026, 4/17/2026, 04/15/2026, and 04/13/2026 in last 30 days (03/20/2026 - 04/20/2026). During an interview on 04/21/2026 at 10:20 am, CNA A stated she worked on 500 hall with Resident #84 and Resident #108. She stated that she worked night shifts: 10 p.m. - 6 a.m. She stated that she was able to round on all residents that required incontinent care, but sometimes residents refused and she did not insist on changing them. She stated that she knew that Resident #84 was incontinent of bowel and bladder. CNA A stated that she did not provide incontinent care in the morning before leaving on 04/20/2026 to 04/21/2026 shift due to Resident #84's refusal. She did not tell anybody about him refusing. She stated that she was taking care of 30 residents on 500 hall and felt like she was able to provide good care for those residents. CNA A stated that not rounding on residents every two hours and not assisting them with incontinent care or showers could lead to neglect and skin problems. During an interview on 04/21/2026 at 1:21 p.m., CNA B stated that she worked day shift (6 a.m. to 2 p.m.) on 400 and 500 halls. She stated that she rounded on residents every two hours and was not sure why Resident #84 was soaking wet and not being changed from the beginning of her shift from 6 a.m. until 10 a.m. She stated that she worked with Resident #108 and provided them with bed bath 3 times a week, but sometimes they refused the care. She stated that it was CNAs responsibility to provide showers, assist with incontinent care and change bed linens after each bathing. CAN B did not recall Resident #108 asking for showers instead of bed baths. CNA B stated that if not doing it timely, it could lead to infection and skin breakdown. She stated that she could provide good care for these residents in a timely manner. During an interview on 04/21/2026 at 10:20 a.m., LVN F stated that she worked as a charge nurse during night shift on hall 500. She stated that CNAs and charge nurses were responsible for rounding on residents and assisting them with incontinent care as needed. She stated that she saw CNAs going to residents' rooms but could not tell if CNA A assisted Resident #84 with incontinent care before she left her shift. She stated it was really challenging and stretching thin for CNAs to provide good care with so many residents at night with only one CNA assigned to 500 hall (30 residents). During an interview on 04/10/2026 at 10:40 am, LVN D, charge nurse on day shift (6 a.m. -2 p.m.) on 500 hall, stated CNAs were responsible for residents' incontinent care and showers but charge nurses assisted them as needed. He stated if a CNA observed any problems with a resident's skin during peri care or showers, they were to report it to charge nurse using shower sheets for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation. He stated he had been in-serviced on incontinent care and showers; however, he did not recall the date. During an interview on 04/21/2026 at 3:58 p.m., DON stated that CNAs were responsible for rounding on each resident every two hours or more often as needed and provide incontinent care if required as soon as possible. She stated that leaving residents who were incontinent without providing incontinent care would lead to skin breakdown and UTIs. She stated that showers or bed baths should be provided to residents on their scheduled days (three times a week) and documented in Point of Care by CNAs and on paper shower sheets and submitted to charge nurses for review if any skin abnormalities were noticed. She stated that electronic Point of Care had an issue with correct documentation of bathing provided to residents and they submitted a ticket to fix it. All refusals had to be documented and reported to charge nurses. She stated that all paper shower reports were collected and reviewed by wound care nurse periodically for assessing wound care needs. She stated that bed linens should be changed after each shower or bed bath by CNAs. She stated that she was not aware about Resident #108 requested showers and not bed baths. She stated that not administering regular showers could cause potential infection. During an interview on 04/21/2026 at 4:15 p.m., ADM stated that nursing staff (CNAs and charge nurses) should round on residents every two hours or sooner. She stated that not providing incontinent care to residents on regular basis could lead to infection, skin breakdown, and other health issues. She stated that nursing management was responsible for monitoring proper care provided including showers and incontinent care. ADM stated that in-cervices on rounding and ADL care is provided to nursing staff annually and periodically throughout the year. 3.Record review of Resident #99's face sheet, dated 04/20/26, reflected Resident #99 was initially admitted on [DATE] and readmitted on [DATE]. He was an [AGE] year-old male diagnosed with dementia, acute respiratory failure, acute kidney failure, muscle weakness, unsteadiness on feet, history of falling, malignant neoplasm of prostate (prostate cancer) and UTI. Record review of Resident #99's quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating her cognition was moderately impaired. Functional Status indicated he required moderate one-person physical assistance to complete personal hygiene. Record review of Resident #99's care plan, dated 03/26/26, reflected that he had an ADL self-care performance deficit r/t activity intolerance, fatigue and impaired balance. The relevant intervention was one staff assistance with personal hygiene and oral care. Observation and interview conducted on 04/19/26 at 10:10 a.m. revealed that Resident #99 was lying in bed, appearing thin and weak. He had a disheveled appearance, with long, untidy hair and facial hair approximately two centimeters long that was unshaved. An examination of his fingers showed overgrown fingernails that were jagged, with a brown substance underneath. The resident stated he preferred to have his hair, beard, and nails trimmed and mentioned that he had his own special shaving set, requesting staff to use it, as his skin was very sensitive. During an interview on 04/19/26 at 10:15 a.m., the FM of Resident #99 stated she was unsure if Resident #99 had requested hygiene care. She explained that Resident #99 was particular about using his own supply of razors and trimmers because he was afraid that the facility's equipment might hurt his sensitive skin. She also mentioned she did not understand why the care was not provided in a timely manner, as she generally observed that the staff at the facility were attentive to residents' personal grooming and overall care. During an interview on 04/20/26 at 11:30 a.m., the DON stated that CNAs were responsible for grooming, trimming, and cleaning residents. She explained that Resident #99 was particular about how these tasks were performed and that he often refused shaving and haircuts due to his sensitive skin. The DON said that maintaining a good appearance and presentation was important to preserve the residents' dignity. She also noted that staff should be aware that residents sometimes need a gentle prompt for grooming and hygiene. The DON highlighted that untrimmed nails could harbor microorganisms, posing a risk of infection, and that jagged nails negatively impact on the resident's overall appearance. Record review of the facility policy Activities of daily living (ADL), supporting, revised in March 2018, reflected: .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident and in accordance with the plan of care, including appropriate support and assistance with:hygiene (bathing, dressing, grooming, and oral care) .c. elimination (toileting). Record review of facility policy Bath, shower/Tub, revised in February 2018, reflected Documentation: the date and time the shower/tub was performed. All assessment data (any reddens areas, sores,. on the resident's skin) obtained during the shower/tub bath. How the resident tolerated the shower/tub bath. If residents refused the shower/tub bath, the reason(s). Reporting: 1. Notify the superior if the resident refuses the shower/[NAME] bath.

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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 observations, interviews and record review, the facility failed to establish a system of accurate reconciliation, determine that drug records were in order, and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 4 medication carts (LVN C's 400-Hall Medication Cart) in the facility affecting 1 resident (Resident #87) and failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 of 4 medication carts (LVN C's 400-Hall Medication Cart) affecting 2 residents (Resident #76 and Resident #12) reviewed for pharmacy services. The facility failed to ensure LVN C accurately reconciled Resident 87's narcotic medication log when she administered but did not sign for Resident 87's Lacosamide Sol 10mg/ml 15ml on 04/21/2025 at 8:00am.The facility failed to ensure the removal of expired medications: Nystatin topical power for Resident #76 and Glucagon Kit 1 mg for Resident #12 from the 400-hall medication cart. These failures could place residents at risk of medication error, drug diversion, and receiving expired medications which could result in delayed healing. Findings included: 1.Record review of Resident #87's face sheet, dated 04/20/2026, reflected a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia (complete paralysis) and hemiparesis (weakness) following cerebral infarction (a medical emergency caused by a blockage in a brain artery, cutting off blood flow and causing tissue death) affecting left non-dominant side, convulsions (rapid, uncontrollable, rhythmic muscle contractions and relaxations, often characterized by shaking), and major depression (a serious mood disorder characterized by persistent sadness, loss of interest, and hindering daily life). Record Review of Resident #87's comprehensive care plan, dated 02/04/2025, reflected a focus: Resident #87 was on anticonvulsant medication related to altered CNS due to chronic disease process with interventions that included: Administer medications per MD orders. Record review of Resident #87's annual MDS assessment, dated 03/31/2026, reflected a BIMS score of 5 indicating a severe cognitive impairment and taking high-risk drug class medication as anticonvulsant (drugs designed to treat epilepsy and seizures by stabilizing abnormal electrical activity in the brain). Record review of Resident #87's order summary report, dated 04/20/2026, reflected Resident #87's order for Lacosamide Oral Solution 10 mg/ml. Give 15 ml by mouth two times a day related to unspecified convulsions with an order start date of 12/20/2024. Record review of Resident #87's medication administration record for 04/2026 indicated Resident #87 received Lacosamide Oral Solution 10mg/ML 15ml by mouth two times a day related to unspecified convulsions including 04/21/2026 at 7:00 a.m. when medication was not documented in controlled medication administration record. During the 400-hall medication cart's reconciliation and interview on 04/20/2026 at 09:46 a.m., LVN C stated she administered the scheduled Lacosamide Sol 15 ml (controlled anticonvulsant medication) to Resident #87 around 8:00 a.m. this morning, documented in electronic medication administration record but failed to document the administration of Lacosamide Sol 15 ml to Resident #87 in the controlled medication log. LVN C stated she was responsible for documenting on the resident's narcotic log when a narcotic medication was administered but she forgot to sign for Resident #87's controlled medications since she was very busy all morning. LVN C stated that not documenting the administration of controlled medications could cause a discrepancy or a medication error, since the next nurse could not know the resident already received the narcotic medication. 2. Record review of Resident #76's face sheet, dated 04/21/2026, reflected a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included: paroxysmal atrial fibrillation (a type of irregular heart rhythm that starts suddenly and stops on its own, usually lasting from minutes to a few days), type 2 diabetes mellites (a chronic condition characterized by high blood sugar due to insulin resistance), and erythema intertrigo (a common (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inflammatory rash that occurs in skin folds, characterized by bright red, burning, or itching skin caused by heat, moisture, and friction). Record Review of Resident #76's comprehensive care plan, dated 01/10/2019, reflected a focus: Altered skin integrity related to fragile skin, eczema (a chronic inflammatory skin condition causing dry, itchy, and discolored patches) and tinea cruris (itchy fungal infection of the groin, inner thighs, and buttocks) with interventions that included: Follow treatment per MD orders. Record review of Resident #76's annual MDS assessment, dated 02/12/2026, reflected a BIMS score of 15 indicating intact cognition and indicated skin treatments: applications of ointments/medications other than to feet. Record review of Resident #76's order summary report, dated 04/21/2026, reflected Resident #76's order for Nystatin Powder 100000 unit/gm. Apply to per directions topically two times a day every Tuesday, Thursday, Saturday and Sunday for intertrigo, skin health with an order start date of 03/12/2026. Record review of Resident #12's face sheet, dated 04/21/2026, reflected a [AGE] year-old female initially on 04/17/2018 with diagnoses that included: Type 1 Diabetes Mellitus (a chronic autoimmune condition where the pancreas produces little to no insulin, requiring lifelong insulin therapy to manage high blood sugar, vascular dementia progressive form of dementia caused by reduced blood flow to the brain, damaging brain tissue), and chronic kidney disease. Record Review of Resident #12's comprehensive care plan, dated 11/21/2024, reflected a focus: Diabetes Mellitus with potential for abnormal blood sugar levels, poor wound healing and pain with interventions that included: Monitor/document/report as needed any signs and symptoms of hypoglycemia (low blood sugar). Record review of Resident #12's quarterly MDS assessment, dated 03/19/2026, reflected a BIMS score of 9 indicating a moderate cognitive impairment and active diagnosis of diabetes mellitus. Record review of Resident #12's order summary report, dated 04/21/2026, reflected Resident #12's order for Glucagon Emergency Kit 1mg. Inject 1 syringe intramuscularly every 24 hours as needed for hypoglycemia. Give if unconscious or unable to swallow and notify nurse practitioner with an order start date of 05/05/2025. During observation of 400-hall Med cart on 04/21/2026 at 8:15 a.m., revealed expired medication Nystatin topical power (prescription antifungal medication used to treat skin infections caused by Candida yeast) for Resident #76, with expiration date: 02/28/2026 and expired Glucagon Kit 1 mg (a life-saving, fast-acting medication used to treat severe hypoglycemia (critically low blood sugar) by triggering the liver to release stored glucose) for Resident #12 with expiration date: 03/01/2026. During an interview on 04/20/2026 at 09:46 a.m., LVN C stated she was responsible for monitoring expiration dates of medications and removing them from the medication cart. She stated that if expired medications were administered to residents, they would not provide the intended therapeutic benefits and not treating health problems as they could potentially harm residents. During an interview on 04/21/2026 at 3:58 p.m., DON stated the narcotic medication administration should be documented immediately after administration in the electronic medication administration record and controlled medication log. She stated that nurses and medication aides were responsible for the documentation of their medication administration. The DON stated that delay in documenting narcotic medication administration could lead to discrepancy in count and potential residents' overdosing. She stated that in-services on medication storage and medication administration including controlled medications were provided to all nursing staff on an annual basis and periodically throughout the year. She stated that nursing managers were responsible for monitoring the proper medication documentation and expired medication removal from medication carts on a weekly basis. She stated that the pharmacist does the training on medication storage every month and whoever works on medication cart was responsible for making sure that expired medications were removed as administering expired medication would not provide the needed therapeutic benefits to residents. During an interview on 04/21/2026 at 4:15 p.m., ADM stated that charge nurses and medication aides were responsible for documenting controlled medications administration immediately after administration of medications to residents. She stated that if not documented medication administration, it could lead to medication error. She stated if expired medications were not removed from the medication carts could lead to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of those medications to residents and potentially hinder their health due to reduced potency of those medications. She stated that ADONs and DON were responsible for overseeing the proper medication documentation and medication storage followed by nursing staff at the facility. Record review of facility's Medication Administration policy, revised 11/2020, indicated that If medication is a controlled substance, sign narcotic book. Record review of facility's Storage of Medications policy, revised 11/2020, indicated that 4. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Record Review of undated Monitoring tool for issue: med carts with frequency: weekly revealed initials of ADON B on the weekly basis from 01/2026 - 04/2026 with last check on 04/07/2026.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Findings included:Observation on 04/19/2026 at 9:15 AM in the kitchen of the walk-in cooler revealed: - Boiled eggs with no open date and a use-by date of 4-12-2026. - Tortillas with an open date of 4-10-2026 and a use-by date of 4-17-2026. - Tortillas with no open date and a use-by date of 4-12-2026. - Turkey lunch meat with no open date and a use-by date of 4-17-2026. - Ham lunch meat with no open date and a use-by date of 4-18-2026. - Turkey lunch meat with an open date of 4-11-2026 and no use-by date. - Jelly with an open date of 4-11-2026 and no use-by date.Observation on 04/19/2026 at 9:23 AM of the walk-in freezer revealed: Garlic Bread with no open date and a use-by date of 4-18-2026. Garlic Bread with no open date and no use-by date. Observation on 04/19/2026 at 9:30 AM of the Kitchen. - Cheerios with no open date and a use-by date of 4-11-2026. - Fruit Loops with an open date of 4-6 and no use-by date. - Pasta with an open date of 4-3 and no use-by date. Observation on 04/19/2026 at 9:36 AM of the Dishwasher chemicals test revealed: DA J tested the chemicals in the dishwasher, and the reading was over 200 parts per million which indicates that the sanitizer is too strong. DA J did not have a hair net covering his whole beard. An interview on 04-19-2026 at 9:30 AM with DA J revealed when testing the water in the dishwasher and the reading on the strip is too dark, there are too many chemicals in the water. DA J stated that he tested the water this morning, and it was not that dark. DA J stated that he does not keep track of the test for the chemicals that was done daily on the dishwasher. An interview on 04-19-2026 at 9:30 AM with DM revealed that the hose on the dishwasher broke and she had to cut the hose and piece the hose back together until it could be repaired. The DM stated that she was not aware that there were too many chemicals in the water. An observation on 04/20/2026 at 9:11 AM of CK doing the purees revealed CK pureed the chicken and rinsed the blender and put the blender back to be used and there was still pureed chicken in the blender. While surveyor was taking a picture of the blender, CK grabbed it and cleaned the blender again. An observation on 04/21/2026 at 11:20 AM CK and DA I were not wearing hair restraint coverings over all of their facial hair. An interview on 04/21/2026 12:38 PM DA J revealed the cooks were the ones responsible for labeling and dating food in the walk-in cooler. DA J stated that all his beard was not covered because the hair net bothers his ears. DA J stated that he has not been trained on the dishwasher chemicals and how to adjust the chemicals. DA J stated that he does not know what could happen to the residents if there are too many chemicals in the dishwasher. DA J stated that all hair should be covered when in the kitchen. DA J stated that hair could get in the food and get residents' sick. DA J stated that if food items are not labeled correctly then residents could eat food that was expired and they could get sick. An interview on 04/21/2026 12:43 PM DH I Started a week ago, DH I. DA I stated that he has only been working at the facility for a week. DA I stated that he is not the one who labels and dates the food in the walk-in cooler. DA I stated that he only labels and dates the beverages. DA I stated that he has not been trained on the dishwashers and the chemicals. DA I stated that he checks the chemicals with the test strip and records it in the log. DA I stated that he has not thought about what could happen if too many chemicals are used in the dishwasher. DA I stated that all hair should be covered. DA I stated that his beard was not fully covered because the beard cover pulls his ears down. DA I stated that residents could get sick if hair were to fall into their food. An interview on 04/21/2026 12:46 PM CK H. CK stated that the cooks and the DM are responsible for labeling, dating, and removing expired food from the walk-in cooler. CK stated that dietary aides are responsible for labeling and dating juices. CK H stated that some items in the cooler were labeled by an ex-employee who was terminated on 4-18-2026. CK H stated that if residents ate out-of-date food, they could get sick. CK H stated that hairnets should always be worn and should cover all hair. CK H stated that he had come from outside the kitchen and forgot to cover his facial hair. CK H stated that hair could fall into the food, and residents could get sick from eating it. CK H stated that when he is making puree, the blender should (continued on next page)

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The Springs Healthcare and Rehabilitation	1500 Cottonwood Creek Trail Cedar Park, TX 78613

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be cleaned and sanitized before using it for the next food item. CK stated that if this is not done, this will just mix food and cause cross-contamination. CK H stated that he ran the blender through the dishwasher, but it was not cleaned. CK H stated that he should have checked it more closely. An interview on 04/21/2026 12:54 PM DM. DM stated that she checks dates in the cooler daily. DM stated that it is everyone's responsibility to label and date food in the kitchen. DM stated that the date on the label, on the use-by line, is the date it was put in the cooler, not the use-by date. DM stated that she can see how confusing that is. DM stated that if residents ate out-of-date food, they could get sick. DM stated that the chemicals in the dishwasher should be checked 3 times a day and documented. DM stated that if the chemicals are incorrect, residents could get sick. DM stated that all staff should wear a hairnet to cover all exposed hair. DM stated that hair could fall into the food, and the residents could get sick. DM stated that when preparing purees, the puree blender should either be rinsed, washed, and sanitized in the sink or run through the dishwasher between each puree. DM stated that when these are not done, there is a risk of cross-contamination. An interview with 04/21/2026 2:03 PM ADM revealed all staff should be always wearing hair nets. The ADM stated that the dishwasher should be tested several times a day to make sure the chemicals are correct. The ADM stated that when doing purees the blender should be washed, rinsed, and sanitized. The ADM stated that not following these procedures could get residents sick. Record review of the facility's Food Preparation and Handling Policy revised on 6/15/2025, reflected: Use clean, sanitized surfaces, equipment and utensils.Record review of the facility's Food Storage Policy revised on 6/15/2025, reflected: Date, label and tightly seal all refrigerated foods using clean, non-absorbent, covered containers that are approved for food storage. Use all leftovers within 72 hours. Discard items that are over 72 hours old.Record review of the facility's Manual Cleaning and Sanitizing of Utensils and Portable Equipment Policy revised on 6/15/2025 reflected: Use a three-compartment sink with running hot and cold water for cleaning, rinsing and sanitizing. Test and record the parts per million concentration of the solution. A sample Test Strip Log for Three-Compartment Sink follows this policy.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 3 residents (Resident #107) and the facility failed to ensure that each resident has the right to secure and confidential personal and clinical records for 1 out of 32 residents on 500 Hall (Resident #2) reviewed for privacy. The facility failed to ensure CNA H provided privacy by drawing the privacy curtain during incontinent care for Resident #107. The personal health information of one resident (Resident #2) was left unlocked and displayed on the computer screen on the medication cart of LVN D who administered medications to residents at 500 Hall. This failure could place residents at risk of lack of privacy, not having residents' rights acknowledged, and residents' personal clinical information being exposed to unauthorized individuals. The findings include: 1.Record review of Resident #107's face sheet, dated 04/20/26, reflected Resident #107 was admitted on [DATE]. She was an [AGE] year-old female diagnosed with fracture of lower end of right femur (thigh bone), dementia, muscle weakness, unsteadiness on feet, cognitive communication deficit and need for assistance with personal care. Record review of Resident #107's quarterly MDS dated [DATE] reflected a BIMS score of 07 indicating her cognition was severely impaired. Further review revealed she needed complete support with toilet hygiene. Record review of Resident #107's care plan dated 03/26/26 reflected that she had an ADL self-care performance deficit r/t activity intolerance, dementia, fatigue, impaired balance, limited ROM and musculoskeletal impairment. The relevant intervention was assistance by one staff member with personal hygiene and oral care. During an observation and interview on 04/20/26 at 9:30 am CNA H had provided incontinent care to Resident #107 in her room. CNA H did not draw the privacy curtain fully during the incontinent care. The incontinent care would have been fully visible to anyone who entered the room if anyone opened the door during the incontinent care. Incidentally, when the incontinent care was progressing, the ADON entered the room to pass on information. During an interview on 04/20/26 at 9:40am Resident #107 stated she believed CNA H had done a good job and she was happy with it. She stated she had neither noticed if the privacy curtain was fully closed nor any visitors had a chance to view the incontinent care. During an interview on 04/20/26 at 9:45am CNA H stated she started her career at the facility two days ago and under orientation. She stated she had more than a year experience as a CNA and was working in another nursing facility as a CNA. She stated incontinent care was part of that job and had been doing it since the beginning of her career as a CNA. She stated it was a mistake that the privacy curtain was not closed. CNA H said she was thinking that it was OK to keep the curtain the way it was as the peri care was not visible to Resident #107's roommate as the curtain had separated Resident #107 from her roommate. She stated she believed the incontinent care was seen by the ADON who entered the room while she was doing the care and it would have been visible to anyone who was entering the room. CNA H said by not closing the privacy curtain she compromised Resident #107's right to maintain her privacy during personal care. During an interview conducted on April 20, 2026, at 10:15 a.m., the ADON stated that she observed the peri-care of Resident #107 upon entering the resident's room. She expressed her concern that the procedure was visible to her at that time and wondered why CNA H had not fully closed the privacy curtain. The ADON noted that CNA H had joined the nursing team only a few days prior and was still in the process of completing her orientation. The ADON stated that, as an experienced CNA, she should have exercised greater caution in maintaining the resident's privacy during peri-care. The ADON concluded that by not fully closing the privacy curtain, CNA H risked compromising Resident #107's dignity and privacy, which are inherently protected during personal care procedures involving the exposure of the resident's naked body. During an interview conducted on April 20, 2026, at 1:30 p.m., the DON stated that it was mandatory to respect and uphold residents' privacy and dignity during all nursing care, including incontinent care, by closing doors, windows, and drawing privacy curtains. She said that the privacy curtain of (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #107 should have been fully closed by the nursing staff prior to beginning the incontinent care. The DON explained that staff training was an ongoing process, and resident rights are a fundamental component of that training. She noted that CNA H had only started working at the facility two days prior and that the facility had ensured she had satisfactorily completed all required nursing skills. Additionally, the DON stated that, according to facility policy, all nursing staff are required to undergo an annual evaluation to assess their nursing skills, knowledge, and competency in respecting residents' rights. Record review of undated facility policy Resident Rights reflected: . Residents will be examined and treated in a manner that maintains the privacy of their bodies. A resident will be granted privacy when going to the bathroom and in other activities of personal hygiene. In situations where a resident requires assistance, authorized staff members are required to respect the individual's need for privacy. Staff members will ensure that privacy curtains are pulled, doors are closed, or the residents are otherwise removed from public view or covered or draped to prevent unnecessary exposure of body parts during the provision of personal care and services. Window coverings should be closed. 2.Record review of Resident #2's face sheet, dated 04/21/2026, revealed a 42-years-old female admitted on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia effecting left nondominant side (a severe or total paralysis on one side of the body caused by brain or spinal cord damage), hydrocephalus (a condition characterized by an abnormal accumulation of cerebrospinal fluid within the ventricles of the brain, increasing pressure on brain tissue), and major depression (a serious, treatable mood disorder characterized by persistent sadness, loss of interest in activities, and low energy). Observation on 04/21/2026 at 8:32 a.m. revealed the computer screen on LVN D's 500 Hall medication cart was open and unlocked, with Resident #2's personal clinical information, MAR, displayed and visible to unauthorized individuals, including visitors or other residents. No visitors and residents were observed near the cart when LVN D left the computer on medication cart unattended. During an interview on 04/21/2026 at 8:36 a.m., LVN D stated that he had an in-service on HIPAA at hire which included instructions not discussing residents' private clinical information with unauthorized individuals and to lock the computer screen when stepping away from the medication cart. He stated that everybody who works with charting computers was responsible for closing it and locking it when not in attendance. He acknowledged that leaving the screen unlocked with clinical information displayed on it could be harmful for residents as anybody could see it. During an interview on 04/21/2026 at 3:58 p.m., DON stated that the facility's policy was to minimize the charting computers' screens when stepping away. She stated that if the screen was not minimized, someone could have unauthorized access to private clinical information displayed on the screen. She stated that HIPAA in-service was provided to all employees at hire and annually through computer modules which include instructions on locking the computer screens. She stated that the person who worked with residents' private clinical information should lock the screen before walking away. She stated that the potential negative effect to residents could be unauthorized disclosure of residents' private information to public. During an interview on 04/21/2026 at 4:15 p.m., ADM stated that all staff had annual training which covered the importance of maintaining the residents' private information. She stated that whoever uses the computer is responsible for shutting it down to ensure the residents' information is not visible. She stated that the potential risk for not shutting down charting computers was the breach of residents' privacy and their emotional distress. Record review of MOCK (an imitation, simulation, or replica of something real) take away's/observation in-services, dated 11/11/2025, revealed: HIPAA: lock your screen when walking away from your computer. Place paper face down at nurses' station when not attended was completed by LVN D. Record review of undated facility's HIPAA - Resident Rights - Abuse: Do's & Don'ts basics policy revealed: Log off computer when leaving for longer periods of time.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure resident assessments accurately reflected the resident's status for 1 of 8 residents (Resident #23) reviewed for accuracy of assessments. The facility failed to accurately code Resident #23's use of an antiplatelet medication on her most recent comprehensive MDS assessment dated [DATE]. This failure could have placed the resident at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being.Findings included:Record review of Resident #23's comprehensive MDS assessment dated [DATE], indicated Resident #23 was a [AGE] year-old female, who was admitted to the facility on [DATE]. Her diagnoses included stroke (when a blood vessel in the brain leaks or bursts, causing bleeding in the brain), Coronary Artery Disease (when coronary become narrowed or blocked due to plaque buildup, which reduces blood flow to the heart), Hypertension (high blood pressure), Diabetes Mellitus (when the body cannot properly use blood sugar, leading to high blood sugar levels), and Hyperlipidemia (a condition which causes high levels of fat or lipids in the blood). Resident #23's BIMS Summary Score was 7, indicating severe cognitive impairment.Record review of Resident #23's comprehensive MDS assessment dated [DATE], reflected other additional active diagnoses for Resident #23, including LONG TERM (CURRENT) USE OF ANTICOAGULANTS.Record review of Resident #23's comprehensive MDS assessment dated [DATE], Section N0415 High-Risk Drug Classes: Use and Indication, reflected the resident was taking an anticoagulant medication (medications that prevent or treat blood clots helping reduce the risk of stroke, heart attack, and blood clots that block and stop blood flow to an artery in the lung) and that there was an indication noted for the use of this drug class. The same comprehensive MDS assessment also reflected Resident #23 was not taking any antiplatelet medication and no indication was noted for the use of this drug class. Record review of Resident #23's care plan dated June 2, 2025, reflected no problems, goals or interventions related to the use of anticoagulant medication(s). The care plan did reflect Resident #23 was on antiplatelet therapy related to CAD and s/p CVA, initiated on June 2, 2025, with the goal being that the resident would have no complications related to antiplatelet therapy through the review date, and interventions including administering antiplatelet medication/s as ordered by the physician, monitoring for abnormal bleeding and excess bruising, and monitoring for adverse reactions of antiplatelet therapy, with those interventions initiated on June 2, 2025. Record review of Resident #23's order summary report dated April 20, 2026, reflected no orders for anticoagulant medication(s). The same order summary report reflected an order for Aspirin EC (special coating that delays absorption until the tablet reaches the small intestine) Tablet Delayed Release 81 MG (Aspirin). Give 1 tablet by mouth one time a day related to CEREBRAL INFARCTION, UNSPECIFIED, ordered on June 3, 2025 and started on June 4, 2025. In an attempted interview on April 20, 2026, at approximately 10:20AM, it was determined Resident #23 was unable to consistently track questions being asked or topics being discussed and forgot information such as how to spell her first name and what her last name was. Therefore, a reliable resident interview could not be obtained in relation to the resident's status or care provided. In an interview on April 21, 2026, the ADM stated the facility did not have a MDS nurse onsite currently. ADM stated that MDS A vacated her position a couple of weeks prior and was not available for interview. ADM stated they had not hired a replacement. ADM referred this surveyor to their Corp. MDS specialist, MDS B, who officed off-site. In a telephone interview on April 21, 2026, at 1:58 PM, MDS B stated that she was a RN who had 15-20 years of experience with the MDS assessment process. MDS B stated that she had been employed with the company that manages and operates the facility for 4 years. MDS B stated that she is in a supervisory position which oversees and trains MDS nurses and specialists, including completing MDS assessments. MDS B confirmed MDS A was the person responsible for conducting the portions of the comprehensive MDS assessment for Resident #23 dated March 20, 2026, including Section I, Active Diagnoses, and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section N, Medications. During the interview, MDS B reviewed Resident #23's MDS assessment dated [DATE], care plan, diagnoses, and orders. MDS B acknowledged MDS A incorrectly completed the resident's MDS assessment, resulting in inaccuracies. MDS B stated MDS A likely miscoded Aspirin as an anticoagulant drug rather than an antiplatelet drug. MDS B acknowledged Resident #23 had no order for an anticoagulant medication and did not have a diagnosis of long term (current) use of anticoagulants. MDS B stated that MDS A should have known the difference between antiplatelet and anticoagulant drugs from her training as a nurse and specialized training provided by the facility. MDS B stated that she spot checks assessments for accuracy and utilizes scrubbers (software tools used to identify errors, inconsistencies, or missing information) to ensure assessments are accurate and complete. Although, MDS B stated that these scrubbers would not have identified this error. MDS B stated there would be no negative impact on the resident because these errors would not alter resident care. MDS B stated that a MDS nurse or specialist should always review their entries for accuracy. If the errors had been caught during her spot checks, MDS B stated that she would have provided additional training for MDS A and reeducation. MDS B stated that she would initiate the correction process for Resident #23's MDS assessment right away. In an interview on April 21, 2026, at 4PM, ADM stated that her expectations regarding the completion of MDS assessments would be that the MDS nurse would comb the resident's chart for the correct data entry information and speak to relevant staff for the clinical information necessary to accurately complete the assessment. ADM stated that she and the DON conduct MDS assessment audits for information and data entry accuracy. ADM stated that a negative impact resulting from inaccurate assessments would be inaccurate clinical data for the resident and the submission of inaccurate financial data. In an interview on April 21, 2026, at 4:05PM, DON stated she has been employed with the facility for several years. She confirmed the facility does not currently have an onsite MDS nurse but their most recent staff member in that position was MDS A. DON stated that she was familiar with the MDS assessment process and also conducted accuracy checks related to nursing care and information. DON stated that she had been informed of the inaccuracies of Resident #23's MDS assessment dated [DATE], after it was brought to MDS B's attention today. DON stated that MDS accuracy matters because it's meant to be a reflection of the resident's status, the care provided to the resident, and the acuity of care to be provided to the resident. DON stated that inaccurate assessment information could negatively impact the facility's quality measures and rating. DON stated that if a mistake is found, appropriate staff are expected to correct or resolve those errors immediately. DON stated that it is important that assessments are accurate as this is the basis for provision of care. Record Review of the Long-Term Care Facility MDS 3.0 RAI User's Manual effective October 1, 2025, reflected, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 medication carts (nursing treatment cart) reviewed for medication storage. The facility failed to ensure that the nursing treatment cart was locked and medications/treatment supplies were secured and not accessible to other staff, residents or visitors. This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the-counter medications. Findings include: Observation on 04/19/2026 at 9:24 a.m. revealed the treatment cart located next to the nursing station and 500 hall was unlocked with medications and treatment supplies that were not secured. The locking mechanism was protruding outward on the treatment cart. The State Surveyor opened the drawers and captured photos. There were no nursing staff in the area of the unlocked treatment cart. Multiple visitors and residents were observed walking near the cart and could have direct access to the treatment cart. During an interview on 04/19/2026 at 9:38 a.m., LVN G stated there was no treatment nurse available in the building on Sunday and charge nurses were responsible for providing wound care and using a treatment cart. She stated that she did not know who worked on the treatment cart last and did not lock it. She stated residents and visitors could have access to the medications in the treatment cart. LVN G stated if residents or visitors had ingested another residents' medications there was a possibility the resident may overdose, have an allergic reaction, and may require further care at the hospital. She stated she was in-serviced on locking medication carts when she was not obtaining medications from the cart. LVN G stated she did not recall the date of the in-service of locking medication carts. Interview on 04/21/2026 at 3:58 p.m., DON stated the medication and treatment carts were expected to be locked unless the nurse or medication aides were standing at the carts. She stated if the medication or treatment carts were in the hallway and the nurse was not standing at the medication cart it was expected to be locked, no exceptions. She stated residents or visitors could take medications out of unlocked medication or treatment carts and if they ingested the medications there was potential for harm. She stated the staff were in-serviced on locking medication carts on a weekly basis. Interview on 04/21/2026 at 4:15 p.m., ADM stated that charge nurses or med aides were responsible for locking medication or treatment carts when not in attendance. She stated that nursing managers, ADONs and DON, were responsible for overseeing the nursing staff following the secured medication storage protocol. She stated that if medication carts were not locked, visitors and residents could get access to medications and treatment supplies in the medication carts and potentially could get hurt. Record review of the facility's policy on Medication Storage in the Facility, reviewed 2020, reflected The community stores all drugs and biologicals in a safe, secure, and orderly manner. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medications carts are not left unattended.

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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 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 observations, interviews, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 6 residents (Resident #107) reviewed for infection control, as indicated by:The facility failed to ensure CNA H changed dirty gloves when handling clean items while providing peri care to Resident #107. Thise failure could place the residents at risk of transmission of diseases and infection. The findings included:Record review of Resident #107's face sheet, dated 04/20/26, reflected Resident #107 was admitted on [DATE]. She was an [AGE] year-old female diagnosed with fracture of lower end of right femur (thigh bone), dementia, muscle weakness, unsteadiness on feet, cognitive communication deficit and need for assistance with personal care.Record review of Resident #107's quarterly MDS dated [DATE] reflected a BIMS score of 07 indicating her cognition was moderately impaired. Further review revealed she needed complete support with toilet hygiene.Record review of Resident #107's care plan dated 03/26/26 reflected that she had an ADL self-care performance deficit r/t activity intolerance, dementia, fatigue, impaired balance, limited ROM and musculoskeletal impairment. The relevant intervention was assistance by one staff member with personal hygiene and oral care.During an observation on April 20, 2026, at 9:30 a.m., CNA H provided peri-care to Resident #107. CNA H donned a new pair of gloves after washing her hands. CNA A removed the old brief and cleaned Resident #107's front and back with wet wipes. She then, without changing the soiled gloves, continued cleaning using wipes directly dispensed from the packet. After completing the task, CNA H operated the bed remote control and pulled up the blanket using the same gloves. In doing so, she contaminated the new brief, the wet wipe packet, the remote control, the bed sheet, and the blanket by touching or handling them with soiled gloves. Finally, before exiting the room, she stored the contaminated wet wipe packet with remaining wipes in the drawer for future use.During an interview on April 20, 2026, at 9:45 a.m., CNA H stated she had started her career at the facility two days prior and was still under orientation. She mentioned she had over a year of experience as a CNA and had been employed at another nursing facility. She explained that incontinent care was part of her previous job and that she had been doing it since the beginning of her career. CNA H requested the state investigator to walk through the peri-care she performed so she could identify her mistakes. She acknowledged that she should have sanitized her hands and changed her gloves at appropriate times and that she should not have handled the wet wipe packet with dirty gloves. She added that she should have handled other clean items only after removing the soiled gloves and sanitizing her hands. She expressed concern that her improper nursing practices could facilitate the spread of various diseases. CNA H stated she wanted to focus on her orientation to learn proper infection control practicesDuring an interview on April 20, 2026, at 1:30 p.m., the DON stated that CNA H should not have handled the wet wipe packet, blanket, or other clean items with soiled gloves. She stated that CNA H was supposed to dispose of the contaminated wet wipe packet instead of saving it for future use. The DON mentioned that she had already conducted a one-on-one in-service with CNA H and planned to extend her orientation to include additional training in peri-care and infection control. The DON emphasized that CNA H's improper practices increased the risk of disease transmission through contaminationRecord review of the facility policy Infection prevention and control Program revised in 08/2016 reflected: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. a. Important facets of infection prevention include:.(3) educating staff and ensuring that they adhere to proper techniques and procedures.