STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676352	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonemere Rehabilitation Center	11855 Lebanon Road Frisco, TX 75035

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 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 observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Medication Cart 3) of 3 carts and 1 of six residents (Resident #30) reviewed for pharmacy services. 1. The facility failed to ensure LVN D responsible for Medication Cart 3, counted controlled drugs every shift change on 06/01/2026, 06/04/2026, 06/05/2026, and 06/08/2026. 2. The facility failed to ensure LVN D documented administering prn cough medication to Resident #30 on 06/09/26. This failure could place residents at risk of not having the medication available due to possible drug diversion and residents may receive the wrong dose Findings Included: 1. Record review and observation on 06/09/26 at 1:27 PM of Medication Cart 3, with LVN C ,revealed missing signatures for Off going staff and On coming staff of the narcotic count sheet for:06/01/2026 (2:00 PM to 10:00 AM shift), 06/04/26 (2:00 PM to 10:00 AM shift), 06/05/26 (2:00 PM to 10:00 AM shift),06/08/26 (2:00 PM to 10:00 AM shift). In an interview on 06/10/2026 at 2:08 PM, LVN D stated he should have signed the narcotic sheet after counting the narcotics, on 06/01/01/26, 06/04/26, 06/05/26, and 06/08/26 at the beginning and at the end of the shift. He stated he got busy and did not go back to sign the count sheet. He stated he knew that he was supposed to sign immediately after the count was done. He stated the risk would be potential for drug diversion. Review of the facility's policy Controlled Substances reviewed December 2025 reflected the following: . Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services . 2. Review of Resident #30's face sheet undated reflected Resident #30 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of lack of coordination, type 2 diabetes (chronic disease characterized by high levels of sugar in the blood), hemiplegia (paralysis) affecting right dominant side and stroke. Review of Resident #30's Annual MDS dated [DATE] reflected Resident #30 had a BIMS of 13 indicating she was cognitively intact. Review of Resident #30's current physician's orders reflected physician order dated 06/08/26 of Robafen DM Cough Oral Liquid 10-100 MG/5ML (Dextromethorphan-Guaifenesin) Give 10 ml by mouth every 4 hours as needed for cough. Interview on 06/10/26 at 10:45 AM with Resident #30 revealed she was coughing yesterday (06/09/2026) and requested from LVN D prn cough medication. She stated LVN D did give her the prn cough medication in the late evening after dinner like 7 or 8 pm. Review of Resident #30's MAR for June 2026 reflected no medication administration of Robafen DM Cough Oral Liquid 10-100 MG/5ML (Dextromethorphan-Guaifenesin) Give 10 ml by mouth every 4 hours as needed for cough for 06/09/26. Review of Resident #30's June 2026 progress notes reflected no documentation of prn cough medication given to Resident #30 on 06/09/26. Interview on 06/10/26 at 2:12 PM with LVN D revealed between 9 pm and 10 pm on 06/09/26, Resident #30 complained of a cough and he gave her the prn cough medication. He stated he should have documented the cough medication prn dose he gave Resident #30.He stated it was important to document at time of medication administration so (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses knew when medication was given especially for prn medications. In an interview on 06/11/26 at 08:34 AM, the DON stated she expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The DON stated if the staff were not signing the narcotic count sheets, she was unable to prove they were counting. The DON stated it was important to ensure a drug diversion did not occur. The DON stated the ADONs would check the carts weekly. The DON stated nurses should document when medication administration was given on the MAR and the risk to the resident could be overdose of medication due to other nurses not knowing resident was given the prn medication. Review of facility's policy Administering Oral Medications last revised December 2025 reflected to provide guidelines for safe administration of oral medications. Under documentation Follow documentation guidelines. This policy did not specify about documenting the medication administration in the MAR.

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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. Based on observations, interviews and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, in that: Dietary [NAME] G and the Dietary Manager failed to wear effective hair restraints during lunch meal preparation on 06/10/26. This failure could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness and food contamination. Findings included: Observation on 06/10/26 at 11:29 AM to 11:36 AM revealed Dietary [NAME] G was wearing a hat that did not cover 0.5 inches in front of both sides of her ears and about 0.5 inches of the back of their hair. Dietary [NAME] G was observed taking hot food temperatures of lunch food prior to serving. Dietary [NAME] G was putting food on residents' plates for lunch. Observation on 06/10/26 at 11:37 AM and 11:48 AM revealed the Dietary Manager was wearing a hat in which the back of his hair was uncovered about 2 inches, during food meal time at lunch. He went into walk-in refrigerator to get yogurt and health shakes for residents' meal trays. Interview on 06/10/2026 at 1:52 PM with Dietary Manager revealed he was not aware of hair restraints not covering the back of his hair and on Dietary [NAME] G not having the hair near their ears being covered. He stated his hair restraint must have slipped up and he thought it was covering all of his hair in the back. He stated the importance of wearing effective hair restraints was to cover all hair, to keep hair from getting into the food and to prevent infection control. Review of facility's policy Procedure undated reflected For all team members.2. Wear hairnets or beard restraints if facial hair present.All hair including any facial hair must be completely covered. Review of the Food and Drug Administration US Food Code 2022 reflected under section 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #36) of 8 residents reviewed for ADLs. The facility failed to ensure Resident #36 had her fingernails cleaned on 6/9/26. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: Record review of Resident #36's Quarterly MDS assessment dated [DATE] reflected Resident #36 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included cerebral infarction (the death of brain tissue caused by a prolonged lack of blood flow and oxygen), age related cognitive decline, and cognitive communication deficit. Her BIMS couldn't be done because Resident #36 was rarely or never understood. Resident #36's cognition was severely impaired. The MDS assessment indicated Resident #36 required extensive assistance with personal hygiene. Record review of Resident #36's Care Plan dated 05/15/26, reflected the following: Focus: [Resident #36] has an ADL self-care performance deficit. Interventions: . [Resident #36] requires staff participation. In an observation on 06/09/26 at 10:22 AM revealed Resident #36 was lying in her bed. Her nails on her right hand were dirty and had yellow greenish colored residue on the nail beds. Resident #36 was confused and her answers were not pertinent to the subject. In an interview on 06/09/26 at 11:08 AM, CNA B stated CNAs and nurses were responsible for cleaning and cutting the residents' nails. CNA B stated did not notice Resident #36's nails. She stated she would do it right then. She stated the risk would be infections. In an interview on 06/11/26 at 8:34 AM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to clean residents' nails if they were dirty. The DON stated the ADONs and the DON would do the routine rounds to monitor. The DON stated residents having dirty nails could be an infection control issue. Record review of the facility's policy Care of Fingernails/Toenails revised December 2025, reflected the following: .The purposes of this procedure are to clean the nails bed, to keep nails trimmed, and to prevent infections.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #88) of two residents reviewed for incontinence care. The facility failed to ensure CNA A provided appropriate perineal care for Resident # 88 when she failed to clean the resident's labia on 6/9/26. This failure could place residents at risk for the development and/or worsening of urinary tract infections. Findings included: Record review of Resident #88's Quarterly MDS assessment, dated 04/17/26, reflected a [AGE] year-old female with an admission date of 11/03/22 with diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning), cognitive communication deficit, and cerebral infarction (occurs when blood flow to a section of the brain is blocked or significantly reduced leading to the death of brain cells). Resident #88 had a BIMS score of 02 which indicated Resident #88's cognition was severely impaired. Resident#88 was always incontinent of urine and frequently incontinent of bowel. Review of Resident #88's care plan, initiated 2/11/26, reflected .Focus: [Resident #88] has . bladder incontinence related to dementia . Goal: Resident will remain free from skin breakdown due to incontinence through next review date. Interventions: [Resident #88] uses disposable briefs. Change as needed. In an observation on 06/09/26 at 11:08 AM revealed CNA A entered Resident #88's room to provide incontinence care and change the resident's clothes. CNA A washed her hands, put on gloves and unfasted the brief to reveal the resident had been incontinent of urine. CNA A pushed the soiled brief down between the resident's legs, which were held tightly together, toward her buttocks and cleaned her peri area from front to back but did not separate the labia and clean down the middle. CNA A rolled the resident onto her side revealing the resident had soaked through her brief. It was noted that the resident's skin was wet but intact. CNA A continued to provide incontinence care, wiping from front to back and applied a clean brief, and she changed resident's clothes. CNA A removed her gloves, and she washed her hands. In an interview on 06/09/26 at 11:41 AM, CNA A stated she failed to separate the resident's labia and by missing that step could lead to an infection. She stated she had been in training and knew the importance of properly cleaning a resident and timely. In an interview on 06/11/26 at 08:34 AM, the DON stated when providing incontinent care staff were to clean the peri area including the labia for female residents then moving toward the buttocks. She stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. The DON stated the ADONs and the DON would do routine rounds for monitoring. Review of the CDC Epidemiology and Prevention of UTI a component of preventing a Urinary Tract Infection is to provide good perineal hygiene.Accessed at https://www.cdc.gov/nhsn/pdfs/training/2018/ltcf/epidemiology-prevention-uti-508.pdf accessed on 06/12/26 . Record review of the facility's policy titled, Perineal/Incontinent Care, revised December 2025, reflected, . For a female resident: . Wash perineal area, wiping from front to back. Separate labia and wash area downward from front to back.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, consistent with professional standards of practice for one (Resident #2) of one resident reviewed for tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) care. The facility failed to ensure LVN E followed the procedure for tracheostomy care for Resident #2 on 06/10/26 by using sterile technique. This failure could place residents at risk for respiratory infections.Findings include:Record review of Resident #2's Quarterly MDS assessment, dated 06/05/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her active diagnoses included acute respiratory failure with hypoxia (absence of oxygen), tracheostomy (a surgical procedure creating an opening in the neck to provide a direct airway). Resident #2 was unable to complete the BIMS. In Section O-Special Treatments, Procedures, and Programs it revealed she required tracheostomy (trach) care during the 14 day look back period. Review of Resident #2's care plan dated 03/26/2026, reflected, Focus: [Resident #2] has tracheostomy. Goal: . resident will have no clear and equal breath sounds bilaterally . Interventions: . Suction as necessary . Review of Resident #2's Consolidated Physician's orders dated June 2026, reflected, .Tracheostomy care every shift and as needed. In an observation on 06/10/26 at 8:32 AM revealed RN D washed his hands; he donned gown, clean gloves, and a mask. RN F was in the room wearing a gown and clean gloves and supplies were on the bedside table. LVN E removed the disposable canula and discarded it. He removed his dirty gloves and washed his hands. RN F opened the trach kit and placed it on the bedside table. LVN E opened the sterile gloves and donned the left glove. When putting the second glove on, he touched, with the sterile gloved left hand his bare skin on his right hand, breaking the sterile field. With the contaminated hand he picked up a new inner cannula from the trach kit and inserted it into the resident's trach and locked it. With the same gloves on LVN E attached the suction to the resident's in-line suction line and inserted the suction line into the trach 2 times. LVN E then cleared the line and turned off the suction machine. He discarded the suctioning catheter. Without changing gloves, LVN E put back the trach tube on the stoma. He removes his gloves and discarded them. RN F told him to wash his hands. He washed his hands and donned clean gloves. He checked the resident's oxygen and cleaned the working field. He removed his gloves and gown; he washed his hands and left the room. In an interview and observation with LVN E and RN F on 06/10/26 at 9:04 AM LVN E stated he did not know that he contaminated his sterile gloves. RN F, who was also the ADON, showed LVN E how to wear the sterile gloves and showed him how he contaminated his gloves. LVN E stated he knew the procedure was supposed to be a sterile procedure to reduce the risk of cross contamination. RN F stated the respiratory therapist and DON were responsible for nurses' training and skills checks. Review of LVN E's competency checks for tracheostomy care reflected he was skills checked on 01/03/26 and deemed competent in trach care. In an interview on 06/11/26 at 8:34 AM, the DON stated that trach care was to be an aseptic/sterile technique. She stated failure of staff to follow proper procedures could result in infections. She stated the facility would retrain all nursing staff on trach care and would check their skills. Record review of the facility's policy, Tracheostomy Care reviewed December 2025, reflected, The purpose of this procedure is to guide tracheostomy care .Aseptic technique must be used .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 resident (Resident #10) of 3 observed for infection control. The facility failed to ensure CNA B changed gloves and completed hand hygiene during incontinent care for Resident #10 on 6/9/26. These failures could place residents at risk for infection and cross contamination of pathogens and illness.Findings include: Record review of Resident #10's Quarterly MDS assessment dated [DATE] reflected Resident #10 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia (a decline in cognitive abilities, severe enough to interfere with daily life), cognitive communication deficit, and muscle weakness. Resident #10's BIMS score of 03, which indicated Resident #10's cognition was severely impaired. The MDS assessment indicated Resident #10 required assistance with toileting hygiene. Observation on 06/09/26 at 12:50 PM revealed CNA B entered Resident #10's room to provide incontinent care. CNA B washed her hands and put on gloves. She unfastened Resident #10's brief; she provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. Without changing gloves, she rolled the resident on her side, and she discarded the soiled brief. Without changing gloves, she put a clean brief under the resident's buttocks. She wiped the resident's buttocks area with peri-wipes, front to back. Without changing gloves, she applied skin barrier cream to the resident's peri-area (the area between the vaginal opening and anus)--. She rolled the resident on her back onto the contaminated brief. Once finished, she fastened the resident's brief. She covered the resident and she removed and discarded her gloves and washed her hands. In an interview on 06/09/26 at 1:08 PM, CNA B stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA B stated failing to provide proper care would expose the residents to infections. In an interview on 06/11/26 at 8:34 AM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated nursing staff were trained to perform hand hygiene between change of gloves. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated she would educate all nursing staff, and she would do random rounds for monitoring. Record review of the facility's policy, Hand Washing / Hand Hygiene, revised December 2025, reflected, . This facility considers hand hygiene the primary means to prevent the spread of infections . Use an alcohol-based hand rub, or alternatively, soap and water for the following situations: . Before moving from a contaminated body site to a clean body site during resident care .

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility failed to ensure that the residents' right to review survey results had a posted notice of the availability of the survey results in a prominent, readily accessible to residents, family members and legal representatives of residents for 1 of 1 facility reviewed for postings. The facility failed to ensure a notice of survey results availability was prominent and accessible to residents. This failure could affect residents who reside in the facility and could result in a lack of awareness for visitors, family, and residents regarding the survey results and the plan of correction submitted by the facility.Findings included: In a confidential group interview on 06/10/26 at 10:30 AM with 7 residents revealed they were not aware of the residents' right to access survey results of the facility. They stated they would like to be able to review the survey results but did not know where they were located for them to access the survey results. Interview on 06/11/26 at 9:38 AM with the Activity Director revealed she had been working at the facility for over a year. She had not informed the resident council of the right to review survey results and where they the results were located. She stated the survey results binder was on a table right near the front door entrance. She stated it was important for residents to be informed of where the survey results were located so they could look at them for themselves and be aware of the facility's survey history. Observation on 06/11/26 at 9:51 AM revealed the survey results binder was behind pamphlets at the front entrance on the table to the right. There was no visible signage to indicate where the survey results were located. Interview on 06/11/26 at 9:58 AM with the Administrator revealed it was important for residents and families to know where the survey results of the facility were located so they could be informed of the facility's survey history. He stated residents and families were informed at admission and that he had spoke to resident council in the past about the right to review survey results and where they were located. Review of facility's undated policy Resident Rights Guidelines for all Nursing Procedures reflected to provide general guidelines for resident rights while caring for the resident. It did not specify the residents' right to review survey results of a facility without having to ask.