STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676367	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belterra Health & Rehab	2170 North Lake Forest Drive McKinney, TX 75071

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care to four of eight residents (Residents #56, #83, #109, and #120) reviewed for baseline care plan. 1. The facility failed to ensure Residents #56 had a baseline care plan after admission to the facility on [DATE]. 2. The facility failed to ensure Residents #83 had a baseline care plan after admission to the facility on [DATE]. 3. The facility failed to ensure Residents #109 had a baseline care plan after admission to the facility on [DATE]. 4. The facility failed to ensure Residents #120 had a baseline care plan after admission to the facility on [DATE]. These failures could place the residents at risk of not receiving necessary care, treatment, and services upon admission that could result in worsening conditions.Findings included: 1. Record review of Resident #56's Face Sheet, dated 04/23/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Upon admission, the resident was diagnosed with respiratory failure with hypoxia (insufficient amount of oxygen in the body), congestive heart failure (condition in which the heart cannot pump blood well enough to meet the body's needs), epilepsy (a medical condition characterized by recurring seizures), edema (swelling), shortness of breath, hypertension (high blood pressure), atrial fibrillation (an irregular, rapid heartbeat), benign prostatic hyperplasia (a condition in men in which the prostate gland is enlarged and not cancerous), dementia (a condition characterized by loss of memory and ability to reason), anxiety (intense or excessive fear or worry), and depression (persistent feeling of sadness or loss of interest). Record review of Resident #56's Comprehensive MDS Assessment, dated 04/07/2026, reflected that the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy and had respiratory failure with hypoxia, congestive heart failure, epilepsy, edema, shortness of breath, hypertension, atrial fibrillation, benign prostatic hyperplasia, dementia, anxiety, and depression. Record review on 04/23/2026 of Resident #56's Baseline Care Plan reflected that the resident did not have a care plan after forty-eight hours to address his use of oxygen. The resident's baseline care plan did not include the minimum healthcare information necessary to properly care for the resident immediately upon admission. The plan did not address any resident-specific health issues such as respiratory failure with hypoxia, congestive heart failure, epilepsy, edema, shortness of breath, hypertension, atrial fibrillation, benign prostatic hyperplasia, dementia, anxiety, and depression. The plan did not reflect any goals and interventions to address his current needs. Record review of Resident #56's Progress Notes, dated 04/05/2026, reflected O2 96 % - 4/5/2026 21:29 Method: Oxygen via Nasal Cannula. Record review of Resident #56's Physician Order, dated, 04/05/2026, reflected Administer continuous oxygen at [2 LPM] Liters per [PER NASAL CANNULA OR MASK TYPE]; MAY REMOVE FOR ADLS; KEEP HOB ELEVATED FOR SO WHILE LAYING FLAT every shift for oxygen related to SHORTNESS OF BREATH. During an observation and interview on 04/21/2026 at 9:21 a.m. revealed Resident #56 was sitting in his (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair, awake. It was observed that he was using oxygen via nasal cannula. The resident said he was using oxygen since he was admitted to the facility. 2. Record review of Resident #83's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. Upon admission, the resident was diagnosed with dysphagia (difficulty in swallowing) and gastro-esophageal reflux (stomach acid repeatedly flows back into the tube connecting your mouth and stomach), diabetes mellitus (high blood sugar), gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support), hypertension (high blood pressure), myocardial infarction (heart attack), constipation. Record review of Resident #83's Comprehensive MDS Assessment, dated 04/07/2026, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS 09. The Comprehensive MDS Assessment indicated the resident had a feeding tube, dysphagia, gastro-esophageal reflux, diabetes mellitus, hypertension, myocardial infarction, and constipation. Record review on 04/22/2026 of Resident #83's Baseline Care Plan, dated 04/06/2026, reflected that the resident was only care planned for his dependency on the staff. The resident did not have a care plan for his feeding tube, diabetes mellitus, hypertension, myocardial infarction, and constipation. The resident's baseline care plan did not include the minimum healthcare information necessary to properly care for the resident immediately upon admission. The plan did not reflect any goals and interventions to address his current needs. Record review of Resident #83's Physician Order, dated 04/03/2026, reflected Enteral Feed Order every shift Enteral: Check tube placement via residual and tube visualization before initiation of formula, medication administration, and flushing tube. Record review of Resident #83's Progress Note, dated 04/03/2026, reflected Resident arrived at the facility . G-tube patent and intact. During an observation and interview on 04/21/2026 at 12:25 p.m., revealed that Resident #83 was in his wheelchair, awake. It was observed that the resident had a g-tube to the right upper quadrant of his abdomen. He said he had the g-tube for years. 3. Record review of Resident #109's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Upon admission, the resident was diagnosed with presence of cellulitis (bacterial infection of the skin and the tissues beneath it), injury to left kidney, pain, hypertension, heart block (issue with the heartbeats). Record review of Resident #109's Comprehensive MDS Assessment, dated 04/21/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was on oxygen therapy and had cellulitis, injury to left kidney, pain, hypertension, and heart block. Record review of Resident #109's Baseline Care Plan, dated 04/18/2026, reflected that the resident was only care planned for being full code and having an ADL self-care deficit. The plan did not address the resident's use of oxygen. The resident's baseline care plan did not include the minimum healthcare information necessary to properly care for the resident immediately upon admission. The plan did not address any resident-specific health issues such as cellulitis, injury to left kidney, pain, hypertension, and heart block. The plan did not reflect any goals and interventions to address his current needs. Record review of Resident #109's Physician Order, dated 04/18/2026, reflected Oxygen: Administer continuous oxygen at [2 LPM] Liters per [PER NASAL CANNULA OR MASK TYPE]; MAY REMOVE FOR ADLS; KEEP HOB ELEVATED FOR SOB WHILE LAYING FLAT every shift. Record review of Resident #109's Progress Note, dated 04/18/2026, reflected Patient admitted . on oxygen therapy 2 liter via NC.4. Record review of Resident #120's Face Sheet, dated 04/23/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. Upon admission, the resident was diagnosed with diabetes mellitus, neoplasm of the digestive system, hypertension, depression, atrial fibrillation, neuromuscular dysfunction of the bladder, and retention of urine. Record review of Resident #120's Comprehensive MDS Assessment, dated 04/10/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident had an ostomy, indwelling catheter, hypertension, diabetes mellitus, neoplasm (abnormal growth of tissue in the body) of the digestive system, depression (persistent feeling of sadness or loss of interest) , atrial fibrillation, (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	neuromuscular dysfunction of the bladder (the muscles and nerves that control the bladder do not work properly due to illness), and retention of urine (a condition in which the urinary bladder does not empty completely). Record review of Resident #120's Baseline Care Plan, dated 04/09/2026, reflected the resident was not care planned for her colostomy bag (plastic pouch that collects fecal matter from the digestive tract), catheter (flexible tube inserted into the bladder to remove the urine), hypertension, diabetes mellitus, neoplasm of the digestive system. The resident's baseline care plan did not include the minimum healthcare information necessary to properly care for the resident immediately upon admission. The plan did not address any resident-specific health issues such as colostomy (surgery that creates an opening to the large intestine), indwelling catheter, hypertension, diabetes mellitus, neoplasm of the digestive system, depression, atrial fibrillation, neuromuscular dysfunction of the bladder, and retention of urine. The plan did not reflect any goals and interventions to address his current needs.Record review of Resident #120's Physician Order, dated 04/08/2026, reflected Provide colostomy care with approved cleaning agent. Record review of Resident #120's Progress Note, dated 04/08/2026, reflected patient admitted . patient with a LLQ colostomy. During an observation and interview on 04/23/2026 at 6:08 a.m., the MDS Coordinator said all the residents admitted should have a baseline care plan within 48 hours to be able to meet the immediate needs of the residents. She said Resident #109 had a baseline care plan. She opened Resident #109's profile and navigated through the resident Assessment Notes, Baseline Care Plan v 2 and said that it was the resident's Baseline Care Plan. It was observed that the Baseline Care Plan v 2 did not have any goals and interventions of the resident's oxygen use and her other co-morbidities. She said she was off the week prior and did not know who should be doing the baseline care plan. She said the plan could be done by the admitting nurse, ADON, and the DON. During an interview on 04/23/2026 at 6:26 a.m., the DON said baseline care plans were important because it would give the providers the minimum healthcare information about the residents that needed to be addressed immediately or upon admission. She said the MDS Coordinator was the one doing the baseline care plan. She said the admitting nurses do not do baseline care plans because they were avoiding too many hands handling care plans. She said with new residents, they had 48 to 72 hours to complete the baseline care plan. She said for some of the residents that were newly admitted , the base line care plans were not done because they were busy with an incident that happened to the facility. She said, maybe, she should consider allowing the admitting nurses to do the baseline care plan during admission. She said the expectation was for the residents to have a baseline care plan and said she would coordinate with the MDS Coordinator about the issue. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said the expectation was for all the residents admitted had baseline care plans. She said she would coordinate with the DON and MDS Coordinator about baseline care plans. In an observation and interview on 04/23/2026 at 10:01 a.m., the DON said the Corporate Nurse said to check in the Assessment Notes for the residents' base line care plan and not the usual place where care plans were checked. She navigated on Resident #109's profile to show an example. She ended up looking at the resident's Baseline Care Plan - V 2.Record review of Residents #56, #83, #109, and #120 Baseline Care Plan - V 2 reflected that their Baseline Care Plan v 2 did not have any goals and interventions regarding the residents' immediate medical needs. It only indicated check marks of the initial assessment for the residents.Record review of the facility's policy Care Plans - Baseline 2001 MED-PASS, Inc. revised November 14, 2023 reflected Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . Policy Interpretation and Implementation . 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed withing forty-eight (48) hours of the resident's admission . 2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs . 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received adequate supervision to prevent accidents and/or hazards for 3 (Residents #68, #107, and #110) of 8 residents reviewed for supervision and accidents/hazards.1. The facility failed to ensure there were no germicidal wipes on Resident #107's side table on 04/21/2026.2. The facility failed to ensure there were no germicidal wipes on the floor, in front of Resident #110's room on 04/21/2026.3. The facility failed to ensure Resident #68 received adequate supervision allowing Resident #68 to exit the facility without the knowledge of staff on 04/13/2026 for approximately 20 minutes. Resident #68 was located at Walgreens, which is parallel to the facility approximately 528 yards from the facility. These failures could place residents at risk for injuries, decline in health, and having an environment that was free from exposure to toxic chemicals.Record review of Resident #68's face sheet dated 04/13/2026 revealed a [AGE] year-old male with an admission date of 05/06/2025 and a discharge date of 04/20/2026. Diagnosis included Unspecified Dementia (cognitive decline (memory, thinking, or behavioral issues), Major depressive disorder (persistent low mood, loss of interest in activities, and low energy lasting at least two weeks), and Type II Diabetes (a chronic condition where the body resists the effects of insulin or fails to produce enough to maintain normal glucose levels, causing high blood sugar). Record review of Resident #68's Quarterly MDS dated [DATE] revealed a BIMS score of 4, indicating severe cognitive impairment. Review of the BIMS conducted on 04/13/2026 revealed a score of 7, indicating severe cognitive impairment. Resident #68 MDS reflected the following: he could walk 150 feet with supervision or touching assistance, he did not use a wheelchair, and he did not have a history of wandering. Record review of elopement assessments completed on the following dates: 05/06/2025, 08/06/2025, 10/30/2025 and 01/30/2026, revealed Resident #68 was not an elopement risk. Record review of Resident #68's care plans dated 04/13/2026 revealed there were no care areas regarding supervision, wandering, or elopement as Resident #68 did not have a history of trying to leave the facility. Record review of the weekly body audit conducted on 04/13/2026 at 12:45 p.m. after Resident #68 returned to the facility reflected, Intact, no skin issues. Record review of incident report dated 04/13/2026 at 12 p.m. revealed the following: It was reported that resident was sitting on a rock at [Store] on [Address] and fell backwards. Resident did not hit his head and was assisted by [Store] staff and facility was notified. Resident didn't report a fall when he returned to facility. The incident report revealed the following: Immediate Action Taken: This nurse assessed resident, no obvious injuries noted at this time. Residents deny any pain or discomfort. V/S 118/72, p80, R, 16, Temp 97.8, O2 sat 95% on room air. [Doctor], DON, Administrator, and [Family Member] aware of fall. Resident put on q15 checks, Resident will be sent out to hospital for further management. Injury Type: No injuries observed at time of incident. Mental Status: Oriented to person, place, and situation. Injuries Report Post Incident: No injuries observed post incident. Predisposing Physiological Factors: Gait imbalance and Impaired memory. Predisposing Situation Factors: Ambulating without assist. Continued review of the incident report revealed the following: Statements from relative: Family member, [Family Member] state that they were told by employee at (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Store]'s that resident had entered the store, walked around it, and left the store. But while on his lunch break, the employee went outside to sit in his car and noted the resident sitting on a decorative rock. He asked the resident if he needed any help and the resident stated, I am waiting for a ride. But as employee sat in his car, he observed the resident trying to adjust his shoe and lose balance and fell off the rock backwards. The employee helped him get up, dust off, and go inside the store. The resident was able to tell him his name, that he lives at Belterra and his room [ROOM NUMBER]. The employee then called the facility to notify staff. In an interview on 04/23/2026 at 2:35 p.m., the DON stated that [Store} was about 500 yards from the facility. It was 70 degrees outside. The store was located on the corner of [Address], which is in front of the hospital. She stated the cameras were reviewed and it appeared that Resident #68 followed a group of women out of the front door who had been there providing an activity for the residents. No one was aware he was gone until the employee from [Store] called to alert the staff. Staff took the facility van and brought Resident #68 back. Resident # 68 was assessed when he returned to the facility at approximately 12 p.m. and the family requested he go to the hospital and accompanied him. A full work up was done and there were no negative findings. When he returned to the facility, the social worker assisted the family in finding a memory care unit. Resident # 68 was placed on 1:1 with a sitter until he was discharged from the facility on 04/20/2026. Record review of the 1:1 log for Resident #68 revealed he had a staff member with him until he was discharged on 04/20/26. Record review of the facility's policy titled Wandering and Elopements dated 11/15/26, reflected the following The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measure to help guard against a resident wandering from the facility. The facility strives to prevent harm while maintaining the least restrictive environment for residents. 1. Record review of Resident #107's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with discitis (inflammation of the space between spinal bones). Record review of Resident #107's Quarterly MDS Assessment, dated 04/08/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated that the resident was on antibiotics. Record review of Resident #107's Comprehensive Care Plan, dated 04/14/2026, reflected that the resident was on IV therapy related to discitis and one of the interventions was to administer antibiotic medications as ordered. Record review of Resident #107's Physician Order, dated 04/07/2026, reflected Meropenem Intravenous Solution Reconstituted 500 MG (Meropenem) Use 500 mg intravenously every 8 hours related to DISCITIS, UNSPECIFIED, MULTIPLE SITES IN SPINE . until 05/01/2026 23:59. During an observation on 04/21/2026 at 7:56 a.m. revealed that RN E was about to disconnect Resident #107's IV. It was observed that an opened container of germicidal wipes (substance that destroys germs and microorganisms) was on top of the resident's side table beside some snacks and a box of wipes. During an interview on 04/21/2026 at 8:06 a.m., Resident #107 said he did no know who left the container of germicidal wipes on his side table. He said it had been there for quite some time. During an interview on 04/21/2026 at 10:02 a.m., RN E said she already took the container of germicidal wipes from Resident #107's room. She said she did not know who left it inside the resident's room. She said the germicidal wipes had chemicals in them that could cause skin irritation; that was why the staff used gloves when handling them. She said residents might use the wipes to clean their eyes and faces that could result in irritation. 2. Record review of Resident #110's Face Sheet, dated 04/22/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with acute cystitis (inflammation of the urinary bladder) with hematuria (blood in the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urine). Record review of Resident #110's Comprehensive MDS Assessment, dated 04/10/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had acute cystitis with hematuria. Record review of Resident #110's Comprehensive Care Plan, dated 04/22/2026, reflected that the resident is on IV medications (ABT) r/t acute cystitis and one of the interventions was to monitor midline placement. Record review of Resident #110's Physician Order, dated 04/21/2026, reflected Meropenem Intravenous Solution Reconstituted 500 MG (Meropenem) Use 500 mg intravenously at bedtime for ESBL (Extended-Spectrum Beta-Lactamasesin: bacteria that could cause infection) Urine for 5 Days. During an observation 04/21/2026 at 5:40 a.m. revealed a container of germicidal wipes was on the floor in-front of Resident #110's room. During an observation and interview on 04/21/2026 at 5:46 a.m., RN C said he did not know who left the germicidal wipes in front of Resident #110's room. He said residents passing by could get some and use it to clean the eyes, causing irritation. During an interview on 04/21/2026 at 6:01 a.m., CNA G said she was not the one who left the container of germicidal wipes on the floor. She said the wipes might cause harm especially when used to wipe the genitals. During an interview on 04/23/2026 at 6:26 a.m., the DON said the container of germicidal wipes should not be within reach of the residents because the wipes were harmful if consumed. She said the germicidal wipes should be stored inside the last drawer of the cart for safe keeping. She said the germicidal wipes on the floor might have been left by a CNA that would use it to clean Resident #110's equipment. She said germicidal wipes should not be left inside the rooms of the residents near their food and ordinary wipes. She said the resident might accidentally pull the germicidal wipes instead of the ordinary wipes and use them. She said the expectation was for the staff to not leave the germicidal wipes unattended and within reach of the residents. She said she would start an in-service regarding the disinfectants. During an interview on 04/23/2026 at 709 a.m., the ADON said the container of germicidal wipes should not be within reach of the residents, not on the floor or inside the rooms of the residents, for safety reasons. She said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin, and could result in irritations. She said some residents might consume it. She said anything that had Keep out of reach of children as an instruction should be considered harmful because the facility had confused residents that may not know germicidal wipes from ordinary wipes. She said the DON had already started an in-service about germicidal wipes being left unattended. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said the germicidal wipes should have been secured because the facility had confused residents that could use the wipes inappropriately. She said the DON had already started an in-service about the germicidal wipes. Record review of the facility's policy Storage of Medications 2001 MED-PASS, Inc. revised April 2019 reflected Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 7. Antiseptics, disinfectants, and germicides used in any aspect of resident care have legible, distinctive labels that identify the contents and the directions for use and are stored separately from regular medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for five of twenty residents (Residents #63, #71, #79, #102, and #107) and one of four direct care staff (MA K) reviewed for medication storage. 1. The facility failed to ensure that Resident #71 did not have a pain reliever cream inside his room on 04/21/2026. 2. The facility failed to ensure that Resident #102 did not have a tube of zinc oxide and a bottle of multivitamins inside her room on 04/21/2026. 3. The facility failed to ensure that Resident #63 did not have a tube of zinc oxide inside her room on 04/21/2026. 4. The facility failed to ensure that Resident #79 did not have a tube of zinc oxide inside her room on 04/21/2026. 5. The facility failed to ensure that Resident #107 did not have a roll-on pain relief and a tube of zinc oxide on 04/21/2026. 6. The facility failed to ensure that a container of biofreeze was not left unattended on MA K's medication cart on 04/21/2026. These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions.Findings included: 1. Record review of Resident #71's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with spondylosis (arthritis of the spine) and radiculopathy (condition caused compression of the nerves in the spine). Record review of Resident #71's Comprehensive MDS Assessment, dated 02/05/2026, reflected that the resident had an intact cognition with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had spondylosis and radiculopathy. Record review of Resident #71's Comprehensive Care Plan, dated 02/08/2026, reflected that the resident had an ADL self-care performance deficit related to pain and surgery, and one of the interventions was to assist with personal hygiene. During an observation and interview on 04/21/2026 at 6:01 a.m. revealed Resident #71 was in his bed, awake. It was observed that a tube of pain reliever cream was on top of his side table, beside some foods and drinks, and was in plain view. The resident said the pain reliever cream had always been on his side table, and nobody asked him about it. He said it was not his first tube of pain reliever cream. 2. Record review of Resident #102's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression (persistent feeling of sadness or loss of interest), and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #102's Comprehensive MDS Assessment, dated 03/05/2026, reflected that the resident had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident had depression, and dementia and was incontinent for bladder. Record review of Resident #102's Comprehensive Care Plan, dated 03/07/2026, reflected that the resident had an ADL self-care performance deficit and was using an antidepressant and the interventions were to assist with toilet use and to give anti-depressant as ordered. Record review on 04/22/2026 of Resident #102's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 04/21/2026 at 5:52 a.m. revealed Resident #102 was in her bed, awake. It was observed that a tube of zinc oxide, two sachets of zinc oxide (medicated cream used to prevent skin irritation), and a bottle of multivitamins were on top of the resident's side table. The resident said the staff used the zinc oxide when they cleaned her and changed her brief. She said the vitamins were hers, and the staff knew she had a bottle of multivitamins inside her room. During an interview on 04/21/2026 at 6:09 a.m., RN C said he did not notice that Resident #71 and Resident #102 had medications inside their rooms. He said he would talk to the residents and explain to them that they should not have medications inside their rooms. He said (continued on next page)

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	676367	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belterra Health & Rehab	2170 North Lake Forest Drive McKinney, TX 75071

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the multivitamins, the staff did not know how often and how much the resident was taking her multivitamins and that could result in overdose. He said even the pain-relieving cream could result in skin irritation depending on how often it was used. 3. Record review of Resident #63's Face Sheet, dated 04/23/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia and age-related cognitive decline (gradual loss of cognitive abilities). Record review of Resident #63's Comprehensive MDS Assessment, dated 03/21/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident was at risk of developing pressure ulcers. Record review of Resident #63's Comprehensive Care Plan, dated 03/25/2026, reflected that the resident had impaired cognitive function or impaired thought process r/t dementia and one of the interventions was to reorient as needed. Record review on 04/23/2026 of Resident #63's Clinical Assessment Notes reflected that the resident did not have an assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 04/21/2026 at 9:06 a.m. revealed Resident #63 was in her bed, awake. It was observed that an open sachet of zinc oxide was on top of the resident's side table. She said the staff gave it to her so she could put it on her bottom when it was sore. 4. Record review of Resident #79's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Alzheimer's disease (a disorder that primarily affects memory), transient visual loss (temporary or sudden loss of vision), and incontinence for bowel and bladder. Record review of Resident #79's Comprehensive MDS Assessment, dated 01/29/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #79's Comprehensive Care Plan, dated 02/01/2026, reflected that the resident had bladder and bowel incontinence and one of the interventions was to apply barrier cream after each incontinent care. Record review on 04/22/2026 of Resident #79's Clinical Assessment Notes reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 04/21/2026 at 9:43 a.m. revealed that Resident #79 was in her wheelchair, awake. It was observed that a tube of zinc oxide was on top of the resident's side table and was in plain view. She said the staff would use it when they changed her. She said the staff always leave the tube for zinc oxide on top of her side table and very seldom put it in her drawer. 5. Record review of Resident #107's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with complex regional pain syndrome (chronic pain condition that typically affects an arm or a leg) and benign hypostatic hyperplasia (enlarged prostate). Record review of Resident #107's Comprehensive MDS Assessment, dated 04/08/2026, reflected that the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident had complex regional pain syndrome and benign hypostatic hyperplasia. Record review of Resident #107's Comprehensive Care Plan, dated 04/14/2026, reflected that the resident had discitis and one of the goals was for the resident to be free from discomfort. Record review on 04/22/2026 of Resident #107's Physician Order reflected that the resident did not have orders for roll-on pain relief. During an observation and interview on 04/21/2026 at 8:06 a.m., revealed Resident #107 was in hid bed, awake. it was observed that a tube of zinc oxide and a roll-on pain reliever was on top of the resident's overbed table. The resident said they used the zinc oxide when they were changing him. He said the roll-on pain relief was his medication, and if it was not on his overbed table, it would be on his side table. During an interview on 04/21/2026 at 10:02 a.m., RN E said he had already talked to Resident #107 about the medication inside his room. She said there should be no medications inside the rooms of the residents because the staff could not monitor how often the resident was using the medication. She said the tube of zinc oxide should not be left within reach of any resident because it could be harmful when consumed. She said she asked around, but nobody knew who left the tube and sachets of zinc oxide (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside the resident's room. 6. During an observation on 04/21/2026 at 6:32 a.m. revealed a container of biofreeze was inside the bin at the side of MA K's medication cart. It was observed that MA K left her cart in the hallway unattended when she went to the dining area to talk to a resident.During an observation and interview on 04/21/2026 at 6:36 a.m., MA K said she did not know who placed the container of biofreeze at the side of her cart. She said biofreeze was a medication and should not be left unattended because residents might take them and hide it inside the room and use it inappropriately when nobody was looking. She said the residents might consume them or use them in their eyes. She took the container of biofreeze and gave it to LVN F. During an observation and interview on 04/21/2026 at 6:40 a.m., LVN F took the biofreeze that MA K gave him and put it inside his cart. He said he did not know who placed it at the side of MA K's cart. He said medications should be locked inside the cart and not left unattended because it could be harmful to the residents if they get hold of it and consume it. During an interview on 04/23/2026 at 6:26 a.m., the DON said medications, whether oral or topical, should not be inside the residents' rooms because the residents might use them inappropriately and that could result in adverse reactions, such as overdosing. She said skin barriers were applied topically and could be harmful when ingested. She said the expectation was for the staff to be vigilant when they entered the residents' room to check for any medications and for staff using the skin barriers to not leave the tubes within reach of the residents. She said pertaining to the biofreeze outside the cart, MA K became responsible when she started using the cart, so she should have checked the outside of the cart as well. She said she would talk to the residents and see if they really needed the medications so she could request orders for the medications mentioned. She said she had already started an in-service about medication storage. During an interview on 04/23/2026 at 709 a.m., the ADON said barrier creams with zinc oxide should not be within reach of the residents. She said confused residents might mistakenly consume them or use them inappropriately. She said the barrier creams should be somewhere not accessible to the residents. She said medications, such as multivitamins and topical analgesic, should not be inside the residents' rooms for the same reason. She said if the residents needed the multivitamins and the pain reliever, then the staff should be the one giving it to them or applying it to them. She said the DON had already started an in-service about medication storage. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said the expectation was for the staff to make sure there were no medications and barrier creams inside the residents' rooms because the residents might consume them or use them on their eyes causing irritation. She said she was not a clinician and would let the DON take the lead on the issue of medications inside the rooms of the residents. Record review of the facility's policy Administering Medications 2001 MED-PASS, Inc. revised April 2019 reflected Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so . 3. Medications are administered in accordance with prescriber orders. Record review of the facility's policy Storage of Medications 2001 MED-PASS, Inc. revised April 2019 reflected Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 1. Drugs and biologicals used in the facility are stored in locked compartments . 3. The nursing staff is responsible for maintaining medication storage. Record review of the facility's policy Medication Orders reflected Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders . Supervision by a Physician . 2. A current list of orders must be maintained in the clinical record of each resident.

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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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three of twenty residents (Resident #4, #32 and #71) reviewed for infection control. 1. The facility failed to ensure CNA J did not put Resident #4's catheter bag on top of the resident's bed and changed her gloves after touching the catheter bag on 04/22/2026. 2. The facility failed to ensure CNA H performed hand hygiene and changed her gloves during Resident #32's incontinent care on 04/22/2026. 3. The facility failed to ensure CNA G wore a gown when she emptied Resident #71's catheter bag and when she checked if the resident was wet on 04/21/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #4's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with reflux neuropathic bladder. Record review of Resident #4's Comprehensive MDS Assessment, dated 03/14/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter. Record review of Resident #4's Care Plan, dated 04/15/2026, reflected that the resident had a Foley catheter r/t reflux neuropathic bladder and one of the interventions was to position the catheter and tubing below the level of the bladder. Record review of Resident #4's Physician Record, dated 03/12/2026, reflected Catheter: Urinary Catheter change Foley catheter bag and accessories size: _16 fr___, bulb: 10cc_every day shift every 30 day(s). During an observation on 04/22/2026 at 2:15 p.m. revealed CNA I and CNA J were about to do Resident #4's incontinent care. They both washed their hands before putting on gowns and pairs of gloves. During the process of incontinent care, CNA J told CNA I to hand her the resident's catheter bag. CNA I handed over the resident's catheter bag to CNA J and CNA J placed the catheter bag on top of the bed, near the resident's feet. The right foot was noted to have a wound with dressing. The catheter bag was on top of the bed all throughout incontinent care and was entangled on the resident's blanket. When CNA I was cleaning the resident, CNA J assisted with fixing the brief without changing her gloves. After incontinent care, CNA I used the same blanket that had contact with the catheter bag to cover the resident. During an interview on 04/22/2026 at 2:36 p.m., CNA I said it did not occur to him that the catheter bag was dirty and should not be on top of the bed touching the linens that Resident #4 was using. He said placing the catheter bag on top of the bed could result in cross contamination. During an interview on 04/22/2026 at 2:40 p.m., CNA J said it did not occur to her that the catheter bag should not be placed on top of the bed because it was dirty. She said placing the catheter bag on top of the bed could cause infection. She said since the catheter bag was dirty, then she should have changed her gloves after touching it, 2. Record review of Resident #32's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection and prostatic hyperplasia. Record review of Resident #32's Comprehensive MDS Assessment, dated 03/20/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had bowel and bladder incontinence. Record review of Resident #32's Comprehensive Care Plan, dated 04/03/2026, reflected the resident had bladder incontinence and one of the interventions was to clean the perineal area after each episode. During an observation on 04/22/2026 at 9:40 a.m. revealed CNA H was about to do Resident #32's incontinent care. She washed her hands and put on a pair of gloves. She then went on the other side of the bed to get the trash can. After touching the trash can, she took the brief from the resident's overbed table, opened it, and placed it at the side of the resident. She cleaned the resident's perineal area using the front to back technique. After cleaning the perineal area, she rolled the resident and cleaned the resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottom. After cleaning the resident's bottom, she pulled the brief from the side of the resident and placed it under the resident. She did not change her gloves after cleaning the bottom and before touching the new brief. During an interview on 04/22/2026 at 9:51 a.m., CNA H said she should have changed her gloves when she touched the trash can and after she cleaned the resident's bottom because technically her gloves were dirty. She said not changing the gloves after touching something dirty could result in infection. 3. Record review of Resident #71's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with obstructive (a blockage in the urinary tract) and reflux uropathy (urine flows back from the bladder to the kidneys). Record review of Resident #71's Comprehensive MDS Assessment, dated 02/05/2026, reflected that the resident had an intact cognition with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter. Record review of Resident #71's Comprehensive Care Plan, dated 02/08/2026, reflected that the resident had a urinary catheter in place related to obstructive uropathy and one of the interventions was to do Foley care q shift. During an observation on 04/21/2026 at 6:01 a.m. revealed CNA G was about to do Resident #71's incontinent care. It was observed that the resident had a catheter. She went inside the resident's room and emptied the resident's catheter bag. She did not wear a gown while emptying the catheter bag. After emptying the catheter bag, she checked the resident's brief to see if it was wet. In the process of checking the resident, it was observed that she was leaning on the catheter's tubing and catheter bag. It was observed that there was sign outside the resident's room that the resident was on EBP During an interview on 04/21/2026 at 6:17 a.m., CNA G said Resident #71 had a catheter and she should have worn a gown. She looked at the sign outside, and saw that a gown was required during catheter care. She said the risk could be transferring microorganisms from one resident to another. During an interview on 04/23/2026 at 6:26 a.m., the DON said if a resident was on EBP, then the staff doing care should wear a gown every time they had contact with the resident to prevent cross contamination and spread of infection. She said for a resident with a catheter, a gown was needed to empty the catheter bag and to do incontinent care. She said gloves should have been changed after cleaning the resident's bottom and after touching the trash can and the catheter bag to make sure they were using clean gloves when touching the new brief. She said the catheter bag should not have been placed on top of the bed because it was dirty. She said, since the catheter bag already touched the linens, then it should not be used to cover the resident again. She said the concerns discussed were all infection control issues. She said the expectation was for the staff to wear a gown when needed, change their gloves after touching anything dirty, and not to place anything dirty on top of the bed. She said she already started an in-service about hand hygiene and EBP and would add not placing the catheter bag on top of the bed. During an interview on 04/23/2026 at 709 a.m., the ADON said the staff should have sanitized their hands and changed their gloves after touching the trash can, the catheter bag, and after cleaning the resident's bottom because the gloves were technically dirty. She said the facility's protocol was to go from clean to dirty and not the other way around. She said she was not sure if the catheter bag was dirty because it was a closed circuit, but the best practice was not to put it on top of the bed. She said, as per the mandate of CDC, gowns should be worn when a resident was on EBP to prevent development of infection. She said the DON had already started an in-service about infection control. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said the expectation was for the staff to be mindful not to spread any infection and that the staff would adhere to the policy of hand hygiene, EBP, and infection control. She said she was not a clinician and would let the DON take the lead on the issue of infection control. Record review of the facility's policy Infection Control Guidelines for All Nursing Procedures . Purpose: To provide guidelines for general infection control while caring for residents . General Guidelines . 3. Employees must wash their hands . c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin . In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub . e. Before handling clean or soiled dressings, gauze pads, etc. f. Before (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moving from a contaminated body site to a clean body site during resident care . h. After handling used dressings, contaminated equipment, etc. 5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials. Record review of the facility's policy Implementation of Standard and Transmission-Based Precautions revised March 2024 reflected Policy Statement: Infection control measures are implemented in attempts to prevent the spread of communicable diseases . 3. Enhanced Barrier Precautions (EBP) - Expand the use of PPE and refer to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . Examples of Enhanced-Based Precaution residents . Indwelling medical devices . urinary catheter . II. Enhanced-Based Precautions are indicated during . Providing hygiene . Changing briefs . Device care or use . urinary catheter.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to personal privacy during personal care and confidentiality of personal and medical records for one of twenty residents (Resident #4) reviewed for privacy and confidentiality. The facility failed to ensure CNA I and CNA J closed the blinds of Resident #4's window, which was overlooking the parking lot, during incontinent care on 04/22/2026. This failure could place the residents at risk of not having their personal privacy maintained while care was provided, which could result in the residents feeling uncomfortable during care.Findings included: Record review of Resident #4's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with lumbar spina bifida (the spinal cord fails to form during pregnancy) and weakness. Record review of Resident #4's Comprehensive MDS Assessment, dated 03/14/2026, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident had bowel incontinence (unable to control). Record review of Resident #4's Care Plan, dated 04/15/2026, reflected that the resident had an ADL self-care performance deficit related to spina bifida and one of the interventions was to assist during toilet use. During an observation on 04/22/2026 at 2:15 p.m. revealed CNA I and CNA J were about to do Resident #4's incontinent care. It was observed that the resident's bed was parallel to the window, was overlooking the parking lot, and did not have a curtain. CNA J closed the door, while CNA I prepared to do incontinent care, but did not close the window blinds. In the process of incontinent care, CNA I exposed the resident's genital area until the conclusion of the incontinent care. At this point, the blinds were still open. During an interview on 04/22/2026 at 2:36 p.m., Resident #4 said the staff never closed his blinds when they were changing him and he got used to it. During an interview on 04/22/2026 at 2:39 p.m., CNA I said he was focused on doing the right procedure for incontinent care that he forgot to close Resident #4's blinds. He said the blinds should be closed, as well, when doing incontinent care. During an interview on 04/22/2026 at 2:41 p.m., CNA J said the blinds should have been closed to provide privacy. She said if the doors were closed and the privacy curtains were pulled, then the blinds should also be closed. During an interview on 04/23/2026 at 6:26 a.m., the DON said the staff should have closed the blinds during incontinent care so that the resident would not be exposed from the parking lot. She said, the issue was not if the residents minded or not, but that the staff did not provide privacy. She said all the staff were expected to provide full privacy during care. The DON stated she would start an in-service about privacy and would personally monitor if the staff were in compliance with the policy. During an interview on 04/23/2026 at 709 a.m., the ADON said the best practice was to close the blinds while doing incontinent care to provide privacy. She said staff closed the doors and pulled privacy curtains to provide privacy from the inside of the facility so why not close the blinds as well to provide privacy from the outside of the facility. She said the DON had already started an in-service about privacy. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said the best practice was to provide privacy during incontinent care. She said the expectation was for the staff to provide privacy during care, not just during incontinent care. She said she would collaborate with the DON about the issue regarding privacy. Record review of the facility's policy, Resident Rights 2001 MED-PASS, Inc. revised October 4, 2022, reflected Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . Policy Interpretation and Implementation . 1. Federal and state laws guarantee certain basic rights to all residents of this facility . t. privacy. Record review of the facility's in-service Resident Rights to Privacy, dated 04/23/2026, reflected During resident car, privacy needed to be maintained at all times, doors and blinds need to be closed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for one of twelve residents (Resident #26) reviewed for care plans. The facility failed to ensure that Resident #26 had a care plan for her BiPAP on 04/21/2026.This failure could place the residents at risk of not receiving the necessary care and services.Findings included: Record review of Resident #26's Face Sheet, dated 04/21/2026, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a solitary pulmonary nodule (a single round spot in the lung). Record review of Resident #26's Comprehensive MDS Assessment, dated 03/31/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a solitary pulmonary nodule. The resident's next ARD (assessment reference date: specific date that marks the end of observation) was 07/01/2026. Record review of Resident #26's Comprehensive Care Plan, dated 04/17/2026, reflected the resident did not have a care plan for her BiPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs). Record review of Resident #26's Physician Order, dated 04/16/2026, reflected BIPAP IPAP (inspiratory positive airway pressure: pressure delivered during inhalation) 10, EPAP (expiratory positive Airway pressure: lower pressure applied during exhalation) -6 QHS & PRN/NAPS at bedtime related to SOLITARY PULMONARY NODULE. During an observation and interview on 04/21/2026 at 9:10 a.m., revealed Resident #26 in her bed, awake. It was observed that a nasal pillow BiPAP mask was on top of her side table. The resident said the Respiratory Therapist brought the BiPAP five days ago and had been using it since then. During an observation and interview on 04/23/2026 at 6:08 a.m., the MDS Coordinator said Resident #26's BiPAP should have been care planned when she started using it. She said it was not communicated to her that the resident started using the BiPAP, so the staff would know if it was effective and if the resident was doing it right. She said anybody could do the care plan for the BiPAP. She said whoever transcribed the order could have done the care plan. She said it was the ADON who transcribed the order for the BiPAP. During an interview on 04/23/2026 at 6:26 a.m., the DON said Resident #26's BiPAP should have been care planned and should have been communicated to the MDS Coordinator so the MDS Coordinator could have made a care plan for it. She said ADON A do not do care plans but should have communicated it to the MDS Coordinator.During an interview on 04/23/2026 at 7:09 a.m., the ADON said the MDS Coordinator was the one doing the care plans. She said whatever was new, like a change in condition about a particular resident was discussed during the morning meeting, and she did not know why the BiPAP was not captured. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said that all the residents should have a care plan in line with their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. She said the expectation was for all the residents to be care planned appropriately. She said she would coordinate with the DON and the MDS Coordinator to make sure all the residents were care planned. Record review of the facility's policy Care Plans, Comprehensive Person-Centered Care Plan reflected Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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	676367	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belterra Health & Rehab	2170 North Lake Forest Drive McKinney, TX 75071

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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 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 observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection for one of five residents (Resident #4) reviewed for incontinent care. The facility failed to ensure that CNA J did not place Resident #4's catheter on top of the Resident #4's bed rendering the catheter not below the bladder for the duration of incontinent care on 04/22/2026. This failure could place the residents at risk of backflow of urine resulting to urinary tract infection.Findings included: Record review of Resident #4's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with reflux neuropathic bladder (bladder does not function properly due to damaged nerves). Record review of Resident #4's Comprehensive MDS Assessment, dated 03/14/2026, reflected that the resident had a severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident had an indwelling catheter (a thin, flexible tube inserted in the bladder to allow the urine to flow in the catheter bag). Record review of Resident #4's Care Plan, dated 04/15/2026, reflected that the resident had a Foley catheter r/t reflux neuropathic bladder and one of the interventions was to position the catheter and tubing below the level of the bladder. Record review of Resident #4's Physician Order, dated 03/12/2026, Catheter: Urinary Catheter change Foley catheter bag and accessories size: _16 fr (French: unit of measurement for catheter sizes) ___, bulb: 10cc___every day shift every 30 day(s). During an observation on 04/22/2026 at 2:15 p.m. revealed CNA I and CNA J were about to do Resident #4's incontinent care. During the process of incontinent care, CNA J told CNA I to hand her the resident's catheter bag. CNA I handed over the resident's catheter to CNA J and CNA J placed the catheter bag on top of the bed, near the resident's feet. It was observed that the tube of the catheter had urine in it. The catheter bag was on top of the bed all throughout incontinent care. During an interview on 04/22/2026 at 2:36 p.m., CNA I said when he handed over Resident #4's catheter bag, it did not occur to him that she would put it on top of the bed. He said, what he knew was that the catheter bag should always be below the bladder to prevent urine in the catheter bag going back inside the resident. During an interview on 04/22/2026 at 2:40 p.m., CNA J said it did not occur to her that the catheter bag should not be placed on top of the bed and should be always below the bladder because it could result to urinary tract infection. She said she asked for the catheter bag and placed it on the top of the bed because she was afraid that they might pull the catheter tube when they turn the resident. She said she should have hung the catheter bag on the other side of the bed when they turned the resident. During an interview on 04/23/2026 at 6:26 a.m., the DON said the catheter bag should always be below the bladder to prevent backflow of urine from the catheter bag to the bladder. She said if there was a backflow, it could result to urinary tract infection. She said the staff could always hang the catheter bag to the other side of the bed if they need to turn the resident. She said the expectation was for the staff to always hang the catheter bag below the bladder. She said she would start an in-service about catheter care. During an interview on 04/23/2026 at 709 a.m., the ADON said the catheter bag should have been hung on the other side of the bed to keep the bag below the bladder to prevent the possibility of urinary tract infection. She said the DON had already started an in-service about catheter care. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said the expectation was if the catheter bag should be below the bladder, then it should always be below the bladder. She said the DON had already started an in-service about catheter care. Record review of the facility's policy Catheter Care, Urinary 2001 MED-PASS, Inc. revised January 3, 2023, reflected Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Maintaining Unobstructed Urine Flow . 3. The urinary drainage bag must be always held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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Belterra Health & Rehab	2170 North Lake Forest Drive McKinney, TX 75071

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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 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 observations, interviews, and record review the facility failed to ensure that residents who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of six residents (Resident #26) reviewed for respiratory care. The facility failed to ensure Resident #26's BiPAP mask was properly stored when not in use on 04/21/2026. This failure could place residents at risk of respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #26's Face Sheet, dated 04/21/2026, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with a solitary pulmonary nodule. Record review of Resident #26's Comprehensive MDS Assessment, dated 03/31/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had a solitary pulmonary nodule. The resident's next ARD was 07/01/2026. Record review of Resident #26's Comprehensive Care Plan, dated 04/17/2026, reflected that the resident did not have a care plan for her BiPAP. Record review of Resident #26's Physician Order, dated 04/16/2026, reflected BIPAP IPAP 10, EPAP-6 QHS & PRN/NAPS at bedtime related to SOLITARY PULMONARY NODULE. Record review of Resident #26's Physician Order, dated 04/16/2026, reflected Ensure CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open)/BIPAP humidification chamber is full and clean. Clean CPAP/BIPAP mask, nasal pillows, and with soap and water and allow them to air dry between uses. When dry and not in use, store them in a covered device (e.g., plastic bag, etc.). Clean Headgear (strap) with warm, soapy water and mild detergent as needed. Allow to air dry. During an observation and interview on 04/21/2026 at 9:10 a.m., revealed Resident #26 in her bed, awake. It was observed that a BiPAP mask was on the resident's side table, unbagged. The resident said the mask had been on her side table since the night before. She said that since last night, approximately six staff already went back and forth to check on her but did not say anything about her mask being on top of the table. She said the staff did not give her bag where she could put the mask. During an interview on 04/21/2026 at 9:47 a.m., RN D said she did not notice that Resident #26's BiPAP mask was not bagged when she checked on her. She said she would get a bag, clean the BiPAP mask, and put it inside the bag. She said the mask should be bagged to prevent respiratory infection. During an interview on 04/23/2026 at 6:26 a.m., the DON said the BiPAP mask should be inside a plastic bag when not in use to maintain its cleanliness as well as its patency (unobstructed). She said bagging the BiPAP mask was important to prevent cross contamination and development of infections. She said the staff were responsible for bagging the mask or at least provided a bag and educated the resident of the reason why the mask should be bagged. She said she already started an in-service about bagging the BiPAP mask. During an interview on 04/23/2026 at 709 a.m., the ADON said the BiPAP masks should be in a plastic bag when not in use to prevent cross contamination and respiratory infection. She said the staff were responsible for bagging the mask. She said the DON had already started an in-service about respiratory care. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said everything that the residents were using for their respiratory issues should be kept clean to prevent any respiratory issues. She said the DON had already started an in-service about respiratory care as soon as she heard the BiPAP mask was not bagged. She said she would coordinate with the DON and the ADONs to provide additional in-services and monitor their compliance. Record review of the facility's policy CPAP/BiPAP Support 2001 MED-PASS. Inc. revised April 4, 2025, reflected Purpose . 3. To promote resident comfort and safety . General Guidelines for Cleaning . 5. Masks, nasal pillows, and tubing: . Place and store mask in covered device (i.e. plastic bag, kangaroo pouch, etc.,) between uses.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one of ten residents (Resident #83) reviewed for pharmaceutical services. The facility failed to ensure LVN F did not administer Resident #83's esomeprazole along with the other medications and the resident's formula on 04/22/2026. This failure placed residents at risk of not receiving the full benefit of their medication. Findings included: Record review of Resident #83's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing) and gastro-esophageal reflux (stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of Resident #83's Comprehensive MDS Assessment, dated 04/07/2026, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident had a feeding tube and had gastro-esophageal reflux. Record review of Resident #83's Comprehensive Care Plan, dated 04/06/2026, reflected the resident was not care planned for his feeding tube and GERD. Record review of Resident #83's Physician Order, dated 04/03/2026, reflected ESOMEPRAZOLE 40 MG PACKET Give 1 packet via PEG-Tube (procedure to place a feeding tube in the stomach) one time a day related to GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (inflammation of the esophagus) . MIX W/15 CC OF H2O & LET SET FOR 2-3 MINS & GIVE PER G-TUBE EVERY DAY THEN FLUSH WITH 15 ML OF WATER. The order did not specify to give to give the medication on an empty stomach. Record review of Resident #83's Physician Order, dated 04/03/2026, reflected Coreg Oral Tablet 3.125 MG (Carvedilol) Give 1 tablet via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD IF SBP < 110 AND DBP < 60 AND HR < 60. Record review of Resident #83's Physician Order, dated 04/03/2026, reflected Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals) Give 1 tablet via G-Tube one time a day related to VITAMIN DEFICIENCY, UNSPECIFIED. Record review of Resident #83's Physician Order, dated 04/03/2026, reflected Senna Oral Tablet 8.6 MG (Sennosides) Give 1 tablet via G-Tube two times a day related to CONSTIPATION, UNSPECIFIED. Record review of Resident #83's Physician Order, dated 04/13/2026, reflected five times a day Enteral (delivery of food through feeding tube): Enteral Nutrition via Bolus (large dose of medication or food given at once): Diabetisource AC give 1 can (250 ml) Five times per day) via bolus per Gtube) at 0800, 1200, 1600, 2000 and 0000. 1500 ___ kcal, 75 __ grams protein, _1920 ml___ free water. During an observation on 04/22/2026 at 8:11 a.m. revealed LVN F was about to administer Resident #83's medication via g-tube. He prepared five medications and one of them was esomeprazole. After preparing the medications, he went inside the resident's room and started to administer the medications. He flushed the g-tube with 30 cc of water and administered the medications one-by-one and flushing in between with 30 cc. The last medication administered was the esomeprazole. After administering the omeprazole, he flushed the g-tube with 30 cc of water then flushed it again with 90 cc of water, gave the formula, and flushed it again with 90 cc of water. The omeprazole was not given on an empty stomach.During an interview on 04/22/2026 at 8:49 a.m., Resident #83 said his medications in the morning were given to him at the same time. He said there was no medication that was given to him before the other medications. During an interview on 04/22/2026 at 9:09 a.m., the DON said she would ask the pharmacist about the esomeprazole regarding when and how it should be administered. During an interview on 04/22/2026 at 10:07 a.m., the DON said she already talked to the pharmacist and was informed that the esomeprazole should be given by itself and not administered with the other medications and in an empty stomach to ensure effectiveness of the medication. She said she already talked to LVN F about the esomeprazole being (continued on next page)

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	676367	A. Building B. Wing	04/23/2026

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Belterra Health & Rehab	2170 North Lake Forest Drive McKinney, TX 75071

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given by itself. She said LVN F already changed the order for Resident #83's esomeprazole. She said they would also audit if other residents were taking esomeprazole and would change the order as appropriate. During an interview on 04/22/2026 at 12:09 p.m., LVN F said he had already changed the schedule of Resident #83's esomeprazole to one hour before the rest of his medications and morning formula. He said the rationale behind giving the esomeprazole by itself was to make sure the medication was absorbed effectively. He said the gastric juice, that would be triggered by food or liquid, could hamper absorption of the medication. During an interview on 04/23/2026 at 709 a.m., the ADON said esomeprazole should be given 30 minutes to one hour before food and medications to ensure absorption of the medication. She said the DON already talked to LVN F and changed the time for the esomeprazole. During an interview on 04/23/2026 at 7:41 a.m., the Administrator said she was not a clinician and would let the DON handle the issue about the esomeprazole Record review of the facility's policy Administering Medications 2001 MED-PASS, Inc. revised April 2019 reflected Policy Statement: Medications are administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 4. Medication administration times are determined by resident need and benefit. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure the nurse staffing data information was posted daily for 1 of 1 facility reviewed for required postings.The facility failed to post the daily staffing information for 04/20/26.This failure could place residents, family members, and visitors at risk of not having access to information regarding staffing data and facility census.Findings included:During an observation on 04/21/26 at 5:35 AM, revealed a document labeled Daily Staffing Log and dated 04/19/2026 which was posted in a plastic protector on a desk in the entranceway across from the ADMIN's office. The document included the staff titles: Registered Nurse, Licensed Vocational Nurse, Certified Nurse Aide, Certified Med Aide. The document included the number of staff under each title, the number of hours, the total number of hours worked for each staff title type, the total number of hours worked, and the daily census. Record review on 04/21/26 at 11:45 AM, of the facility's nursing staff information reflected the facility failed to complete and post the nursing staff information on the following dates: 04/20/26. During an interview on 04/23/26 at 10:54 AM DON stated she was aware of the required posted document for Nurse Staffing, but indicated she is not the one responsible for posting the daily nurse staffing and census document. The is done by the HR representative, and added they have an administrative staff member post this daily for the facility. She said the posting showed the staff coverage for the facility based on the census for the residents and if it were not posted then family or visitors would not have the information.During an interview on 04/23/26 at 1:55 PM HR stated that the task of posting the Daily Nurse Staffing Information had been assigned given to the administrative staff. On the date in question when you all showed up in the morning, she hadn't had the opportunity to replace it with the current one. HR could not provide a reason as to why the updated Daily Nurse Staffing Information posting was not done for 04/20/26. HR stated essentially when the administrative staff clocks in the morning. They go by the nursing station takes a picture of the Daily Nurse Staffing Information at the station and then comes to her desk and fills it out. She acknowledged that it was an oversight of not getting it done. During an interview on 04/23/26 at 2:05 PM the ADMIN stated the posting should include the facility name, date, census, with the nursing breakdown which included RNs, MAs, LVNs and & CNAs. The ADMIN stated the posting should include the facility name and the census on the day it was posted but she did not know why the information displayed in the lobby did not have that information. The ADMIN stated the posting is to provide residents, family, and visitors to see what staff were in the facility for the day. She said if the posting were not put up then visitors and residents would not be able to see how the facility was staffed.Record review of an undated facility policy on Posting Direct Care Daily Staffing Numbers, revealed: Policy StatementPolicy Interpretation and ImplementationOur facility will post on a daily basis for each shift the number of nursing personnel responsible for providing direct care to residents.Within 2 hours of the beginning of each shift , the number of Licensed Nurses (RN's, LPNs and LVNs) and the number of unlicensed personnel (CNA's) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. a. The name of the facility b. the date for which the information is posted.c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facilitye. The shift for which the information is postedf. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift.