STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676387	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Meadows	1870 John King Blvd Rockwall, TX 75032

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 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 observations, interviews, and record reviews, the facility failed to ensure the resident's environment remained free of hazards as was possible for 4 of 6 residents (Residents #46, #55, #70, and #96) reviewed for accident hazards.The facility failed to ensure Residents #46 and #55 did not have a can disinfectant stored in their room.The facility failed to ensure Resident #70 had her fall mat placed alongside her bed for fall prevention. The facility failed to ensure Resident #96 had physician orders for a scoop mattress (a scoop mattress features raised sides and a concave center) to ensure it was not a hazard for the resident. These failures could prevent the residents from having an environment that was free from accidents, and potential injury.Findings included:Record review of Resident #46's Face Sheet, dated 05/13/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had diagnoses of depression and COPD (difficulty breathing).Record review of Resident #46's Quarterly MDS Assessment, dated 04/22/26, reflected the resident had a BIMS score of 14 (intact cognitive response). The MDS assessment reflected the resident had diagnoses of depression and COPD.During an observation on 05/12/26 at 10:32 a.m., revealed Resident #46 had a can of disinfectant spray on his nightstand.Record review of Resident #55's Face Sheet, dated 05/13/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #55 had a diagnosis of depression.Record review of Resident #55's Quarterly MDS Assessment, dated 03/17/26, reflected the resident had a BIMS score of 6 (severe cognitive impairment). The MDS assessment reflected the resident had a diagnosis of depression.During an observation on 05/12/26 at 10:32 a.m., revealed Resident #55 had a can of disinfectant spray in her bathroom.During an interview and observation on 05/12/26 at 11:16 AM, RN J was shown by the Surveyor Resident #46 and Resident #55 had a can of disinfectant in their room. She stated the resident should not have the disinfectant in their room because it was a hazard to the resident. She stated family members often bring in these items for the resident. Record review of Resident #70's Face Sheet, dated 05/13/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #70 had a diagnosis of repeated falls.Record review of Resident #70's Quarterly MDS Assessment, dated 03/17/26, reflected the resident had a BIMS score of 12 (moderate cognitive impairment). The MDS assessment reflected the resident had a diagnosis of restless leg syndrome.Record review of Resident #70's Comprehensive Care Plan, dated 03/11/26, reflected the resident being a fall risk, and an intervention included having a fall mat placed alongside her bed. During an observation on 05/14/26 at 11:35 a.m., revealed Resident #70 was lying in bed, and the fall mat was observed leaning against a 5-drawer chest. The fall mat was not placed alongside the resident's bed.During an interview and observation on 5/14/26 at 9:12a.m., LVN E stated Resident #70 was a fall risk and needed the fall mat placed alongside her bed. She observed the resident's fall mat leaning on a 5-drawer chest and placed it alongside the resident's bed. She stated the nursing staff often forgot to place the fall mat back in place after providing care to the resident. She stated not having the fall mat alongside the resident's bed result in the resident sustaining a severe injury if she fell out of the bed. Record review of Resident #96's Face Sheet, dated 05/13/26, reflected an [AGE] year-old male who (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was admitted to the facility on [DATE]. Resident #96 had a diagnosis of shaking.Record review of Resident #96's Quarterly MDS Assessment, dated 04/28/26, reflected the resident had a BIMS score of 2 (severe cognitive impairment). The MDS assessment reflected the resident had a diagnosis of seizure disorder.Record review of Resident #96's Comprehensive Care Plan, dated 05/12/26, reflected the resident being a fall risk, but there was no intervention including the use of a scoop mattress.Record review of Resident #96's Physician's Order, dated 05/13/26, reflected no physician's orders for a scoop mattress.During an observation on 05/14/26 at 11:35 a.m., revealed Resident #96 had a scoop mattress on his bed. During an interview on 05/14/26 at 10:41 a.m., ADON T was informed by the Surveyor of Resident #96 not having physician orders for the scoop mattress on his bed. She stated she was unsure if the resident had physician orders or not. She stated physician orders would be required because it was a care being provided and the physician was aware of the care. She stated it was the ADON and DON's responsibility to ensure the resident had physician orders for the device. During an interview on 05/14/26 at 10:45 a.m., ADON T was informed by the Surveyor of Resident #46 and Resident #55 had a can of disinfectant in their room. She stated the residents were not allowed to have the chemicals in their room because it could be harmful to the residents and were flammable. She stated family members often bring the items in for the residents' use and they had to take them away. During an interview on 05/14/26 at 10:47 a.m., ADON T was informed by the Surveyor of Resident #70 not having the fall mat placed alongside the resident's bed when observed on 05/12/26 and 05/14/26. She was informed the fall mat was observed leaning against the 5-drawer chest in the room. She stated the resident was a fall risk and needed the fall mat placed alongside her bed to reduce the impact of a fall. During an interview on 05/14/26 at 11:48 a.m., the DON was informed by the Surveyor of Resident #46 and Resident #55 with cans of disinfectant in their room. She stated it should not be in their room because it was a hazard for them and they could harm themselves. She stated family members bring them for the resident, and they had repeatedly advised them not to, but they continue to do it. She stated the staff were responsible for checking to ensure they did not have these items in their room when they conducted their rounds. The DON was informed by the Surveyor of Resident #70 not having her fall mat placed alongside her bed while she was lying in it. She stated the resident was a fall risk and staff needed to ensure the fall mat was placed alongside the resident's bed to minimize the risk of injury if the resident fell out of bed. The DON was informed by the Surveyor of Resident #96 having a scoop mattress but no physician orders. She stated the resident was a fall risk and an intervention included the use of a scoop mattress. She stated the physician orders were needed because it was part of the care needed for the resident.Record review of the facility's policy, Falls and Fall Risk, Managing, dated March 2025, reflected Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Record review of the facility's policy, STATEMENT OF RESIDENT RIGHTS, undated, You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate, or retaliate against your for exercising your rights.If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint with the facility administrator or with the Texas Department of Human Services by calling [PHONE NUMBER].You have a right to:1) All care necessary for you to have the highest possible level of health;2) Safe, decent and clean conditions;

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three of seven (Residents #46, #70, and #71) reviewed for respiratory care. The facility failed to ensure Resident #46's nebulizer mask was bagged when not in use on 05/12/26. The facility failed to ensure Resident #70's nasal canula was properly stored in a bag when not in use on 05/12/26.The facility failed to ensure Resident #71's nebulizer and CPAP mask were bagged when not in use on 05/12/26.The facility failed to ensure Resident #71 had physician orders for use of the nebulizer. These failures could place the residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met.Findings included: Record review of Resident #46's Face Sheet, dated 05/13/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had diagnoses of depression and COPD (difficulty breathing).Record review of Resident #46's Quarterly MDS Assessment, dated 04/22/26, reflected the resident had a BIMS score of 14 (intact cognitive response). The MDS assessment reflected the resident had diagnoses of depression and COPD.Record review of Resident #46's Physician Order, dated 05/12/26, reflected Ipratropium-Albuterol Inhalation Solution 0.5-2.5(3) mg/3ml. 3 ml inhale orally via nebulizer. During an observation on 05/12/26 at 10:32 a.m., revealed Resident #46's nebulizer mask on his nightstand unbagged. Record review of Resident #70's Face Sheet, dated 05/13/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #70 had a diagnosis of COPD.Record review of Resident #70's Quarterly MDS Assessment, dated 03/17/26, reflected the resident had a BIMS score of 12 (moderate cognitive impairment). The MDS assessment reflected the resident had a diagnosis of COPD.Record review of Resident #70's Physician Order, dated 05/12/26, reflected Oxygen continuous @ 2-4 LPM via nasal canula.During an observation on 05/12/26 at 10:35 a.m., revealed Resident #70's oxygen tank, attached to her wheelchair, had a nasal canula attached, which was sitting on the seat of the wheelchair under a pair of sneakers, unbagged.Record review of Resident #71's Face Sheet, dated 05/13/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #71 had diagnoses of obstructive sleep apnea and chronic atrial fibrillation (irregular heartbeat).Record review of Resident #71's Quarterly MDS Assessment, dated 04/28/26, reflected the resident had a BIMS score of 2 (severe cognitive impairment). The MDS assessment reflected the resident had a diagnoses of obstructive sleep apnea and chronic atrial fibrillation (irregular heartbeat).Record review of Resident #71's Physician Order, dated 05/12/26, reflected apply CPAP at bedtime and fit mask for patient comfort. The resident had no physician orders for the use of a nebulizerDuring an observation on 05/12/26 at 10:45 a.m., Resident #71's nebulizer mask and CPAP mask were laying on top of the nightstand and unbagged. During an interview and observation on 05/12/26 at 11:16 AM, RN J observed Resident #46's nebulizer mask unbagged, Resident #70's nebulizer and CPAP mask unbagged, and Resident #71's nasal canula unbagged. She stated the devices needed to be bagged to avoid cross contamination. She stated staff should be checking for this when they make their rounds every two hours.During an interview on 5/14/26 at 9:12 a.m., LVN E stated Resident #71 used his nebulizer on an as needed basis and he often refused. She was informed by the Surveyor of Resident #71 not having physician orders for the use of the device. She stated she was new to the facility and was not sure why the resident did not have physician orders for it. She stated the resident needed a care plan for the use of the device but did not state why.During an interview on 05/14/26 at 10:41 a.m., ADON T was informed by the Surveyor of Resident #46, #70, and #71 not having their breathing mask or nasal canula bagged. She stated the items needed to be bagged when not in use to avoid contamination. She was informed Resident #71 did not have physician orders for the use of the nebulizer and she stated Resident #71 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed physician orders for their plan of care and the physician signing off on the care needed. She stated she did not think Resident #71 used a nebulizer and should not have it in his room.During an interview on 05/14/26 at 11:48 a.m., the DON was informed by the Surveyor of Resident #46, #70, and #71 not having their breathing mask or nasal canula bagged. She stated the items needed to be bagged when not in use to avoid cross contamination. She stated staff should be checking to ensure these items were bagged when they made their round. She was informed of Resident #71 not having active physician orders for any medication requiring the use of a nebulizer and she stated she had to research why the resident did not have physician orders. Record review of the facility's policy, Oxygen Administration, dated 2001, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.2. Review the resident's care plan to assess for any special needs of the resident.3. Assemble the equipment and supplies as needed.

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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 observations, interviews, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for three of seven residents (Residents #29, #46, and #96) reviewed for medication storage. The facility failed to ensure Resident #29 did not have a container of eye drops on his bedside table on 05/12/26. The facility failed to ensure Resident #46 did not have a container of allergy medication and antacid medication on his nightstand on 05/12/26. The facility failed to ensure Resident #96 did not have a container of earwax removal on his nightstand on 05/12/26.These failures could place the residents at risk of accidental overdose, misuse of medications, and possible adverse reactions. Findings included:Record review of Resident #29's Face Sheet, dated 05/13/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #29 had diagnoses of dementia (memory decline) and damaged retina.Record review of Resident #29's Quarterly MDS Assessment, dated 02/23/26, reflected the resident had a BIMS score of 13 (intact cognitive response). The MDS assessment reflected the resident had diagnoses of Alzheimer's (cognitive decline) and damaged retina.During an observation on 05/12/26 at 10:32 a.m., Resident #29 had a container of eye drops on his bedside table.Record review of Resident #46's Face Sheet, dated 05/13/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had diagnoses of acid reflux and COPD (difficulty breathing).Record review of Resident #46's Quarterly MDS Assessment, dated 04/22/26, reflected the resident had a BIMS score of 14 (intact cognitive response). The MDS assessment reflected the resident had diagnoses of acid reflux and COPD.During an observation on 05/12/26 at 10:35 a.m., Resident #46 had a container of allergy medication and antacid medication on his nightstand.Record review of Resident #96's Face Sheet, dated 05/13/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #96 had a diagnosis of tremors.Record review of Resident #96's Quarterly MDS Assessment, dated 04/28/26, reflected the resident had a BIMS score of 2 (severe cognitive impairment). The MDS assessment reflected the resident had a diagnosis of seizure disorder.During an observation on 05/12/26 at 10:45 a.m., Resident #96 had a container of earwax removal on his nightstand.During an interview on 05/14/26 at 10:34 a.m., LVN E was informed by the Surveyor of Resident #29 having a container of eye drops on his bedside table, Resident #46 having a container of allergy medication and antacid medication on his nightstand, and Resident #96 having a container of earwax removal on his nightstand. She stated the residents were not allowed to have the medication in their rooms because they could overdose on them or ingest them. During an interview on 05/14/26 at 10:41 a.m., ADON T was informed by the Surveyor of Resident #29 having a container of eye drops on his bedside table, Resident #46 having a container of allergy medication and antacid medication on his nightstand, and Resident #96 having a container of earwax removal on his nightstand. She stated the residents' family members brought in medication and they had to educate the family not to. She stated staff should be checking for this when checking on the residents. She stated they checked for this daily and confiscated them when they see it. During an interview on 05/14/26 at 10:41 a.m., the DON was informed by the Surveyor of Resident #29 having a container of eye drops on his bedside table, Resident #46 having a container of allergy medication and antacid medication on his nightstand, and Resident #96 having a container of earwax removal on his nightstand. She stated the residents' family members brought in medication and they had repeatedly educated the family not to. She stated staff should be checking for this when checking on the residents. She stated the risk of the residents having the medication in their room could result in overdose.Record review of the facility's policy, Storage of Medications, dated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November 2020, reflected The facility stores all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.

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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 observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services.The facility failed to properly seal the tea dispenser once the tea had brewed on 05/12/26. The facility failed to ensure the ice scoop, in the kitchen, was thoroughly cleaned on 05/12/26.The facility failed to ensure the sanitizer bucket (red bucket) in the kitchen area had the appropriate level of sanitizer fluid in it on 05/12/26. The facility failed to ensure a large tray of thawing raw meat, in the walk-in refrigerator, was not stored above cooked foods. These failures placed residents at risk of exposure to food contamination and illness. Findings included:Observations on 05/12/26 from 9:11 a.m. to 9:19 a.m. in the facility's only kitchen revealed: The tea dispenser in the kitchen area, had tea in it and was not covered. A large tray of thawing raw meat, in the walk-in refrigerator, was stored above cooked foods. An ice scoop holder storing an ice scoop, located in the kitchen, had white and brownish stains on the bottom of the inside of it. During an interview and observation on 05/13/26 at 11:40 a.m., the DM stated the sanitizer bucket (red bucket) had sanitizer fluid in it and she tested the PPM in the morning. She tested the solution in the container, and the PPM registered at 0, which indicated no sanitizer solution was registered in the mixture. During an interview on 05/14/26 at 9:47 a.m., Dietary Manager and Food Service Supervisor were informed of the concerns observed in the kitchen area. The DM and FSS stated the tea dispenser needed to be covered to prevent something from falling into it. They stated the tray of raw meat needed to be placed on the bottom rack and not on a rack above other foods to prevent anything from contaminating the other foods. They stated they cleaned the ice scoop holder out at least once a week and will ensure it was clean to avoid contamination. The DM stated the sanitizer bucket needed to have the appropriate amount of sanitizer fluid to clean spills and sanitize the serving area if spill occur.During an interview on 05/14/26 at 10:06 a.m., the Administrator was informed of the concerns observed in the kitchen area. She stated she was informed of the concerns in the kitchen by the DM. She stated she was informed by the DM they were in the process of making more tea, which was why the tea was uncovered. She stated her DM informed her the tray of raw meat did have a solid tray underneath it and the bags were sealed so there was no risk of the food under it getting contaminated. She stated she understood ensuring the ice scoop holder was cleaned to avoid contamination. She stated she was informed about the red bucket not having sanitizer fluid in it, but she stated the DM told her they were going to check it prior to using it, if they had to use it.Record Review of the Facility's policy titled Food Receiving and Storage, dated 2001, revealed, Foods shall be received and stored in a manner that complies with safe food handling practices. 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). 9. Uncooked and raw animal products and fish are stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods to prevent meat juices from dripping onto these foods. Sanitization - The food service area is maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. 9. Service area wiping cloths are cleaned and dried or placed in a chemical sanitizing solution. 10. Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions.Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICESSUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD Texas Chapter 228 Retail Food adopts the U.S FDA Food Code. 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. 3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepare.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 set forth 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 1 of 12 residents (Resident #46) reviewed for care plan. The facility failed to ensure Resident #46's care plan for fall prevention included the intervention of a fall mat placed alongside bed. This failure could place residents at risk of their needs not being met. Findings include:Record review of Resident #46's Face Sheet, dated 05/13/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had diagnosis of a fractured thigh.Record review of Resident #46's Quarterly MDS Assessment, dated 04/22/26, reflected the resident had a BIMS score of 14 (intact cognitive response). The MDS assessment reflected the resident had pain in unspecified joint.Record review of Resident #46's Comprehensive Care Plan, dated 05/05/26, reflected the resident was a fall risk; however, there was no intervention of a fall mat to be placed alongside his bed. During an observation on 05/12/26 at 10:32 a.m., Resident #46 had a fall mat placed alongside his bed.During an interview on 05/14/26 at 10:41 a.m., ADON T was informed by the Surveyor of Resident #46 observed with a fall mat placed alongside his bed on 05/12/26 at 10:32 a.m., and 05/14/26 at 9:00 a.m.; however, his care plan for fall risk did not include an intervention for the use of a fall mat. She stated she was not sure if the resident used a fall mat. She stated she would have to research this. She later returned on 05/14/26 at 11:15 a.m. and stated the fall mat should not have been there. She was advised by the surveyor of the progress notes dated 03/12/26 indicating the resident was found on his knees on the fall mat. She stated it was the ADON, DON, and MDS nurse's responsibility to ensure care plans were updated and it was important because it showed the resident's plan of care. During an interview on 05/14/26 at 11:48 a.m., the DON was informed by the Surveyor of Resident #46 observed with a fall mat placed alongside his bed on 05/12/26 at 10:32 a.m., and 05/14/26 at 9:00 a.m.; however, his care plan for fall risk did not include an intervention for the use of a fall mat. The DON stated it was the interdisciplinary team's responsibility to ensure care plans were updated. She stated normally it was the ADON's responsibility to ensure the care plan was updated. She stated if the resident's care plan was not updated with the interventions used as part of the resident's plan of care he may not receive the appropriate care. Record review of the facility's policy, Falls and Fall Risk, Managing, dated March 2025, reflected Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Record review of facility's policy, Comprehensive Care Plans, dated 2022, reflected It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.