STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676345	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel Air at Teravista	4105 Teravista Club Drive Round Rock, TX 78665

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards or practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 6 (Resident # 128) residents reviewed for pain management. The facility failed to administer pain medication to Resident #128, who had pancreatic cancer, from the time she was admitted [DATE] at 7:30 p.m. to 6/2/26 at 10:00 a.m. This failure could place the residents at risk of delayed healing, physical, mental, and psychological distress.Findings included: Record review of Resident #128's face sheet, dated 06/03/2026, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of malignant neuroendocrine tumors (pancreatic cancer), secondary malignant neoplasm (cancerous tumor) of liver and intrahepatic bile duct (a network of tiny, branching tubes located inside the liver), and pain. Record review of Resident #128's base line care plane, dated 06/01/2026, reflected a focus: Pain management (acute/chronic) with interventions : assess for presence of pain at frequent routine intervals and before/after specific activities and If is unable to self-report pain, discuss pain management history with family/caregiver, observe for behaviors that may indicate pain (rubbing, moaning, crying, guarding, withdraw, agitation), review clinical condition for contributory factors and review any psychological factors that may play a role in pain management. Record review of Resident #128's admission MDS, dated [DATE], reflected an assessment of pain at admission: Resident #128 reported pain in coccyx area (last bone at the base of spine) with Resident #128 was able to communicate pain level: 3/10 (mild pain. An observation and interview of Resident #128 on 06/02/2026 at 11:05 a.m. revealed Resident #128 appeared to be sleepy closing her eyes while talking and showed some discomfort when Resident #128's Family member attempted to reposition her in bed. She stated she was ok and was not able to give more details regarding her pain level or condition. During an interview on 06/02/2026 at 11:05 a.m. Resident #128's Family member reported that Resident #128 did not receive any pain medications from 7:30 p.m. last night when she was admitted to the facility from the hospital until 10 a.m. on 06/02/2026. Resident #128's Family member stated she could have brought Resident #128's pain medication from home sooner had she known the nursing facility would not be able to provide the pain medication as prescribed. Resident #128's Family member stated Resident #128 was crying in pain this morning when she woke up and that was when the facility reported they did not have Resident #128's pain medication. Resident #128's Family member stated she went home at 9:00 a.m. and brought Resident #128's pain medication from home because the facility was unable to provide the prescribed pain medications. She stated Resident #128 frequently required Dilaudid overnight as the pain was worse overnight. Resident #128's Family member reported that Resident #128 told her that she was in pain and when she repositioned her in bed she was complaining of pain. She stated that when Resident #128 was admitted last night, after transferring and moving her from the ambulance stretcher to facility's bed caused her a lot of discomfort and she asked nurses for pain medication before 9:00 p.m. She stated that she was told that pain medication should be delivered from the pharmacy soon. She stated that RN B administered trazodone which helped Resident #128 fall asleep and sleep some of the night, but RN A did not check (continued on next page)

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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	on Resident #128 to see if she was ok or needed anything else for pain. She stated that she was told again that medications did not come in the morning and that when she went to get Resident #128's pain medication from home because Resident #128's pain was getting worse and it would be hard to get it back to the tolerable level even though Resident #128 had a high pain tolerance level. Record review of physician orders, dated 06/01/2026, revealed Resident #128 was on scheduled and PRN pain medications: fentanyl transdermal patch (a potent transdermal opioid used to manage severe, chronic pain that requires around-the-clock medication) q72hrs 50 mcg/hr, Hydromorphone HCl (Dilaudid) (a potent, semi-synthetic opioid analgesic [narcotic] derived from morphine. It is used to manage moderate-to-severe acute and chronic pain-typically when other treatments were ineffective or cannot be tolerated) Oral Tablet 8mg PRN, give 1.5 tablets (12mg) by mouth every 3 hours as needed for pain related to pain and Naproxen oral tablet 500 mg: give 1 tablet by mouth two times a day related to pain, pregabalin oral capsule 100mg: give 1 capsule by mouth three times a day related to pain. Record review of Resident #128's medication administration record, dated June 2026, revealed that Resident #128 did not receive Hydromorphone HCl oral tablet 8 mg 1.5 tablet by mouth on 06/01/26 and 06/02/2026 until 10 a.m. Resident #128 received Trazodone HCl oral Tablet 50 mg on 06/01/2026 at 9:00 p.m. (for depression and sedation). Naproxen Oral tablet 500 mg was not administered on 06/01/2026 at 9:00 p.m. and administered 1st time on 06/02/2026 Pregabalin oral capsule 100mg was not administered on 06/01/2026 at 9:00 p.m. and administered on 06/02/2026 at AM. Record review of Resident #128's pain assessment revealed on 06/02/2026 at 03:57 am - 7/10 documented by RN A and 9:48 am - 9/10 documented by RN C. There were no interventions provided for the high pain levels reported until 10:00 a.m. when RN C asked Resident #128's Family member to bring Resident #128's home pain medications until they receive their pain medication from the pharmacy. Resident #128's Family member brought pain medications from home and RN C administered Dilaudid 12 mg to Resident #128 which provided the pain relief and resident was able to relax. Record review of Resident #128's progress notes, dated 06/01/2026 at 10:17 p.m. and signed by RN B, revealed [Resident #128] admitted to facility post hospitalization related to altered mental status and acute on chronic pain. Resident arrived at facility about 7:30 p.m. in stretcher accompanied by EMT, with daughter following behind them. No progress nursing notes by RN A on 06/01/26-06/02/2026 with recorded attempts to request pain medications for Resident #128 were identified in Resident #128's medical records. Record review of Resident #128's progress notes, dated 06/02/2026 at 6:59 a.m. signed by RN C, revealed that [Resident #128's] Lyrica, Dilaudid, fentanyl patch and naproxen are not here. Phoned on call pharmacy to ask if they have a script or not, on call pharm took the information for missing meds and said someone will call me back. Also notified NP. Resident #128 currently has fentanyl patch to left upper arm dated 6/1/26. Resident #128's Family member at bedside. During an interview with RN C on 06/02/2026 at 11:05 a.m., she stated that she assessed Resident #128 this morning around 7 a.m. and she was not in pain and was sleeping. She stated that at 9:38am she assessed Resident #128 and she was in pain 9/10. She stated that when she spoke to Resident #128's Family member, she told her that they don't have Resident's Dilaudid available at the facility and Resident #128's Family member offered to bring this medication from home and when she did, it was administered to Resident #128 at 10:00 a.m. RN C stated that she received the report about residents on her hall from the night shift nurse, RN A, in the beginning of her shift, 6:00 a.m. She stated that Resident #128 had orders for pain medication on discharge from the hospital. She stated that she called the on-call provider and the pharmacy requesting medications. She stated that all charge nurses, including night nurses, were responsible for calling on call providers if medications were not available at the facility and residents were in pain. She stated that when she asked RN A about Resident #128's pain medications, she told her that she did not call providers and did not request any new orders for pain relief because she thought her orders already were in the pharmacy and they should send those medications in the morning. She stated that nothing was done last night and she was doing everything this morning: contacted the provider and trying to (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	get Resident #128's medications. She talked to Resident #128's Family member who stayed overnight at the bedside and suggested to bring home medications while they were waiting for the facility's pharmacy to deliver ordered medications. She messaged NP K to get new orders for pain management. She stated that if the pain was not treated, Resident #128 could be in excruciating pain due to her diagnosis of cancer. During an interview with RN A on 06/02/2026 at 1:31 p.m., she stated she worked at this facility for a few months on night shifts 10 p.m. - 6 a.m. She stated that charge nurses were responsible for entering new orders on the system for newly admitted residents. She stated that Resident #128 was admitted on evening shift around 7 p.m. with RN B. She stated that she asked Resident #128's RP if she brought medications from the hospital and she said she did not. RN A stated that RN B told her that there were no medications and Dilaudid were available at pyxis (a secure, automated medication dispensing system) and they checked together. She stated that Resident #128 was in pain during her shift as Resident #128's Family member told her. She stated that when she assessed Resident #128, she was sleeping and did not have grimaces indicating pain, but when Resident #128's Family member asked Resident #128, she said that she was in pain. Resident #128 did not receive her ordered pain medication on her shift, but she gave Resident #128 the ordered trazadone which helped her to fall asleep. She stated that Resident #128's medications did not come from the pharmacy, and this resident did not receive pain medication on her shift. She stated that according to the change of condition protocol, charge nurses should call on call providers, but she did not call because that resident already had orders and she just got here at the end of the evening shift. She stated that her orders had been processed and nothing could be done, just wait until next morning. She stated that nobody explained to her how to get medication from the emergency kit. She stated that she did not contact the on-call provider as she thought this resident could not get another order if she already had the orders in place. She stated that she could not get a different order because the on-call provider could not proscribe anything else if this resident already had pain medication orders. She stated that the unmanaged pain could cause discomfort to residents. During an interview with RN B on 06/02/2026 at 1:53 p.m., she stated that she worked on 6/1/2026 from 2-10pm. She stated that according to the policy for new admissions, she assessed Resident #128, confirmed her ordered medication that were already entered in the system by ADON and verified with NP K, and she explained the medication administration schedule to resident and family. She stated that she received a report from the hospital nurse regarding Resident #128's diagnoses and she was aware that Resident #128 received the medications for chronic pain. She did not ask about pain level at discharge and the hospital nurse did not ask RN B what pharmacy medications should be sent to for Resident #123. She stated that she assumed that medications would be sent to the facility's pharmacy. RN B asked Resident #128 about pain during admission assessment, and she told her that she had pain in coccyx area, but no painful expression was observed during her assessment. She stated that she found out that Dilaudid was not in the pyxis when RN A asked to check if Dilaudid was there. They did not call the pharmacy as she was leaving, but per facility's protocol if medications were not available at the facility charge nurses were responsible for calling the pharmacy and on call physician to get new orders as needed. RN B stated that if pain was not managed properly, residents' condition could decline. During interview with ADON on 06/04/2026 at 11:08 a.m., she stated that she was working at the facility for 12 years as infection preventionist. She stated that she was responsible for communicating with case workers at the hospital and entering new medical orders in the computer system and communicating those orders to providers to get approvals. She stated that she received the discharge hospital orders for Resident #128 approximately an hour before her admission on [DATE] and entered her medication orders in the computer. She stated that she received those orders by e-mail, sent them to NP K for verification and received her approval for those medical orders. She stated that she left on 06/01/2026 PM and was not informed that Resident #128 did not have pain medications available at the facility. She stated that charge nurses were responsible for admitting residents, assessing them, and calling the facility's pharmacy to get (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	medication orders filled and request different medications from on call providers that are available during nighttime if medications were not available at the facility. She stated that it was important to treat pain promptly to prevent worsening pain and causing distress to residents. She stated that DON was responsible for following up and overseeing that orders were correctly entered and follow-up with additional training for nursing staff as needed. She stated that she had been in-serviced on change of condition and notified the provider immediately if change of condition included worsening and not managed pain. During an interview with NP K on 06/02/2026 at 12:36 p.m., she stated that she received the call this morning from RN C regarding Resident #128's pain medications. She was informed that the hospital sent the narcotic triplicate to a different local pharmacy. She stated that the facility has an emergency kit and the hydromorphone (Dilaudid) was not available in the facility's emergency kit. She stated that the facility has a policy to contact on-call providers if there were any medical concerns or changes of condition and no call regarding Resident #128 was received last night. She stated nurses should try to work around this issue (not available medication); ask family to provide medication if available at home while waiting for medication from the pharmacy. She stated that hospitals usually send a controlled drug triplicate to the facility's pharmacy and it was extremely rare to be sent outside of facility's pharmacy. She stated nurses should have called the on-call physician. If this resident did not receive pain meds, it could cause the increased discomfort from cancer and pain level increase. She stated that the consequences of not getting pain medications depended on each resident's situation. During an interview with CNA H on 06/03/2026 at 11:56 a.m., she stated that she worked with Resident #128 starting from 06/02/2026 6 a.m. for two-day shifts (6am-2pm). She stated that when she repositioned Resident #128, she was grimacing and complained of pain during changing positions and during incontinent care and she reported it to RN C. During an interview with CNA E on 06/03/2026 at 10:06 p.m., she stated that she took care of Resident #128 on 2-10 p.m. shifts, and she noticed this resident needed assistance with repositioning and incontinent care. Resident #128's Family member stayed in the room with her. She stated that Resident #128 has a wound in lower back, and she complained of pain when being repositioned, but not a lot and only when moving. She stated that Resident #128 could assist with repositioning holding to the bed rail. She stated that she worked during the shift when Resident #128 was just admitted to the facility and assisted RN B with taking blood pressure and changing this resident. She stated that she did not remember if Resident #128 complained of pain at that time. She stated that she did not remember Resident #128 being in pain a lot, just when moving. Attempted to call the night shift CNA N who worked with Resident #128 on the night of admission, 06/01/2026 - 06/02/2026 and the call was not returned. Attempted to call the oncology providers for Resident #128 and left a message with desk to request a call back which was not returned. During an interview with DON on 06/04/2026 at 1:14 p.m., he stated that he was DON at this facility for 4 years. He stated that medication orders for new admissions were received a few hours before residents were admitted to the facility and ADON entered orders on the system. Resident #128's medications were sent to the wrong pharmacy and that was the reason facility's pharmacy did not receive those orders and did not send those medications to the facility on the night of Resident #128's admission. He stated that admitting charge nurses were responsible for calling on call providers to request additional medications needed for residents if medications were not available at the facility. He stated that Resident #128 had her fentanyl patch applied at the hospital on the day of discharge, so she did have some pain medication that day. He stated that he became aware of this resident complaining of pain and not receiving her pain management on the morning of 06/02/2026. He stated that RN A who worked on 06/02/2026 10 p.m.-6 p.m. was responsible for contacting the pharmacy to verify that ordered medications were coming and contacting on call provider to get a new order for Resident #128's pain management. He stated that RN A could ask the family to bring their own medication from home and utilize that until they were able to get the medication from the pharmacy. DON stated he was notified that night about this issue with medications, even though he called the facility regarding the different questions and (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	spoke to RN A, and she did not tell him that she had an issue with Resident #128's medications. He stated that RN A was a PRN nurse and worked at this facility for a very short time and would not be working here again. He stated that not providing pain medications to Resident #128 could cause an increase in distress levels and other complications. During interview on 06/03/2026 at 2:34 p.m. with ADM, he stated that he was trained on the admission policy regarding all newly admitted residents' medication orders should be entered in PCC. He stated that charge nurses were responsible for entering new medication orders in the residents' charts. He stated that nurses knew that Resident #128 was coming to the facility and orders were sent from the hospital. He stated that Resident #128's orders should have been entered into the system before her admission. ADON and DON were responsible for reviewing medication orders and putting new orders in each resident's order profile in PCC according to physician orders. He stated that when residents were admitted to the facility, the admitting providers see them withing 24hrs, but an on call provider was available to verify orders and adjust orders as needed. ADM stated that admitting nurses were responsible for assessing and reassessing residents, including pain assessment. He stated that residents should be assessed throughout the shift multiple times and assessments including pain assessment should be documented in PCC (medical records). He stated that when residents come and medications were not delivered to the facility, and if residents or residents' RPs were reporting pain, charge nurses were responsible for contacting on call providers requesting pain medication. He stated that the facility's expectation was obtaining new orders to relieve Resident #128's pain as soon as possible. ADM stated that charge nurses were responsible for monitoring that medications arrived from the pharmacy and were available for residents. If pain was not relieved timely and pain would not subside, it could lead to a lot of side effects. During an interview with MD J on 06/05/2026 at 1:56 p.m., she stated that she saw Resident #128 yesterday, 06/04/2026, and she was doing well. She stated that there were physicians and NPs on call for nurses at the facility to contact when they need to get medications due to change of condition. MD J stated that on call providers could assist with ordering medications to be delivered to the facility or order a different pain medication that was available from emergency medication kit at the facility. She stated that it could be tricky if the hospital sent medications to the wrong pharmacy and it could delay getting those medications transferred to the facility's pharmacy, getting new medication orders or getting new narcotic triplicates, but it could be done. She stated that it was an unfortune incident that this resident had to wait for pain medications that long. She stated that nurses at the facility could and should contact a physician or NPs on call to get new orders if the resident complained of pain and did not have any ordered pain medication available at the facility. She stated that she was on call at nights last weekend and it was a common practice to get new orders for new admitted residents at 10-11 p.m. or any other time they needed. She stated that residents with cancer diagnosis including pancreatic cancer were known to experience a fair amount of pain and that was the reason Resident #128 was ordered strong pain medications and required pain management. She stated that not having pain medication available to Resident #128 while she was experiencing pain could cause distress and discomfort. Record review of Pain Management Policy, dated 12/01/2025, revealed Pain management and treatment: based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.

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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 nutrition, grooming and personal and oral hygiene for 3 of 10 residents (Resident #13, Resident #48, and Resident #86) reviewed for ADL care. The facility failed to ensure, Resident #48, and Resident #86 did not have unwanted facial hair.The facility failed to ensure Resident #13 was changed or toileted every two hours. This failure could place residents at risk of embarrassment and diminished quality of life.Findings included: 1. Record review of Resident #13's face sheet, dated 06/03/2026, reflected an [AGE] year-old female admitted on [DATE]. Resident #13 had diagnoses which included: traumatic subdural hemorrhage without loss of consciousness (blood collects between the brain and the skull's outermost protective covering following a head injury), history of falling and syncope (fainting or passing out.) chronic diastolic (congestive) heart failure (an individual with a long-standing, stable history of stiff, poorly relaxing heart muscles [chronic diastolic heart failure] has experienced a sudden, severe worsening of their symptoms [an acute decompensation], typically resulting in dangerous fluid buildup), need for assistance for personal care, urinary tract infection, and hypertensive (high blood pressure) heart disease with heart failure. Record review of Resident #13's admission MDS assessment, dated 05/09/2026, reflected Resident #13's BIMS score of 15 which indicated intact cognition response. The MDS also stated Resident #13 was occasionally incontinent for urine and frequently incontinent for bowels. Resident #13 was Partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort). Resident #13's MDS revealed (Resident #13 had no current skin issues Record review of Resident #13's care plan, dated 05/10/2026, reflected the following: Focus: ADL self-care performance deficit related to mobility.Goal: [Resident #13] will improve current level of function through the review date.Interventions: The resident requires 1 staff for toileting. The resident requires assistance from 1 or 2 staff to move between surfaces. This may fluctuate with weakness, fatigue, or weight bearing status.Observation of Resident #13 on 06/02/2026 at 1:43 p.m., revealed she was lying in her bed. Her nails were long and had what appeared to be dirt underneath them.During an interview with Resident #13 on 06/03/2026 at 10:19 a.m., she stated that she has to wait to be changed for 2 hours in a wet bed sometimes through different shifts. She stated that she takes diuretics for her heart condition and it makes her urinate more often. She stated that even her pajamas get wet sometimes as nobody comes to check on her and assist her with going to the bathroom. She stated that not being assisted with going to the bathroom timely bothers her due to feeling uncomfortable in wet clothes. She stated that sometimes she could not wait for help any longer and just got up by herself, but she knows she should not get up on her own due to falling at home before and hurting herself. During an observation of Resident #13 on 06/04/2026 at 11:29 a.m., she was sitting in the wheelchair and combing her hair, while CNA H was removing sheets from Resident #13's bed. The sheets on the bed were observed wet with stains of urine. During an interview with Resident #13 on 06/04/2026 at 11:31 a.m., she stated that she was waiting again for somebody to come and change her and her bed was soaking wet due to her urinating on herself and not receiving timely assistance. She stated that the last time she was changed was around 5:00 a.m. Resident #13 stated that CNA H delivered a breakfast tray to her around 8:00 a.m. and she did not see anybody after that until around 11:00 a.m. when therapy came and assisted her with getting up. She stated that she pushed the call light three times and nobody assisted her to go to the bathroom until around 11:00-11:30 a.m. Resident #13 stated: That is what I told you yesterday. I ask for help and have to wait for a while before getting help. During an interview on 06/04/2026 at 11:45 a.m. with CNA H, she stated that she had been trained on answering call lights as soon as possible and checking on residents every two hours. She stated that she brought Resident #13 a breakfast tray (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around 8 a.m. this morning and did not have time to check on her until now. She stated that she felt bad not checking on Resident #13 all morning due to being extremely busy with other residents on the 700-hall. She stated that this resident was wet and she was changing her sheets due to being wet with urine. She stated that she did not see a call light for this resident and did not know who answered the call light. She stated that she felt that sometimes it could be overwhelming with amount of work on the 700 hall and not being assisted by other team members. During an interview on 06/04/2026 at 11:56 a.m. with RN C, she stated that she was a charge nurse on 700 hall and was taking care of Resident #13. She stated that per facility policy, charge nurses and CNAs were responsible for answering call lights as soon as possible and assisting residents with what they need. She stated that she was busy with other residents all morning and did not see a call light for Resident #13. She stated that she was not aware of Resident #13 was wet and waiting for assistance for a while. She stated that not providing residents with toileting and changing wet clothes could cause the skin breakdown, infection, and concerns' with their dignity. She stated that she felt that she was able to take care of 25 residents on her case load, but it could be hard if some residents required more care and took more time to provide treatments while admitting a new resident. She stated that it was everybody's responsibility to answer call lights and she had training on call lights to be answered as soon as possible. During an interview with the DON on 06/04/2026 at 2:22p.m., he said he had been trained on ADL care. He said the policy was to change the residents every two hours or more if needed. He said the CNAs and nurses were responsible for ensuring the residents were changed. He said if a resident was not changed regularly the resident could have discomfort, skin breakdown and depending on the resident, dignity could be compromised. He said management monitored to ensure staff were changing the residents. He said management monitored by doing rounds on the residents. He said he did not know why Resident #13 was soaked in her brief. He said the aide told him she did not notice her call light was on. During an interview with the ADM on 06/04/2026 at 2:53p.m., he said he had been trained on ADL care. He said the policy for changing the residents was that staff were to change the residents every two hours or as soon as possible. He said the CNAs were responsible for changing the residents. He said if a resident was not changed regularly the resident could have skin breakdown, infections, and dignity issues. He also added that a resident should not be left wet. He said the nurses monitored to ensure the CNAs were changing the residents. He said the nurse monitored by doing skin assessments on the residents. He said he did not know why Resident #13 was not changed. 2. Record review of Resident #48's face sheet dated 06/04/2026 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included history of falling, heart failure, muscle weakness, chronic kidney disease stage 3 (a serious condition where the kidneys are severely damaged), hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (paralysis and weakness on right side after stroke), hyperlipidemia (high cholesterol), and hypertension (high blood pressure).Record review of Resident #48's admission MDS assessment, dated 04/22/2026, reflected a BIMS score of 0, which indicated severe cognitive impairment. [Resident #48] was [required] Supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity).Record review of Resident #48's care plan, dated 04/16/2026, reflected the following: Focus Self-Care - Personal hygiene: Resident requires supervision or touching assistance.Goals: The resident will complete personal hygiene (brush teeth, comb hair) with Set assistance from staffInterventions: Encourage resident to use call light for assistance. Encourage/give good oral hygiene to prevent staining of the teeth, dentures. Praise all efforts at self-care. Set-up items for personal hygiene. Allow resident to complete as much of the task as possible. Assist as needed.During an observation of Resident #48 on 06/02/2026 at 10:44a.m., revealed she was lying in her bed. She had facial hair on her chin.During an interview with Resident #86 on 06/02/2026 at 10:46a.m., she said that she had been at the facility for two months. She said she had not noticed the hair on her chin. She said no one had offered to shave her hair on her chin. She said she did not feel (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	good about having the hair on her chin.3. Record review of Resident #86's face sheet dated 06/04/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #86 had diagnoses which included dementia (memory, thinking, difficulty), chronic obstructive pulmonary disease (chronic progressive lung disease), chronic kidney disease stage 4 (a serious condition where the kidneys are severely damaged), heart disease, history of falls, pain, and major depressive disorder (mental health disorder characterized by persistent depressed mood).Record review of Resident #86's admission MDS assessment, dated 05/06/2026, reflected a BIMS score of 0 which indicated severe cognitive impairment. The MDS revealed Resident #86 was Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity required supervision or touching assistance from staff for personal hygiene, which indicated the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) on staff for personal hygiene.Record review of Resident #86's care plan, dated 05/18/2026, reflected the following: Focus: Self Care- Personal hygiene: Resident requires supervision or touching assistance.Goals: The resident will complete personal hygiene (brush teeth, comb hair) with Set assistance from staff.Interventions: Encourage resident to use call light for assistance, Encourage/give good oral hygiene to prevent staining of the teeth, dentures. Praise all efforts at self-care. Set-up items for personal hygiene. Allow resident to complete as much of the task as possible. Assist as needed.During an observation of Resident #86 on 06/03/2026 at 8:42a.m., she was sitting in her recliner eating her breakfast. She had facial hair on her chin.During an interview with Resident #86 on 06/03/2026 at 8:43a.m., she said she had tried to cut her whiskers, but she could not get them. She said staff have not tried to help her shave. She said she would feel better with the whiskers shaved off.Durning an interview with LVN N on 06/04/2026 at 10:03a.m., she said she had been trained on ADLs. She said the policy for facial hair was if the resident does not refuse the CNA should shave the resident to remove the facial hair. She said the CNA was responsible for shaving the residents on their shower day. She said if a resident had unwanted facial hair the resident may feel embarrassed and may not want to talk to people. She said the nurses monitored to ensure the CNAs were shaving residents who wanted to be shaven. She said the nurse monitored by signing off on the shower sheets after the aide had completed a shower. She said the nurse will also go and check to ensure the resident was shaven. She said she did not know why Resident #86 and Resident #48 were not shaven when they did not want the facial hair. During an interview with CNA O on 06/04/2026 at 11:04a.m., she said she had been trained on ADLs. She said the policy for facial hair was to shave the resident on their shower days. She said sometimes the staff shave the residents and sometimes the family does it. She also said sometimes the resident would shave themselves if they were cognitive enough. She said the CNAs and the nurses were responsible for ensuring the residents did not have unwanted facial hair. She said if the resident did not want facial hair the resident may feel embarrassed. She said the CNA's monitored to ensure the residents were shaven. She also said if the resident did not want the CNA to cut the facial hair the CNA would let the nurse know. She said she did not know why Resident #86 and Resident #48 were not shaven when they did not want the facial hair. During an interview with CNA P on 06/04/2026 at 11:22a.m., she said she had been trained on ADLS. She said the policy was that the resident was to be shaved on their shower days. She said if the resident refused the CNA could not do anything about it. She said the CNAs were responsible for shaving the residents, but they have some that only allow the family to shave them. She said the if the resident had unwanted facial hair the resident may be upset. She said the nurses monitored to ensure the residents were being shaved on their shower days. She said the nurses monitored by observation. She said she had shaved Resident #48 on Tuesday. She said she did not know why Resident #86 was not shaved. During an interview with the DON on 06/04/2026 at 2:18p.m., he said he had been trained on ADLs. He said the policy for facial hair was the resident was to be shaved and some residents would refuse. He said it was up to the resident on when their facial hair (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was there and if they wanted it shaved. He said the CNAs were responsible for shaving the residents. He said the resident may feel uncomfortable or unattractive if they had unwanted facial hair. He said everyone monitored to ensure the residents got shaved. He said everyone monitored by rounding on the residents. He said he did not know why Resident #48 and Resident #86 had not been shaved. During an interview with the ADM on 06/04/2026 at 2:49p.m., he said he had been trained on ADLs. He said the policy for facial hair was that staff were to follow resident rights and ask the resident if they want to shave. He said the CNAs were responsible for shaving the residents. He said if the resident had unwanted facial hair the resident may have a dignity issue and their preference was not being honored and enforced. He said the nurses monitored to ensure the residents were getting shaved. He said then the managers would check with the residents daily and ask the resident if everything is up to their standards. He said management would also make observations. He said he did not know why Resident #86 was not shaved. He said Resident #48 would change her mind from time to time. Record review of the Promoting/Maintaining Dignity Policy dated 10/01/2025 revealed It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintains or enhances resident's quality of life by recognizing each resident's individuality. Groom and dress residents according to resident preference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of the resident, that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 3 of 7 residents (Resident #28, Resident #13, and Resident #127) reviewed for quality of care. The facility failed to ensure: Nursing staff weighed Resident #13 and Resident #127 every day according to their care plan and physician's orders due to their CHF diagnosis. Nursing staff provided wound care for Resident #28 according to her care plan and physician's orders. These failures could place the residents at risk of fluid overload, infection, and hospitalization.Findings included. 1.Record review of Resident #13's face sheet, dated 06/03/2026, reflected [AGE] year-old female admitted on [DATE] with diagnoses that included: traumatic subdural hemorrhage without loss of consciousness (blood collects between the brain and the skull's outermost protective covering following a head injury), history of falling and syncope (fainting or passing out), acute on chronic diastolic (congestive) heart failure (an individual with a long-standing, stable history of stiff, poorly relaxing heart muscles [chronic diastolic heart failure] has experienced a sudden, severe worsening of their symptoms [an acute decompensation], typically resulting in dangerous fluid buildup), need for assistance for personal care, urinary tract infection, and hypertensive (high blood pressure) heart disease with heart failure. Record review of Resident #13's admission MDS assessment, dated 05/09/2026, reflected Resident #13's BIMS score of 15 - intact cognition and active diagnoses indicated heart failure (congestive heart failure). Record review of Resident #13's comprehensive care plan, dated 05/10/2026, reflected a focus: Resident has altered cardiovascular status related to Atrial Fibrillation (a heart arrhythmia), CHF, hypertension, hyperlipidemia, Aortic stenosis (type of heart valve disease that prevents the aortic valve from opening fully) with interventions Assess and monitor cardiovascular status/identify complications. Monitor for signs and symptoms that the cardiovascular condition could be worsening or not controlled., and focus: risk for falls with interventions: Anticipate and meet the resident's needs., focus Resident is on diuretic therapy (the use of prescription medications, commonly called water pills to help the kidneys eliminate excess salt and water from the body through urine leading to frequent urination). Record review of weights and vitals summary for Resident #13, dated 06/03/2026, revealed the weight was measured on 05/07/26, 05/12/26, 05/16/26, 05/18/26, 05/19/26. 05/20/26, 05/21/26, 05/22/26, 05/23/26, 06/24/26, 05/25/26, 05/30/26, 05/31/26 and 06/01/2026 which indicated inconsistency with the order to weight Resident #13 daily. Record review of order summary report dated 06/03/2026, revealed an order with start date of 05/06/2026: Weight every day shift related to acute on chronic diastolic (congestive) heart failure. Notify provider f weight gain/loss >3 pounds. Observation of Resident #13 on 06/04/2026 at 11:29 a.m. did not reveal any signs and symptoms of fluid overload (occurs when the body retains too much water and sodium, placing excess strain on the heart, lungs, and kidneys. Common signs include rapid, unexplained weight gain, noticeable swelling in the limbs and face, and shortness of breath). During an interview on 06/04/2026 at 11:29 a.m. with Resident #13, she stated that she never refused to be weighed as she understood the importance of monitoring her weight for her heart condition. She stated that she takes a water pill for getting rid of extra fluid in her body, that's why she pees a lot and needs to be changed more often. Record review of Resident #127's face sheet, dated 06/03/2026, reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included: fracture of lower end of left femur, fracture around internal prosthetic left knee joint, and acute on chronic diastolic (congestive) heart failure. Record review of Resident #127's admission MDS assessment, dated 05/30/2026, reflected Resident #127's BIMS score of 15 - intact cognition and active diagnoses indicated heart failure (congestive heart failure). Weight was identified as 115 pounds. Record review of Resident #127's comprehensive care plan, dated 05/28/2026, reflected a focus: Resident #127 has (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an implanted cardiac pacemaker with interventions of monitoring vital signs. Notify MD of significant abnormalities. Record review of order summary report for Resident #127 revealed an order with start date of 05/29/2026: Weight every day shift related to acute on chronic diastolic (congestive) heart failure. Notify MD/NP of weight gain/loss > 3 pounds. Record review of weights and vitals summary for Resident #127, dated 06/03/2026, revealed the weight record for only for one day recorded: 6/2/2026 - 107.2 pounds which was 7.8 pounds less than at admission. No other weights were documented for Resident #127. Record review of Resident #127's progress notes did not identify any nursing notes regarding unobtained weights and reasons why they were not obtained. During an interview on 06/04/2026 at 9:43 a.m. with Resident #127, she stated that she never refused to be weighed as she understands why her doctor ordered it to monitor her fluids going in and out. She stated that not all CNAs and nurses have time to weigh her and she was not weighed regularly. During an observation Resident #127 on 06/04/2026 at 9:53 a.m., she was sitting in a recliner with elevated legs. The signs and symptoms of fluid overload (rapid weight gain, noticeable swelling [edema]in the extremities or abdomen, and shortness of breath) were not observed at that time. During an interview with UM M on 06/04/2025 at 11:15 a.m., she stated that she was responsible for overseeing that residents' weighing was completed and documented according to physician's orders and their care plans. She stated that CNAs and charge nurses were responsible for weighing residents on their hallways. She stated that the DON was monitoring and going over completion of weights during morning meetings especially for residents with congestive heart failure as those residents had been closely monitored for fluid retention. She stated that tracking these small changes could allow for noticing the change of condition sooner. She stated that Resident #13 and Resident #127 had orders to be weighed every day and not following those orders could affect their health and lead to hospitalization. During an interview on 06/04/2026 at 11:46 a.m. with CNA H, she stated that CNAs were supposed to weigh certain residents according to the list they received from the charge nurses and sometimes they did not have time or residents were busy at therapy, so they could not always weigh them according to the order. She stated that she weighed Resident #13 and Resident #127 several times and could not remember when she did not do that. She stated that she understood the importance of weighing these residents due to their heart condition. She stated that these residents never refused to be weighed. She stated that she was supposed to notify thecharge nurses about weight results and nurses documented results in the electronic charts and if she did not weigh those residents, she was supposed to let nurses know, so next shift would weigh them. During an interview on 06/04/2026 at 12:06 p.m. with RN C, she stated that charge nurses were responsible for monitoring residents' weights and specifically residents with CHF (congestive heart failure) diagnosis. She stated that she provided her CNAs with a list of residents at the beginning each shift and expected them to complete that task. She stated that some CNAs were better and some were not as responsive to her instructions. She stated that sometimes CNAs were too busy and residents were not available, but still she was responsible for following up and documenting weights in residents' charts. She stated that residents with CHF diagnosis like Resident #13 and Resident #127 were on an everyday weight order and should be weighed every day due to the need to monitor their weights closely to prevent fluid overload which could cause change of condition and hospitalization. She stated that nurses were responsible for notifying the provider if weights were out of normal range or not completed. She stated that these residents were not weighed on several occasions and she was not sure why, but it was not documented and physician was not notified according to the nursing notes. She stated that not weighing those residents according to the physician's orders could be potentially harmful to residents. During an interview with ADON on 06/04/2026 at 12:34 p.m., she stated UM M was responsible for monitoring residents' weights per physician orders. She stated that CNAs were responsible for following charge nurses' orders to take weights for specific residents and with different frequency as some residents that have diagnoses of CHF (congestive heart failure) were required to be weighed every day to prevent the fluid overload. ADON stated that they discuss (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weights at morning clinical meetings and the DON monitors the following of orders to weigh residents and reminds nurses if weights were not taken or not documented in residents' charts. She stated if they did not follow ordered weights, these residents could experience change of condition and hospitalization. She stated that wound care should be provided on a regular basis without missing treatments and document/notify nursing management, providers, and residents' RPs if wound care treatment was missed. She stated that if wound care was missed, it could cause worsening of condition and delay in wound healing. 2.Record review of Resident #28's face sheet, dated 06/03/2026, reflected a [AGE] year-old female, admitted on [DATE] with diagnoses of multiple fracture of ribs, left side, history of falling, and pain. Record review of Resident #28's admission MDS, dated [DATE], revealed BIMS 15 - intact cognition with indication of prior surgery involving fusion of spinal bones and surgical wound/wound care treatment. Record review of Resident #28's base line care plan, dated 05/28/2026, reflected a focus: Risk for impaired skin integrity related to pressure from TLSO Brace (a rigid or semi-rigid medical-grade spinal brace.): with intervention in place: Remove per schedule for skin checks and hygiene unless MD ordered not to remove and report redness, blisters, or breakdown immediately. Record review of order summary report for Resident #28, dated 06/04/2026, revealed an order for wound treatment: Xeroform every day shift related to wedge compression fracture. Cleanse wound to upper back with normal saline. Pat dry, apply xeroform to wound. Cover with bordered foam dressing.An observation and interview of Resident #28 on 06/02/2026 at 9:36 a.m. revealed Resident #28 sitting in the recliner without back brace on. She stated that she needed it only when she was walking and it hurt her to keep in on all the time. She stated that she had a wound on her back.Observation and Interview with resident #28 on 06/02/2026 at 9:43 a.m. Resident #28's wound dressing with date of 05/29/2026 signed by TN L revealed the slight redness around the dressing without foul smell or other signs of infection were identified at that time. Resident #28 stated that she worried that her wound was not cleaned every day as it was supposed to be according to the doctor's order. Attempted to observe the wound care on Resident #28 on 06/03/2026 revealed that this resident was sent to the hospital for a routine wound debridement procedure. During an interview with DON on 06/04/2026 at 1:14 p.m., he stated that he was DON at this facility for 4 years. He stated that charge nurses were responsible for making sure that weight orders were followed which could be on the daily, weekly, or monthly basis depending on different diagnosis like residents on dialysis or CHF diagnosis. He stated that it was very important for residents with [NAME] diagnosis to be weighed every day to monitor their fluid retention and prevent fluid overload. He stated that this facility was very busy with a lot of new admissions and acuity of residents, so it was difficult to monitor every single weight was done, but it should be done. He stated that Resident #13 and Resident #127 did not refuse to be weighed and charge nurses and CNAs should document if for some reason they were not able to complete the task which pops up on the computer for nurses to complete and they were supposed to document if it was completed and why it was not completed. He stated that charge nurses were supposed to notify him and providers if weights were not completed for any reason. He stated that the wound care should be completed on a regular basis and he became aware that Resident #28 did not receive her ordered wound care for 3 days including the weekend when a treatment nurse was not in the building and charge nurses were responsible for completing wound care tasks. He stated that he talked to the weekend supervisor emphasizing importance of monitoring that wound care was completed especially since there were not so many residents with everyday orders for wound care. He stated that if wound care was not provided according to physician orders, it could cause wounds to not heal properly and possible worsening of wounds. During an interview on 06/04/2026 at 3:39 p.m. with ADM, he stated that CNAs were responsible for weighing residents as scheduled or ordered by physicians. He stated that the charge nurses were supposed to follow the orders for weighing residents every shift according to the PCC - nursing task, and report daily on the clinical meetings, document in the weight log at each nursing station report to DON who supervised this task was completed and who reported the weight results or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns on the weekly basis on clinical facility wide meetings. He stated that he was not aware that nurses were supposed to notify the provider if weights were not completed. He stated that if residents with CHF were not weighed according to the physician orders, it could deteriorate their health. Nursing staff could catch change by monitoring weight for these residents and attend to their needs before significant changes happened. He stated that the wound care nurse who worked Monday to Friday was responsible to follow up on the orders of physicians. The ADON, DON and ADM, wound care provider and physicians were responsible for monitoring if any change of condition happened and should be notified by charge nurses if orders were not followed. He stated that if not the wound care orders, follow orders, wounds could deteriorate and lead to increase in pain and discomfort. During interview with MD I on 06/03/2026 at 3:44 p.m., he stated that at his professional opinion a treatment nurse was supposed to follow EBP during all wound care procedures regardless of type of wounds. He stated that visitors or nursing staff that come to administer medication or meals did not have to follow EBP with those residents. He stated that without following EBP with those residents could potentially increase risk of complications. During interview with MD J on 06/05/2026 at 8:33 a.m., she stated that wound care was not her specialty, but she was leaving it to facility's discretion and thought it was specific to type of wound. Record review of facility's policy Wound treatment management, dated 12/1/2025, revealed to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatment in according with current standards of practice and physician orders.Policy explanation and compliance guidelines: 1. Wound treatment will be provided in accordance with physician orders, including . the frequency of dressing change.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive and at a safe and appetizing temperature for all residents who consumed foods orally from the only kitchen in the facility that: The facility failed to provide palatable food that was attractive or appetizing to residents who complained the food did not look or taste good and that it was frequently cold. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, food borne illnesses, and diminished quality of life.During an interview on 06/02/2026 at 1:05 p.m., it was revealed that Resident #18's only complaint was that her soup was too salty. During an interview on 06/02/2026 at 3:29 p.m., Resident #17 stated his meals were served cold almost every day. The resident stated he ate in his room daily. The resident stated his meals were rarely ever hot or warm enough. During an interview on 06/02/2026 at 3:34 p.m., Resident #118 stated her meals were served cold often. The resident stated she ate in her room daily. The resident stated meal services rarely ever had hot food. The resident stated her food did not taste good because it was not hot enough. In a confidential resident meeting at an undisclosed date and time, 5 of 9 said soup served on 06/02/26 was watered down. Residents said that the [NAME] was watering it down so it will go further. During an observation on 06/03/2026 at 1:09 p.m., it was revealed that staff were serving meal trays to hallway 300 residents. Resident # 41's pot roast's temperature was at 122 degrees, Resident # 63's carrots were at 128 degrees, and the roasted red potatoes were at 112 degrees. During an observation on 06/03/2026 at 1:18 PM, a test tray was provided by NSD. The test tray contained a bowl of chicken and vegetable soup. The soup was tasted by 3 surveyors, and it was the consensus of the 3 surveyors that the soup was excessively salty. During an observation on 06/04/2026 at 1:37 p.m., a test tray included a puree diet plate that included chicken parmesan, fettuccine, Italian vegetables, garlic bread, and fresh baked cookie. The chicken parmesan puree was only slightly warm, and the fettuccine puree was runny, and it was visually unappealing. During an interview on 06/02/2026 at 9:02 a.m., NSD stated the residents' hot food should be served at 135 degrees or above and the cold food should be served no higher than 37 degrees. NSD stated that the kitchen staff is responsible for maintaining the correct temperature of cooked and prepared food until the food leaves the kitchen. NSD stated the kitchen staff place the prepared food trays on a cart, and the cart is then brought to the appropriate hallways to be delivered to the residents' rooms by the nursing staff. NSD stated it is his expectation that the food temperatures will be maintained until the food is placed in front of the residents. NSD stated residents could get sick from foodborne illness if food is not kept at appropriate temperatures. NSD stated the residents have the right to make special requests for food. NSD stated he attends the Resident Council meetings often so he can get feedback regarding the food from the residents. NSD stated it is the RD's responsibility to report changes in the residents' preferences or dietary requirements. During an interview on 06/02/2026 at 12:25 p.m., it was revealed that DA Q has been trained in food safety. DA Q said the kitchen staff are responsible for cooking the food and maintaining the temperature until the residents have received the food. She said if food temperatures are not maintained a resident could get sick. She said she is responsible for taking the meal plate from the steam table, placing it on the food tray, covering the food plate, and then putting the food tray in the hall cart. During an interview on 06/04/2026 at 10:05 a.m., LVN N revealed staff have been trained in cooked food temperatures. LVN N stated the kitchen staff are responsible for monitoring the palatability and the temperatures of the food. She said the nursing staff are responsible for delivering food to the residents right after it comes out of the kitchen. She said the kitchen should make the food palatable, but the nursing staff can provide residents with additional spices to accommodate their preferences of taste. She said residents have a right to receive food that is served at the proper temperature and that it tastes good. She said the residents could get upset if they do not get their food the way they like it. LVN N said, I would not want to eat it if it didn't taste (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	good or it was not hot enough. She said a resident could be at risk of losing weight if they did not have a palatable diet. During an interview on 06/03/2026 at 9:39 a.m., it was revealed that Regional Culinary Operations Manager has worked for this company for over 10 years and she visits the facility 1 to 2 times per months. She stated her role is in Operations and she is responsible for temperatures of food, and temperatures of dishwasher and refrigeration units. Regional Culinary Operations Manager stated it is her expectation that the food should be served to the residents when it is hot. She said the facility could get more staff on the food line to speed the food tray delivery to the residents. She said the facility has recently purchased another food cart so the food can be delivered quicker. She said the residents should receive palatable food when the nursing staff serve them in the dining room or in their rooms. She said the residents may feel bad if they do not get good tasting food. Record Review of the facility's policy titled, Food: Quality and Palatability dated 5/2014 and last revised on 06/2026 revealed the following: Policy Statement:Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. DefinitionsProper (safe and appetizing) temperature Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimizes the risk for scalding and burns. Procedures2. The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point (HACCP) and time and temperature guidelines as outlined in the Federal Food Code

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for Food and Nutrition Services.The facility failed to ensure dietary staff followed proper handwashing and glove use.These deficient practices could place residents at risk for food borne illness.Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for Food and Nutrition Services.The facility failed to ensure dietary staff followed proper handwashing and glove use.These deficient practices could place residents at risk for food borne illness.The findings were:During an interview on 06/02/2026 at 9:11 a.m., it was revealed that DA Q has been employed at this facility since March of 2026, she has a current Food Handlers Certificate, and she has been trained in Food Service Safety and Sanitation. She stated she has been in-serviced on hand washing and glove use in the kitchen. She said, I must wear gloves for all tasks in the kitchen involving food, then I am to remove gloves between tasks, wash my hands and put on new gloves. I am never to reuse gloves. If we do not use proper hand sanitation, it could cause cross contamination, and a resident could get sick.During an observation and interview on 06/02/2026 at 12:25 p.m., it was revealed DA Q reached over the steam table, obtained a meal plate with bare hands touching the plates food surface. DA Q stated, she was not sure if she was to wear gloves while working on this food service task.During an interview on 06/02/2026 at 10:55 a.m., it was revealed that DA R has worked at this facility for approximately 4 months and she has a Food Handlers Certificate. She stated that she has been trained in hand sanitation and kitchen sanitation. She said, sanitation is to prevent transfer of germs. She said, Someone could get sick if I do not wash my hands for 20-30 seconds. She stated, I must always wear gloves, and I must change gloves between projects or when they get dirty. During an observation in the kitchen on 06/02/2026 at 10:55 a.m., it was revealed that DA R took off one glove from her right hand and she placed it on the steam table. It was observed she used her bare right hand to pick up her mobile phone. DA R held the mobile phone with her left/gloved hand, and she began texting with her right hand. DA R used her right / ungloved hand to place the mobile phone on the steam table between the cloth napkins and the sanitized silverware. DA R said she was texting regarding her schedule for work. Observation included, DA R picked up the right/dirty glove, and she put it back on her right hand. DA R then removed the right/dirty glove and she threw it away. DA R did not wash hands, she then obtained one new glove, and she put it on her right hand, and she continued the task of placing silverware in the napkins.During an observation on 06/02/2026 at 12:10 p.m., it was revealed the DA R walked from the steam table to a kitchen tray storage cart. DA R did not wash her hands or use gloves as she lifted her clothed elbow, and she placed it on the stack of clean lunch trays.During an Interview on 06/02/2026 at 11:05 a.m., it was revealed by NSD that no staff are supposed to have a cell phone in the kitchen. He said, the mobile device is not sanitary. NSD stated it was his expectation that all staff follow proper hand sanitation. He stated that a resident could become ill if they do not follow hand sanitation policy. NSD stated we need to re-educate the staff on hand sanitation.During an interview on 06/02/2026 at 11:07 a.m., it was revealed that RD has worked as a consultant for this facility for 2 years. She said she visits the facility 1 time per week and she regularly observes staff sanitation practices. RD stated, it is my expectation that staff wear gloves when handling food. She said they are to take gloves off if they leave the line, if they touch clothing, or touch their face. She stated, it is unsanitary to bring a cell phone into the kitchen for any reason. RD stated the NSD usually conducts the in-services for the kitchen staff, but I will do an in-service if I am called upon to do so.During an interview on 06/03/2026 at 9:39 a.m., Regional Culinary Operations Manager stated she has worked for this company for around 10 years, and she (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visits the facility 1-2 times per month. She stated her role is Operations, Regulation and temperature and Sanitation. She stated it is her expectation that all staff follow the policies regarding handwashing and kitchen sanitation. She said staff are to wear gloves when handling food. She said staffs' hands or bodies should not meet clean trays and clean serving surfaces. She said staff are to wear gloves when they are moving a dish with food on it from the serving area to a tray. She says staff have all been training on kitchen sanitation including handwashing, glove wearing and glove changing. Food Service Certifications were reviewed for 12 of 12 kitchen staff, and each certificate is current.Record review confirmed that staff was in-serviced on 06/03/2026 on the following topics: proper hand-washing techniques, glove usage and cleanliness of staff uniforms, hair net usage and not bringing foreign objects into the kitchen.Record Review of the facility's document dated March 2003, revised 06/2026, General Sanitation of Kitchen revealed: Policy: The Nutrition Services Staff shall maintain the sanitation of the kitchen through compliance with a written cleaning schedule.Procedure:6. Staff will wear rubber gloves and an apron to protect clothing while .Record Review of the facility's document dated March 2003, revised 06/2026, Hand Washing revealed: Policy Nutrition Staff will wash hands before starting work, when retuning to work, after smoking, eating, drinking, after visiting restrooms, after handling garbage or poisonous compounds, after removing gloves and at other times hands have been soiled. Dishwashers should always wash/sanitize their hands before handling clean dishes. Hand washing facility should be readily accessible and equipped with paper towels and soap.1. Turn on faucet using paper towel.2. Wet hands and forearms with warm water [NAME] antibacterial soap.3. Scrub well with soap and additional water as needed, scrubbing all area thoroughly.4. Rinse thoroughly.5. Dry hands with paper towel, turn off faucets with towel and discard.6. Application of hand lotion is not advised.7. Staff are educated on the importance of hand washing, retraining, and reminding as necessary on the above policy/ procedure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 5 of 12 residents (Resident #128, Resident #90, Resident #41, Resident #37, and Resident #60) reviewed for infection control. Facility failed to ensure: TN L sanitized the over-the-bed table prior to setting supplies on it for Resident #90's wound care, did not put on PPE (gown) before providing care to Resident #128 and Resident #90 and did not sanitize her hands two times between changing gloves during Resident #90's wound care. MA D sanitized her hands between changing gloves after performing eye drops for Resident #60 and failed to sanitize the blood pressure cuff between Resident #37 and Resident #41. These failures could place the residents at risk of infection transmission, sepsis, and hospitalization. Findings included: 1.Record review of Resident #128's face sheet, dated 06/03/2026, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of malignant neuroendocrine tumors (pancreatic cancer), secondary malignant neoplasm (cancerous tumor) of liver and intrahepatic bile duct (a network of tiny, branching tubes located inside the liver), and pain. Record review of Resident #128's base line care plan, dated 06/01/2026, reflected a focus: Enhanced barrier precautions with interventions: implement enhanced barrier precautions and monitor for signs and symptoms of infections. Record review of Resident #128's admission MDS, dated [DATE], no BIMS score was identified, and no information of wound care was identified. Record review of Resident #90's face sheet, dated 06/03/2026, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of cellulitis (bacterial infection of the skin and the soft tissues beneath it) of right lower limb, acquired absence of right leg below knee, sepsis (the body's extreme, life-threatening reaction to an infection), anxiety, and type 2 diabetes mellitus (a chronic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Record review of Resident #90's admission MDS, dated [DATE], reflected a BIMS score of 14 - intact cognition and presence of surgical wound with application of ointments/medications to wound. Record review of Resident #90's care plan, dated 05/07/2026, reflected a focus: Resident #90 has cellulitis of right foot with interventions in place: give antibiotics for infection and mild analgesics to relieve discomfort and no EBP precautions for wound care were reflected in the care plan. During an observation and interview of wound care conducted by TN L on 06/03/2026 at 1:45 p.m., for Resident #128, TN L checked an order and stated that a new order was place for Triad cream every day shift for stage with cleansing wound to sacral/coccyx area with normal saline or skin cleanser. Pat dry. Apply triad cream. Leave open to air. The new order replaced the order: apply triad cream, silver alginate, and cover with mepilex foam dressing with border. Change daily and as needed. She set up the over-the-bed table stating she had already cleaned it. She washed hands and applied gloves. She removed the old dressing with date on it indicating: 06/02/2026. She stated that Resident #128 just got the pain medication. Resident was grimacing when she turned but stated she was ok. TN L cleaned the wound by removing some slough (by product of the body's inflammatory response) and small amount of drainage. No PPE was available in Resident #128's room. TN L removed contaminated gloves, sanitized hands, and reapplied gloves again, she was leaning to Resident #128's bed with her uniform touching Resident #128's sheets. She wiped Resident 128's bowel movement and removed and reapplied gloves with proper sanitizing hands with observation of not sanitizing hands between changing contaminated gloves -one time. TN L washed hands at the sink after completing wound care task and before exiting Resident #128's room. During observation of wound care conducted by TN L on 06/03/2026 at 2:20 p.m. for Resident #90, TN L moved her treatment cart and an over-bedtable with her to Resident #90's room. TN L did not sanitize an over-bedtable before putting wound care supplies on the table. She sanitized her hands before entering the room and put gloves on in the Resident #90's room, she removed old dressing, properly cleaned the surgical incision (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with small, dehisced (to split or bust open) area of incision. She removed her gloves after changing dressing and put on new gloves without sanitizing hands between gloves change on Resident #90. TN L applied the dressing and dated the dressing. She removed contaminated gloves and sanitized her hands before exiting the room. No EBP precaution protocol was followed during the wound care for Resident #90. During interview with TN L on 06/03/2026 at 2:41 p.m., she stated that she had an infection control training last week with ADON who was an infection preventionist. She stated that per policy it was required to sanitize hands between gloves changes and after completing the procedure or before exiting resident's room. She stated that it was a requirement to sanitize an over bed table that she used for placing wound care supplies between residents. She stated that she forgot to sanitize the table between Resident #128 and #90. She stated that, according to her understanding, EBP precautions should be followed only for certain wounds and for Resident #128 and Resident #90 no orders were placed, and no PPE equipment was provided, and signs were posted outside of residents' rooms if they were on EBP or other type of infection control precautions. She stated that if she did not follow proper infection control and hands hygiene, she could introduce infection to other residents. 2.Record review of Resident #60's face sheet, dated 06/03/2026, reflected a 79-years-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of cataract (when normally clear lens inside the eye becomes cloudy), adjustment disorder with mixed anxiety and depression mood, and hypertensive heart disease (high blood pressure) with heart failure. Record review of Resident #60's comprehensive care plan, dated 02/18/25, revealed Resident #60 had an ADL self-care performance deficit related to impaired balance. Record Review of Resident #60's quarterly MDS, dated [DATE], revealed his BIMS score of 15 - intact cognition. Observation on 06/03/2026 at 8:11 a.m. of MA D revealed she administered clear eye drops to Resident #60 and did not sanitize her hands after removing gloves and leaving Resident #60's room. Record review of Resident #37's face sheet, dated 06/03/2026, revealed [AGE] year-old male admitted on [DATE] and readmitted [DATE] with diagnoses of history of embolism and thrombosis (blood clots in blood vessels), gastroesophageal reflux disease without esophagitis (reflux), insomnia. Record review of Resident #37's annual MDS, dated [DATE], revealed his BIMS score of 13 - intact cognition. Observation of MA D after completing using blood pressure cuff on Resident #39, she did not disinfect the cuff before and after using the same blood pressure cuff on Resident #41. MA D was observed putting the blood pressure cuff on her medication cart without sanitizing it. Record review of Resident #41's face sheet, dated 06/03/2026, reflected an [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of dementia with mood disturbance, chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. Record review of Resident #41's quarterly MDS, dated [DATE], revealed his BIMS score of 15 - intact cognition. During an interview on 06/03/2026 at 8:34 a.m., MA D stated she did not sanitize the blood pressure cuff between residents when she checked their BP because she was not aware she was supposed to do it. She stated that she started to work at this facility for 2 weeks and she had hygiene and infection control in her services on hands on her 1st day. She stated she knew that she was supposed to sanitize or wash her hands between gloves change, but she was not trained on sanitizing the blood pressure cuff between residents during medication pass. She stated that not sanitizing her hands between gloves changes and not sanitizing the blood pressure cuff between residents could transmit infection between residents. During an interview with ADON on 06/04/2026 at 11:08 a.m., she stated that she was working at the facility for 12 years as the Infection Preventionist. She stated that she was responsible for overseeing that nursing staff followed infection control and hand hygiene policies properly and provided additional training to staff as needed. She stated that infection control training is provided on hire, annually and as needed. She stated that all staff should sanitize hands between gloves change, sanitize the table before placing the wound care supplies between residents and sanitize the blood pressure cuff between residents to prevent spread of infection. She stated that according to the facility's policy EBP is followed only for residents with specific wounds like chronic (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wounds and with infection. During an interview with DON on 06/03/2026 at 1:31 p.m., he stated that ADON and himself were responsible for monitoring that proper infection control and hand hygiene policies were followed by nursing staff. He stated that infection control training was provided to staff on hire, annually, and as needed basis. He stated that nursing staff were supposed to sanitize their hands between gloves change, sanitize the table before placing clean wound care supplies, and sanitize blood pressure cuff between residents to prevent spread of infection to residents. During interview with ADM on 06/04/2026 at 3:39 p.m., he stated that he had an infection control and hand hygiene training at hire about 3 months ago. He stated that all employees received training on infection control and hand hygiene at time of hire from the Infection Preventionist, ADON, who provided the training. He stated that the web training, assessment on paper, quarterly and annual are available to all employees at the facility. He stated that it was usually a joint effort on abuse and neglect provided by him and infection control presented by Infection Preventionist and other departments present on other topics to new employees during new hire orientation. He stated that he would expect staff follow the proper hand hygiene - sanitizing hands between gloves change, sanitizing table before putting wound care supplies between residents, and sanitizing the blood pressure cuff between residents to prevent the spread of bacteria to residents and staff. He stated that the facility's EBP was to follow the physician orders and follow EBP precautions for dialysis residents, residents with invasive devices like catheters, wounds that are actively infected and not for all wounds. Record review of facility's policy Personal Protective Equipment, dated 11/01/2025, revealed: This facility promotes appropriate use of personal protective equipment to prevent of transmission of pathogens to residents, visitors, and other staff. Indication/consideration for PPE use: -Gloves: Perform hands hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene.-Gown: Wear gowns to protect arms exposed to body areas and clothing from contamination with blood, body fluids, and other potentially infection materials. -Staff will receive training on the why, what, and how of PPE upon hire, annually, when new products are introduced, and as needed. Record review of facility's policy Infection prevention and control program, dated 10/01/2025, revealed Staff education: All staff should receive training, related to their specific roles. Record review of facility's policy Enhanced Barrier Precautions, dated 12/1/2025, revealed Policy: it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms. Initiation of Enhance Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC but my be considered epidemiologically important. Record review of CDC Enhanced Barrier Precautions policy, dated June 28, 2024, revealed that Enhanced Barrier Precautions to include all residents with wounds or indwelling medical devices, regardless of MDRO status. Indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized. Available evidence suggests that the routine use of EBP for residents with wounds or indwelling medical devices would reduce the transmission of staphylococcus aureus and MDROs. In a randomized clinical trial, routine use of EBP among residents with indwelling medical devices reduced acquisition of MDROs including methicillin-resistant Staphylococcus. aureus, and reduced catheter-associated urinary tract infections.16 In a separate quasi-experimental study, routine use of EBP during high-risk care of residents with wounds or indwelling medical devices was associated with a significant decrease in acquisition and transmission of both methicillin-susceptible and methicillin-resistant Staphylococcus aureus. 19 Interruption of S. aureus and MDRO transmission likely occurs through at least two potential mechanisms: preventing contamination of healthcare personnel clothing by MDRO-colonized residents, and providing protection against MDRO acquisition (continued on next page)

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