STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676394	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Place Rehabilitation Suites	5600 Woodlands Trail Denison, TX 75020

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had a safe, clean, comfortable and homelike environment including clean bed linen in good condition for seven (Resident #55, Resident #11, and 5 confidential residents in group interview) of 16 residents and 4 of 4 bed linen closets reviewed for resident rights and homelike environment. 1. The facility failed to ensure Resident #55 and #11's and 5 confidential residents' in group interview fitted bed sheets were in good condition free of holes, tears and threadbare areas. 2. The facility failed to ensure 4 of 4 bed linen closets on resident halls did not have clean fitted bed sheets with holes, tears and threadbare areas. These failures place residents at risk of an unsanitary environment and a decline in quality of life.Findings included: Review of Resident #55's face sheet reflected Resident #55 was a [AGE] year old male admitted to the facility on [DATE] with diagnoses of cerebral palsy (brain disorder permanently affects body movement and muscle coordination), mixed receptive-expressive language disorder (neurodevelopmental condition that affects person's ability to understand and produce language), dysphagia (difficulty swallowing), cognitive communication deficit and ataxia (poor muscle control resulting in shaky, clumsy or unsteady movements). Review of Resident #55's Annual MDS dated [DATE] reflected Resident #55 was severely impaired in cognitive skills for daily decision making. Observation on 02/25/2026 at 8:32 AM of Resident #55 was in bed with his toes sticking out of a large hole in the top sheet. Resident #15's fitted sheet was very thin and threadbare in places. In a confidential group interview on 02/25/26 at 2:15 PM revealed 5 of 13 residents stated their bed linen at times was torn and had holes in them. They stated the facility would run out of bed linen. Review of Resident #11's face sheet reflected Resident #11 was a [AGE] year-old female readmitted to the facility on [DATE] with included diagnoses of sclerosis (hardening and stiffening of tissues commonly caused by disease, inflammation or the replacement of normal cells with fibrous connective tissue) and chronic obstructive pulmonary disease (progressive, chronic inflammatory lung disease causing obstructed airflow, making it difficult to breathe). Review of Resident #11's Annual MDS assessment dated [DATE] reflected Resident #11 had a BIMS score of 15 , indicating she was cognitively intact. Observation and interview on 02/25/26 at 3:13 PM with Resident #11 revealed she requested surveyor to go with her to look at her bed linen that was in poor condition. Observation revealed Resident #11's bed fitted sheet appeared to have large areas that were threadbare. Observations on 02/26/2026 from 12:58 PM to 1:09 PM with Contract Housekeeping Supervisor revealed 4 of 4 linen closets had the following:-100 hall linen closet had 1 fitted bed sheet with tears.-200 hall linen closet had 2 fitted bed sheets with holes and tears and large thinned areas that were threadbare.-300 hall linen closet had 2 fitted bed sheets with holes and tears.-400 hall linen closet had 1 fitted bed sheet with large thinned areas were threadbare and stained. Interview on 02/25/2026 at 1:12 PM with Contract Housekeeping Supervisor revealed she expected housekeeping to put linen in closets that were free of holes, tears and stains. She stated she had ordered 12 bed fitted sheets last week and needed to order more bed linen to replace the ones not in good condition. She stated residents should have fitted bed sheets that are free of holes and tears. Interview on (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/26/2026 at 1:57 PM with Administrator revealed that any time there are holes in resident bed linen they should be replaced. He stated he expected staff to use bed linen without holes. He expected housekeeping staff to ensure there were no holes in fitted sheets put in the linen closet for staff to use on resident beds. He stated the residents have the right to have bed linen without holes or tears and be in good condition. He stated direct care staff should not be putting fitted bed sheets on resident beds that have holes or are torn. Review of facility's policy Maintenance/Housekeeping Policies and Procedures Subject: Laundry dated 03/2006 reflected under all linens .4. Linens are examined for wear and tear and are to be replaced when in disrepair.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 residents (Resident #47, Resident #66, Resident #84, and Resident #55) of 20 residents reviewed for ADLs.The facility failed to ensure Resident #s 47, 66, and 84 had their fingernails trimmed on 2/24/26.The facility failed to provide timely incontinent care for Resident #55 on 2/24/26.These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and skin breakdown, and a decreased quality of life.Findings include:Record Review of Resident # 47 Annual MDS dated [DATE] reflected, Resident #47 was a [AGE] year-old female with initial admission date of 2/17/2025 to the facility. Her pertinent diagnoses included: Hypertension (high blood pressure), Diabetes mellitus (elevated blood glucose levels) , Hyperlipidemia (elevated lipid levels in blood), Age related cognitive decline. Her BIMS score was 5, which indicated Resident #47 had severe cognitive impairment. Resident # 47 needed supervision from staff for her personal hygiene.Review of Resident #47 's Comprehensive Care Plan, revised 2/12/2026 reflected, Category: ADLs Functional Status/Rehabilitation Potential. [Resident #47] requires up to extensive assistance with ADL's related to poor balance, decreased mobility, weakness post hospital. Approach: . Provide assistance with hygiene and grooming and dressing as needed .In an interview and observation on 02/24/2026 at 10:25 AM with Resident #47 revealed she had long and jagged fingers nails on both hands measuring approximately 0.2 - 0.4 inches in length extending from the tip of her fingers. Resident #47 stated that she would like her fingernails clipped. She stated that she did not recall if the staff had offered her nailcare.Record Review of Resident #66's Annual MDS assessment dated [DATE] reflected, Resident #66 was a [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included the following: Hypertension (high blood pressure), peripheral vascular disease (reduced blood flow to the limbs especially legs), Unspecified Dementia. Her BIMS score was 15, which indicated Resident #66 had intact cognition. Resident # 66 needed supervision from staff for her personal hygiene. Review of Resident #66's Comprehensive Care Plan, revised 12/18/2025 reflected, Category: [Resident #66] Requires extensive assistance with ADLs related to poor balance, decreased mobility. Approach: Provide assistance with hygiene and grooming and dressing as needed.In an interview and observation on 02/24/2026 at 10:47 AM with Resident #66 revealed Resident #66 had long, jagged nails on both hands, measuring approximately 0.4 inches in length extending from the tip of her fingers. Resident #66 stated she would like her nails clipped and staff had not offered to clip her nails for a long time. She stated that she was unable to trim her own nails.Record Review of Resident #84's admission MDS dated [DATE] reflected, Resident #84 was an [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included the following: Hypertension (high blood pressure), coronary artery disease (thickening of the heart arteries related to plaque buildup), Septicemia, (blood stream infection), Hyperlipidemia (elevated blood lipid levels). Her BIMS score was 15, which indicated Resident #84 had intact cognition. Resident # 84 needed moderate assistance from staff for her personal hygiene.Review of Resident #84 's Comprehensive Care Plan, revised 2/24/2026 reflected, Category: [Resident #84] Requires extensive assistance with ADL's related to poor balance, decreased mobility, weakness post hospital . Approach: . Provide assistance with hygiene and grooming and dressing as needed .In an interview and observation on 02/24/2026 at 11:25 AM with Resident #84 revealed Resident #84 was scratching with her nails on her left forehand. The left forehand had a skin tear. Resident # 84 had long and jagged fingernails on both hands, measuring approximately 0.3 inches in length extending from the tip of her fingers. Resident stated that she had fragile skin and often scratched herself. She stated that she would like her fingernails to be trimmed but was unable to do so by herself since she was admitted in the facility. She stated that staff had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not offered her fingernail care in the facility.In an interview on 02/25/2026 at 10:03 AM with CNA C she stated that CNAs were responsible for nail care including trimming and cleaning them, unless the resident had diabetes. She stated that nailcare should be provided on shower days and as needed. She stated that some residents had their nails done during Activities, once a week. She stated that risks of long, jagged fingernails were potential skin tears and loss of dignity. In an interview on 2/25/26 at 10:10 AM with LVN D stated that Nurses and CNAs were responsible for clipping fingernails. She stated that for diabetic residents, Nurses should clip their fingernails. She stated that the expectation was CNAs performed nail care on residents on shower days and as needed. She stated the risks of long and jagged fingernails were skin tears and possibility of infections.In an interview on 2/26/26 at 10:40 AM with the DON revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had diagnosis of diabetes. She stated the charge nurses were supposed to monitor. She stated that some residents do participate in Nail care activity with the Activities coordinator but that does not replace grooming and ADL care that nursing staff were expected to provide to residents. The DON stated residents having long and jagged fingernails could cause lapses in infection control and dignity concerns. The DON stated that she will ensure that residents will receive nailcare soon after the interview. The DON stated that in order to maintain quality of life for residents in the facility, she and management staff conducted daily rounds on all residents.Record review of Resident #55's face sheet dated 2/25/26 reflected he was a [AGE] year-old male with an original admission date of 11/22/16 and a readmission date of 2/21/26. Resident #55 had the following active diagnoses: cerebral palsy (a neurological disorder that affects movement, muscle tone and posture), need for assistance with personal care, contracture of knee (loss of motion where the joint is fixed in a bent position), mixed receptive-expressive disorder (a communication disorder where individuals struggle to both understand and produce spoken language), unspecified lack of coordination and Anxiety Disorder (a mental health condition characterized by persistent, excessive and uncontrollable fear or worry that interferes with daily life).Record review of Resident #55's Quarterly MDS assessment dated [DATE] reflected Resident #55 was rarely understood and therefore could not complete the BIMS interview. Resident #55 had impairments on both sides to his upper and lower extremities and used a wheelchair. Resident #55 was fully dependent on staff for toileting hygiene and was always incontinent of bowel and bladder.Record review of Resident #55's Care Plan dated 12/22/25 reflected .Problem Start Date: 02/21/2026 Requires assistance one to two person assist with ADL's related to poor balance, decreased mobility, weakness Edited: 02/24/2026. Approach Start Date: 02/21/2026 Provide assistance of one with hygiene and grooming and dressing as neededEdited: 02/22/2026 Approach Start Date: 02/21/2026 Nursing Provide assistance of one with incontinent care as needed Edited: 02/22/2026. Problem Start Date: 02/21/2026 Category: Continence Status (Bowel/Bladder) Resident #55 is incontinent of bladder R/T: Cerebral Palsy Edited: 02/24/2026 Long Term Goal Target Date: 03/24/2026 Resident #55 will remain clean, dry, and odor free with no occurrence of skin breakdown over the next review period Edited: 02/24/2026 Approach Start Date: 02/21/2026 Monitor for incontinent episodes frequently. Change promptly and apply a skin barrier to skin. Edited: 02/22/2026 Approach Start Date: 02/21/2026 Monitor for S/S skin breakdown - report to MD and responsible party. Edited: 02/22/2026 Approach Start Date: 02/21/2026 Urinary Incontinence Type: Stress Edited: 02/22/2026.Record review of Resident #55's Point of Care History from 2/19/26 to 2/25/26 dated 2/25/26 reflected toileting hygiene was performed the following times on 2/24/26: 1:13am, 1:20pm, 9:32pm and 10:54pm.During an observation and interview with LVN A on 02/24/2026 12:55 PM revealed Resident #55 was sitting in his wheelchair at the nurses' station with LVN A. Resident #55 was observed wet on the front of his pants and on his t-shirt in the shape of an incontinent brief. Surveyor made LVN A aware Resident #55 was soiled LVN A displayed a surprised look and stated Oh Yes, he is! We need to get him changed. LVN A stated Resident #55 was not wet a bit ago. LVN A had not known the last time Resident #55 was changed. Resident #55 was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with LVN A at the end of the observation.An interview with CNA J 02/25/2026 at 10:15 AM revealed she was the CNA J assigned to Resident #55 on 2/24/26 and 2/25/26. CNA J stated Resident #55 liked riding around the facility, and he only came to his room during the day when he needed incontinent care or wasn't feeling well. CNA J stated Resident #55 could have been found in his room around 2pm every day because that was when he would take a nap. CNA J stated Resident #55 was not on a specific schedule for incontinent care, however she typically checked him every 2-3 hours. CNA J stated she looked Resident 55 over when she saw him and checked for incontinence. CNA J stated Resident #55 was able to tell the staff when he was incontinent if they asked him. CNA J stated on 2/24/26 she changed Resident #55 at around 7am and checked him around lunch time, which was about 11am. CNA J stated his brief had a yellow strip that would turn blue if he was wet. She stated he was dry at 11am. CNA J stated she had not checked Resident #55 for incontinence after 11am. CNA J stated Resident #55 was in the activity room when she checked to see if he needed changing. CNA J stated she had not taken Resident #55 back to his room after she changed him at 7am. CNA J stated Resident #55 was changed before the end of her shift at 2pm on 2/24/25. She changed him yesterday at 7am. CNA J stated it was impossible for her to check Resident #55 every two hour because he was riding around the whole facility, however he was typically with staff, and they kept an eye on him and notified her if he needed to be changed. CNA J stated the risk to the resident of not being changed timely was he could have gotten a wound or something, but he had not had a wound. An interview with LVN G on 02/25/2026 at 10:42 am revealed she was not a regular employee of the facility but had worked with Resident #55 several times. LVN G stated Resident #55 was typically out and about throughout the facility and was never in his room. LVN G stated everyone tended to monitor Resident #55 and if they saw something wrong with him they would have taken him to his nurse or CNA. LVN G stated she checked Resident #55 every hour due to his medical condition. LVN G stated Resident #55 could not verbalize when he was wet and was unsure if he typically came back to his room when he was wet. LVN G stated the risk to the residents of not being checked regularly for incontinence was possible skin integrity issues.An interview with ADON K on 02/26/2026 at 11:08 AM revealed Resident #55 was not in his room very often and therefore the CNAs should have gotten him and checked him for incontinence at least every 2 hours throughout the day. ADON K stated she was unsure how the facility staff were monitoring whether Resident #55 had gotten checked for incontinent care. An interview with the DON on 02/26/2026 at 11:19 AM revealed when Resident #55 was observed wet by the surveyor on 2/24/26 it was ice and water and not urine on his clothing. The DON stated her staff was checking Resident #55 at least every 2 hours and stated checking him included taking him to his room and checking his brief. The DON stated the Point of Care History was inaccurate because it was not done in real time rather it was done at the end of the CNA's shift. The DON stated it was the responsibility of the charge nurses to ensure Resident #55 was rounded every two hours. The charge nurses were making sure the rounding was done. The DON stated if the wetness on the Resident #55 was urine the risk to the resident would have been dignity and a lot of other issues. Record review of the facility policy titled Activities of Daily Living revised on 5/5/2023 reflected, .The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store food in accordance with professional standards for food safety for the facility's only kitchen in that:The facility failed to ensure food items in the walk-in refrigerator were covered and sealed on 2/24/2026.This failure could affect residents who received their meals from the facility's kitchen, by placing them at risk for food-borne illness, if consumed and food contamination.Finding included:Observation on 2/24/26 at 9:38 AM of the walk-in refrigerator revealed two gallon-size Ziplock bags having 8-10 grilled sandwiches in them were left open and not sealed shut. The Ziplock bags had a date of 2/23/26 written on them. In an interview on 02/25/2026 at 12:32 PM with the Dietary Manager revealed that the grilled cheese sandwiches were made on 2/23/26 for dinner service and leftovers were stored in the refrigerator for later use. She stated that the Dietary Aide E left the bags open after she had completed helping serve dinner on 2/25/2026. She stated that everyone in the kitchen, including dietary aides and cooks, were responsible for covering food items. She stated she expected all kitchen staff to cover all food items. She stated that risk of not appropriately covering food items was food contamination and could make the residents sick. She stated that she provided frequent in-services to all kitchen staff on appropriate food storage. In an interview on 02/26/2026 at 11:45 AM with Dietary Aide E revealed she had been working in the facility for about 6 months. She stated that everyone in the kitchen was responsible for covering food items She stated that the grilled cheese sandwiches were prepared the day before and stored in the refrigerator. She stated she used some sandwiches for dinner on 2/25/26 and did not close the zip lock bags all the way. She stated that risk of not appropriately covering food items was food contamination and food borne illness.In an interview on 2/26/26 at 11:51 AM with [NAME] F, she stated all food items in the kitchen should be covered appropriately. She stated that everyone in the kitchen was responsible for covering food items. She stated that if the food was not covered, it needed to be discarded since it posed a risk of cross contamination and food borne illness. Record Review of the facility policy titled Food Storage revised 7/21/2023, reflected, .Always cover, label and date leftovers that are to be stored. They should be date marked with the use by date.Review of the Food and Drug Administration Food Code, dated 2022, reflected, 3-305.11 Food Storage.(B) .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 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

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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. Based on observation, interview, and record review, the facility failed to 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 4 of 10 residents (Resident #15, Resident #51, Resident #55 and Resident #86) observed for infection control. 1. The facility failed to ensure Agency RN H prevented cross contamination of the multi-resident use glucometer test strips and failed to maintain a clean and dirty side of diabetic caddy used for supplies to obtain fingerstick blood for Resident #15 on 02/24/26, when she placed the contaminated glucometer back in the clean side of the caddy next to the bottle of glucose test strips. 2. The facility failed to ensure MA I prepared Resident #51's medication without cross contaminating her medications on 02/25/26. 3. The facility failed to ensure Agency LVN G utilized Enhanced Barrier Precautions while performing G tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) medication administration for Resident # 55 on 02/25/26. 4. The facility failed to ensure CNA B and hospice RN used the required Personal protective Equipment (PPE) for Resident #86 who was on enhanced barrier precautions (EBP) due to her wounds, while performing a mechanical lift transfer on 02/24/2026. These failures could place the residents at risk of cross-contamination and development of infection.Findings included: 1. In a medication administration observation on 02/24/26 at 11:05 a.m. with Agency RN H revealed her at the medication cart obtaining supplies needed to check Resident #15's fingerstick blood sugar. Agency RN H pulled out a caddy which had a sharps container on one side, and she placed her disinfected glucometer, a bottle of test strips and several lancets, and alcohol prep pads on the other side. Agency RN H entered Resident #15's room, opened an alcohol prep pad, cleaned the resident's finger and discarded the used alcohol prep pad in a cup in the caddy by the sharp's container. Agency RN H then handed the resident her own personal lancet device and pricked her finger to obtain a sample of blood. Agency RN H opened the test strips and placed a test strip in the glucometer and obtained a blood sugar reading of 214. Agency RN H discarded the test strip in the sharps container and then placed the soiled glucometer back on the clean side of the caddy, next to the bottle of test strips. Agency RN H returned the caddy to the top of the medication cart and pulled out a bottle of bleach wipes with a disinfectant time of 3 minutes. Agency RN H wiped down the glucometer and placed it back in the caddy beside the bottle of test strips, without disinfecting the inside of the caddy or the bottle of test strips. Agency RN H then removed her gloves, performed hand hygiene. In an interview on 02/24/26 at 11:10 a.m. with Agency RN H she stated she knew there was supposed to be a clean side and a dirty side of the caddy, and she stated she should have placed the glucometer in the cup by the sharps container since that side would be considered dirty. She stated by placing the glucometer on the side with the bottle of test strips after she had used it, it was no longer considered the clean side, and she had contaminated the test strips as well as the caddy. She stated the risk was the spread of blood borne pathogens to other residents. In an interview with the DON on 02/24/26 at 4:00 p.m. she stated the staff had all been in-serviced on the use of the caddy when obtaining blood sugars. She stated the caddy was supposed to have a clean side and dirty side. She stated the sharps container was on the dirty side with a plastic cup for the used for the glucometer after it was used and they were to discard the test strips, lancets and alcohol prep pad in the sharp's container. She stated the clean side was for the disinfected glucometer, a few test strips, not the whole bottle, and lancets and alcohol prep pads. She stated once the blood sugar was completed the glucometer needed to be placed on the dirty side until it was disinfected, and any remaining supplies not used should be discarded and not returned to the medication cart. She stated they had serviced the staff on numerous occasions but stated she was not sure if they had reviewed it with the Agency staff. She stated they do have an orientation packet the agency staff review and sign and stated they would be including the procedure for the use of diabetic caddy. She stated she was also going to label each (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	side of the caddy to clearly state clean side and dirty side. She stated the risk of not following the proper steps was cross contamination of the caddy, as well as any supplies placed in the caddy. 2. A medication pass observation on 02/25/26 at 7:40 a.m. revealed MA I at the medication cart. MA I began to pull Resident # 51's morning medications. MA I placed 2 gel caps of coenzyme Q10 (vitamin) 50 mg and 1 capsule of Lactobacillus acidoph-L.bulgar (probiotic) in a separate medication cup and the remaining morning medication tablets in a separate cup. MA I crushed the tablets and added them to a small medicine cup of protein supplement. MA I then opened the capsule of Lactobacillus with her bare hands and placed the content of the capsule in with the other crushed medications. She then retrieved a pair of scissors and cut the gel capsules of coenzyme Q10 and extracted the contents of the gel caps into the cup containing the other crushed medications and mixed them up. MA I then wiped the scissors off with a tissue. MA I entered Resident #51's room and administered the medications. In an interview with MA I on 02/25/26 at 8:05 a.m. she stated she was supposed to wear gloves when separating the capsules and stated it was a risk of infections when she touched them with her bare hands. She stated she should have sanitized the scissors with a sanitizing cloth instead of a tissue. She stated she was sorry she stated she just forgot. 3. In an observation of G-tube medication administration on 02/25/2026 at 8:32 a.m. Agency LVN G was at the medication cart preparing Resident #55's morning medication. A sign was posted outside of room which indicated he was on EBP. Agency LVN G entered room, washed her hands and put on gloves but no gown. Agency LVN G checked residual with air auscultation and drew back to check for residual. Agency LVN G then flushed the G-Tube with 30 cc of water and then administered medications one at a time with 10 cc of water flushes between each medication and finished with 30 cc of water. In an interview with Agency LVN G on 02/25/2026 at 08:50 a.m. she stated residents who had G-tubes were on EBP which meant staff were to wear gloves and gowns. She stated she just forgot about the gown. She stated the risk was spreading infections from residents to residents. 4. Record Review of Resident #86's physician order dated 2/20/2026 reflected EBP related to wound . In an observation on 02/24/2026 at 2:06 p.m. revealed EBP signage outside Resident #86's room and PPE kit with gloves, gowns and hand sanitizer placed outside the room. Resident #86 was observed sitting in her wheelchair in her room. CNA B and Hospice RN J were present inside Resident #86's room. Both CNA B and Hospice RN J performed hand hygiene and put on gloves but did not put on a gown. Both staff maneuvered the lift around Resident #86's chair and hooked the sling to the lift. They transferred the Resident to her bed by lowering the mechanical lift onto the bed. Hospice RN J adjusted Resident #86 legs in her bed. Hospice RN J proceeded to check Resident # 86's wound on her right heel. CNA B performed hand hygiene and took the mechanical lift and left the room. In an interview on 2/24/26 at 2:34 p.m. with CNA B revealed Resident #86 had wounds and she stated she was aware that EBP required wearing appropriate PPE which included gowns and gloves while providing close contact care for residents. She stated she should have worn a gown and gloves while transferring the resident to the bed with the mechanical lift. She stated the risk of not using appropriate PPE for EBP could cause spread of infection. In an interview on 02/24/2026 at 2:37 p.m. with Hospice RN J revealed she was aware Resident # 86 had stage three pressure ulcers on right heel. She stated EBP was used for residents with wounds, catheters, or any other infections while providing care including transfers. She stated she did not wear appropriate PPE including a gown before transferring the resident and examining her wound. She stated the risk of not using appropriate PPE for EBP could cause spread of infection. In an interview on 02/24/2026 at 2:52 p.m. with LVN A stated Resident #86 had orders for EBP related to wounds. She stated any resident on EBP required the use of appropriate PPE which included gowns and gloves while providing close contact care such as transfers. She stated the risk of not using appropriate PPE for EBP resident can cause lapses in infection control. In an interview on 02/26/26 at 10:35 a.m. with the DON she stated staff had been taught to use gloves when they had to separate capsules and never touch medications with their bare hands to prevent cross contamination plus prevent the risk of the staff absorbing the medication onto their skin. She stated MA I was a new (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication aid and they needed to do a little more training with her. She stated they had done multiple trainings on the use of Enhanced Barrier precautions and what PPE was required and when. She stated the signage also tells them every situation they are required to wear PPE for. She stated she expected the hospice staff to adhere to the protocol just like the facility staff. She stated she and the ADONs do spot checks to ensure compliance with infection control. She stated the staff had no excuse for not following the protocol. Record Review of the facility's undated protocol titled, Using Diabetic Caddy, reflected, .Ensure caddy is clean and disinfected. 1. On clean side you place 1 small drinking cup in which you put your supplies into 2 strips, prep and lancet. 2 Assure glucometer is clean and disinfected and place on clean side. 3. On dirty side you have a Sharps and a Blue top wipe (germicidal wipe) in bottom to put dirty glucometer on after blood sugar. 4. All dirty supplies lance, strip and bloody pad goes in sharps.DO NOT PLACE DIRTY GLUCOMETER ON CLEAN CART PUT ON BLUE TOP WIPE. Record review of the facility's policy titled, Medication Management Program, dated January 2025, reflected, .Administering the Medication pass.Perform hand hygiene.Do not touch the mediation when opening a bottle or unit dose package. Record review of the facility's policy titled, Transmission Based/Standard Precautions, and Enhanced Barrier Precautions, dated May 2023, reflected, Enhanced Barrier Precautions expand the use of PPE (gowns and gloves) during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.EBP will be implemented for All resident with the following.Wounds and/or indwelling medical devices (urinary catheter, feeding tube.)regardless of MDRO colonization status.EBP will be implemented during the following high-contact resident care activities.Transferring.Device care or use.feeding tube.

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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 interview, and record review, the facility failed to ensure the comprehensive care plan described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #7) of 5 residents reviewed for comprehensive care plans. The facility failed to ensure Resident #7 was care planned for limited range of motion related to his contracture. This failure could put Residents at risk of receiving unnecessary treatments, not receiving care or services and further decline of their physical health. Review of Resident #7's Face sheet dated 2/26/26 reflected a [AGE] year-old male with an initial admission date of 10/20/22 and readmission date of 9/9/25. The resident had the following active diagnoses: unspecified dementia, parkinsonism (a syndrome characterized by a combination of motor symptoms, slowness of movement along with tremor, rigidity and balance issues), Hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) and muscle weakness. Review of Resident #7's quarterly MDS assessment, dated 12/11/25, reflected no impairment in cognition with a BIMS score of 15. The resident had upper and lower extremity impairment on one side and used a wheelchair. Resident #7 was coded as not having had any therapy. Review of Resident #7's physician orders on 2/26/25 revealed an active order dated 9/10/25 Contractures (Location): Left hand and Left Elbow Review of Resident #7's comprehensive care plan revised on 2/2/26, reflected, .Problem Start Date: 9/9/25 Resident #7 has a history of Cerebrovascular Accident (Stroke) with Hemiplegia edited 2/2/26. Long Term Goal Target date: 5/2/26 Resident #7 will maintain current levels of ADLs and not have another Cerebrovascular Accident over the next 90 days edited 2/2/26 Approach Start Date: 9/9/25 Therapy referral as needed edited 9/10/25. An interview with ADON K on 02/26/2026 on 11:13 AM revealed the Resident #7 had a contracture and believed he had a brace on yesterday. ADON K stated the contracture, and interventions should have been in his care plan. ADON K stated it was the responsibility of ADONs and DON to update the care plans. An interview with the DON on 02/26/2026 at 11:32 revealed it was the MDS Nurse Coordinator's responsibility to put information in the care plan related to contractures and interventions. The DON stated a splint or any interventions for a contracture should have been put in a care plan. The DON stated she was unable to say what the risks to the resident would have been if his contracture was not in the care plan because it was a rehab thing. An interview with the MDS Nurse Coordinator on 02/26/2026 at 11:55 AM revealed he completed care plans for long term residents and completed Resident #7's care plan. The MDS Nurse Coordinator stated the resident had a contracture but had no splint. The MDS Nurse stated Resident #7's care plan had no interventions for his contracture. The MDS Nurse Coordinator reported he typically entered contracture interventions on resident care plans when rehab discussed them at their Interdisciplinary meetings or when a doctor's order was entered in their medical record. The MDS Nurse Coordinator stated Resident #7 had no interventions for his contracture in place, however he had entered the contracture to the care plan earlier that day under the portion related to Cerebrovascular Accident. The MDS Nurse Coordinator stated staff still monitored residents in the same way, thus not having it on the care plan would not affect his care. The MDS Nurse Coordinator stated the care plan was developed for staff as a guideline and items on the Care Plan were related to residents' needs and concerns. The MDS Nurse Coordinator stated not having had contracture interventions in the care plan did not affect the care of the residents because the residents would have gotten the same care and their needs were met regardless. Review of facility's policy Care Plan Process, Person-Centered Care revised May 5, 2023 reflected .11.The person-centered care plan includes.e. interventions, discipline specific services and frequency.h. resolution/goal analysis.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 (Resident #7) of 5 residents reviewed for range of motion. The facility failed to implement interventions to prevent further decline of Resident #7's contracture to his left hand upon discharge from therapy services on 9/3/25. This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Review of Resident #7's Face sheet dated 2/26/26 reflected a [AGE] year-old male with an initial admission date of 10/20/22 and readmission date of 9/9/25. The resident had the following active diagnoses: unspecified dementia, parkinsonism (a syndrome characterized by a combination of motor symptoms, slowness of movement along with tremor, rigidity and balance issues), Hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) and muscle weakness. Review of Resident #7's quarterly MDS assessment, dated 12/11/25, reflected lno impairment in cognition with a BIMS of 15. The resident had upper and lower extremity impairment on one side and used a wheelchair. Resident #7 was coded as not having had any therapy. Review of Resident #7's physician orders on 2/26/25 revealed an active order dated 9/10/25 Contractures (Location): Left hand and Left Elbow with no interventions listed. Review of Resident #7's comprehensive care plan revised on 2/2/26, reflected, .Problem Start Date: 9/9/25 Resident #7 has a history of Cerebrovascular Accident (Stroke) with Hemiplegia edited 2/2/26. Long Term Goal Target date: 5/2/26 Resident #7 will maintain current levels of ADLs and not have another Cerebrovascular Accident over the next 90 days edited 2/2/26 Approach Start Date: 9/9/25 Therapy referral as needed edited 9/10/25. Review of Resident #7's Occupation Therapy Discharge summary dated [DATE] revealed .Discharge Recommendations: Nursing to assess for Restorative Nursing Program. Restorative Program Established / Trained = Not Indicated at This Time. Function Maintenance Program Established/Trained = Not indicated at this time. An interview and observation with Resident #7 on 2/24/26 at 1:51pm revealed resident was unable to open and close his left hand. Resident #7 stated he used a roll at times, however he was unsure how often he needed to use it or for how long. He stated staff had not been prompting him to use the roll but he would put it on at night when his hand bothered him. An interview with CNA L on 02/25/2026 at 10:30 revealed she had never seen Resident #7 with objects in his left hand. She stated he could not use his left hand. CNA L stated she had not done any exercises with him nor put any splint or object in his left hand. An interview with Agency LVN G on 02/25/2026 at 10:42 AM revealed she was not aware of any splints or devices for Resident #7's contracture. Agency LVN G reviewed Resident #7's medical record and stated he had not had any orders for management of his contracture. Agency LVN G stated she had not found in his medical record any exercises or anything she should have been doing with Resident #7 to manage his contracture. An interview with the Assistant Director of Rehab on 02/25/2026 at 1:42 PM revealed Resident #7 was not on therapy services. Resident #7 was last on physical therapy on 11/17/25 and occupational therapy 9/3/25. The Assistant Director of Rehab stated Resident #7 was discharged from therapy due to him having reached his highest potential. The Assistant Director of Rehab stated Resident #7 had no recommendations for Restorative services and there were no orders for contracture management. The Assistant Director of Rehab stated if the resident had needed a splint there would have been an order and the CNAs would have been trained to put the splint on the resident. An interview with the Director of Rehab on 02/26/2026 at 9:08 AM revealed Resident #7 had physical therapy until about 10/25/25. The Director of Rehab stated Resident #7 had not gotten as much therapy as before because he was on Hospice. The Director of Rehab stated Resident #7 was discharged from Occupational therapy in September of 2025 with a hand roll as tolerated. The Director (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Rehab stated she was unsure of who was monitoring whether he was using the hand roll and she had not talked to any CNAs about the need for the resident to use the hand roll. The Director of Rehab stated she believed the Restorative Aid might have picked him up for services, but she was unsure. The handroll was to prevent any further contracture. The Director of Rehab stated she typically had not written orders for handrolls. The risk to the residents of not having had interventions in place for the contracture would have been the contracture could have gotten worse. The Director of Rehab stated although Resident #7 had no written contracture interventions the Rehab Department screened him every 90 days from his last service to assess him for needs and changes. An interview with Restorative Aid M on 02/26/2026 11:03 AM revealed Resident #7 was not on restorative services with her and he had never been referred to her. Restorative Aid M stated rehab had referred residents with contractures so she could do stretches and help monitor any devices the resident had such as a splint. Restorative Aid M stated if a resident needed a hand roll, rehab typically wrote an order, it was entered in the medical file and she was provided with a copy of it. She had never been provided with an order for Resident #7. An interview with ADON K on 02/26/2026 at 11:13 AM revealed Resident #7 had a contracture, and she remembered him having a brace on in the past week. ADON K stated braces and handrolls required an order so that staff were aware of their need to use them. ADON K stated if a resident hadn't worn their brace or handroll as prescribed by a doctor or therapist they would have been at risk for more damage to the contracted area. An interview with the DON on 02/26/2026 at 11:32 AM revealed it was the responsibility of therapy to ensure residents with contractions had the appropriate interventions. The DON reviewed Resident #7's orders and was unable to find any orders regarding contracture interventions. The DON stated if rehab made a recommendation for a splint or other intervention resident needed to have an order for it. The DON stated she was unable to say what the risks were of not having had interventions in place for Resident #7's contracture because that was a rehab thing. Record review of the facility's policy Restorative Nursing Policies and Procedures revised 10/25/24 .Patients/residents will be assessed for joint mobility limitation upon admission, re-admission, quarterly, annually and with significant changes through the comprehensive nursing assessment. A restorative program will be implemented through the care plan to increase, maintain or prevent deterioration of joint mobility and to maximize physical function when referral to therapy is not indicated or upon discharge from skilled therapy.Appropriate candidates for the Nursing Restorative Range of Motion Program may include, but are not limited to patients/residents with the following conditions: Contractures.

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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 and administering of all medications to meet the needs of each resident for one of six residents (Resident #15) reviewed for pharmacy services. The facility failed to ensure Agency RN H followed the manufacturer's instructions to prime (means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly) the Humalog pen (Insulin Lispro) (Hormone) prior to dialing in required amount of Insulin to be administered to Resident #15. These failures placed residents at risk of not receiving full dosage of medication. Findings included: Record review of Resident #15's, Face sheet, dated 02/26/26 reflected a [AGE] year-old female with an admission date of 02/05/26. Resident #15 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) Record review of Resident #15's Physician's Order for February 2026, reflected, Insulin lispro insulin pen: 100 unit/ml; amt: Per Sliding Scale; If blood sugar is. 181 to 220, give 4 units.before meals and at bedtime. with a start date of 02/05/26. An observation on 02/24/26 at 11:05 a.m. revealed Agency RN H performed hand hygiene and put on gloves and entered Resident #15's room to obtain a fingerstick blood sugar. The blood sugar reading was 214. Agency RN H returned to the medication cart and checked the computer to determine the amount of insulin per sliding scale was 4 units of Lispro insulin. Agency RN H retrieved the insulin pen from the medication cart and retrieved a needle for the insulin pen and re-entered Resident #15's room. Agency RN H removed the cap from the insulin pen, attached the needle and dialed in 4 units without priming the pen to ensure all air was expelled, and administered the insulin to Resident #15. In an interview with Agency RN H on 02/24/26 at 11:10 a.m. she stated she was unaware the she was required to prime the insulin pen before each injection. She stated she had been a nurse for 6 years and had never been told she had to prime the pen. She stated it made sense, because otherwise you do not know if the pen was functioning or didn't have air in the chamber. She stated going forward she would prime the pen before each time. In an interview with the DON on 02/26/26 at 10:30 a.m. she stated the insulin pen was to be primed with 2 units before each injection to ensure the air was out of the pen and to determine it was working correctly. She stated failure to do so could result in the resident receiving too little medication which could result in ineffective treatments and uncontrolled blood sugars. She stated all of the facility staff had been trained on the proper protocol but stated they will In-service the staff again as well as the Agency staff to ensure compliance. Record review of the facility's reference material titled, Insulin Pen Quick Reference Guide, dated 2021, reflected, Humalog (lispro) U100 Kwikpen .Air shot before each use-2 units hold dose knob for 5 seconds.References: Manufacturer Full Prescribing information and/or instructions for use. Review of the manufacture instructions for Lispro obtained from https://www.lillyinsulinlispro.com/ searched on 02/28/26 reflected, .Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle, and repeat priming steps.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for the facility's one (hall 300 cart) of four medication carts reviewed for storage. The facility failed to ensure Resident # 15's Lispro Insulin (Hormone) Pen, that was used on [DATE], was dated when opened. These failures could affect residents resulting in diminished effectiveness and not receiving the therapeutic benefits of the medications. The findings included: Record review of Resident #15's, Face sheet, dated [DATE] reflected a [AGE] year-old female with an admission date of [DATE]. Resident #15 had a diagnosis which included Type 2 diabetes (condition where the body cannot control blood sugar and use it for energy) An observation on [DATE] at 11:05 a.m. revealed Agency RN H performed hand hygiene and put on gloves and entered Resident #15's room to obtain a fingerstick blood sugar. The blood sugar reading was 214. Agency RN H returned to the medication cart and checked the computer to determine the amount of insulin per sliding scale was 4 units of Lispro insulin. Agency RN H retrieved the insulin pen from the medication cart. Observation of the insulin pen revealed no date on the pen indicating when it was opened. Agency RN H retrieved a needle for the insulin pen and re-entered Resident #15's room, removed the cap from the insulin pen, attached the needle and dialed in 4 units and administered the insulin to Resident #15. In an interview with Agency RN H on [DATE] at 11:10 a.m. she stated the Insulin pen was supposed to be dated when they opened a new pen. She stated she was not sure who opened the pen or when it was opened. She stated they were to discard Insulin 28 days after it was opened. She stated by not dating it could result in giving a resident expired insulin which could make it ineffective. In an interview with the DON on [DATE] at 10:30 a.m. she stated the insulin pen was to be dated once it was opened. She stated failure to do so could result in the resident receiving an expired medication which could result in ineffective treatments and uncontrolled blood sugars. She stated the nurses are responsible for dating the pens once they are opened. She stated the ADONs are responsible for checking the medication carts daily and she stated she does a weekly random check of medication carts. She stated they will In-service the staff again as well as the Agency staff to ensure compliance. Record review of the facility's policy titled, Medication Management Program, dated [DATE], reflected, .Prior to administering medications, the nurse is responsible for .Checking for expiration dates and removing any expired products.once any multi-dose packaged medication or biological is opened, nursing will mark multi-dose package with the date opened and follow guidelines for expiration dates.Humalog (lispro) U100 Kwik pen.in use storage.room temp 28 days.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident call system was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area from each resident's beside and toilet and bathing facilities for one (Resident #23) of six residents reviewed for physical environment. The facility failed to ensure Resident #23's toilet and shower call button were working in resident's bathroom. This failure placed residents at risk of a delay in resident getting assistance from staff.Findings included: Review of Resident #23's face sheet undated reflected Resident #23 was an [AGE] year old female admitted to the facility on [DATE] with diagnoses of dementia (loss of memory, language and problem solving, thinking abilities severe enough to interfere with daily life), type 2 diabetes (chronic condition in which the body resists insulin or fails to produce enough, causing high blood sugar), heart disease and abnormalities of gait and mobility. Review of Resident #23's MDS assessment dated [DATE] reflected Resident #23 had a BIMS score of 15 indicating she was cognitively intact. Resident #23 required substantial/maximal assistance with ADLs. Observation and Interview on 02/24/2026 at 10:02 AM of Resident #23's emergency shower and toilet revealed the call light in bathroom did not work. The call lights did not light up when pulled down. The shower call light in bathroom had tape on it. Resident #23 stated the shower call light had been out for a couple of weeks and the Administrator along with Maintenance were aware of it. She was not aware the toilet call light was not working. Observation and Interview on 02/24/26 at 10:11 AM Aide C stated both the shower and toilet call lights in Resident #23's bathroom were not working. She was not aware of it until now. Interview on 02/25/2026 at 11:36 AM with Administrator revealed Maintenance Supervisor had been on leave for about 3 weeks and he was assisting while Maintenance was out. He stated he was not aware of any issues with Resident #23's shower and toilet call lights not working until yesterday when it was brought to his attention after surveyor notified his staff. He stated contract company came to look at Resident #23's call light in shower and toilet yesterday afternoon. He stated they had to order a part in order to fix it. He stated the risk to a resident is he or she could fall and there could be a delay in getting assistance. Review of facility's policy Safety and health Policies and Procedures last revised 12/20/24 reflected Call-light is to be easily accessible to the patient. It did not specify the working condition of the call lights.