STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676424	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farmersville Health and Rehabilitation	205 Beech St Farmersville, TX 75442

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medical treatment and personal care and confidentiality of personal and medical records for four of twenty residents (Resident #1, #36, #69, and Resident #75) reviewed for privacy and confidentiality. The facility failed to ensure LVN E pulled the privacy curtain while connecting Resident #1's formula to his g-tube on 03/15/2026. The facility failed to ensure CNA J provided privacy while transferring Resident #36 on 03/16/2026. The facility failed to ensure LVN E closed, locked, or minimized her laptop monitor before leaving her cart, thus exposing Resident #69's medical information, on 03/15/2026. The facility failed to ensure RN D did not disclose Resident #75's treatment to her roommate and the roommate's family member on 03/16/2026. These failures could place the residents at risk of not having their personal privacy maintained while treatment and care were provided, which could result in the residents feeling uncomfortable during treatment and having their personal and medical record exposed to unauthorized individuals.Findings included: Record review of Resident #1's Face Sheet, dated 03/16/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support). Record review of Resident #1's Quarterly MDS Assessment, dated 02/24/2026, reflected that the resident had severe cognitive impairment (resident required significant assistance and support in daily life) with a BIMS score of 03. The Quarterly MDS Assessment indicated that the resident had a feeding tube (medical device that helps deliver nutrition and medication directly to the person's stomach). Record review of Resident #1's Comprehensive Care Plan, dated 03/05/2026, reflected the resident required a PEG tube (procedure to place a feeding tube in the stomach), (a flexible feeding tube inserted directly to the stomach) and one of the interventions was to check for placement and gastric residuals (food, liquid, and secretions remaining in the stomach). Record review of Resident #1's Physician Order, dated 02/26/2026, reflected Enteral Feed (delivery of food through feeding tube). Order every 4 hours G-TUBE - FLUSH [routine] = Flush g-tube w/ 225 cc of water Q 4 hours. HOB elevated 30-45 degrees at all times. Check tube placement prior to each feeding, meds and fluids per auscultation (listening to the sounds produced within a body using a stethoscope) and residual Q shift. If 100 cc, HOLD feeding. Record review of Resident #1's Physician Order, dated 02/09/2026, reflected Enteral Feed Order every shift G-TUBE - ENTERAL FORMULA [CONTINUOUS] = Enteral Formula: NUTREN 2.0 @ 50 cc for 22 hours/day via g-tube and pump. Head of bed elevated 30-45 degrees at all times. During an observation on 03/15/2026 at 1:04 PM revealed LVN E was about to connect Resident #1's enteral formula to his g-tube. She went inside the resident's room and started the process. It was observed that Resident #1 was in a wheelchair and his roommate was sitting at the side of the bed facing Resident #1. LVN E did not pull the privacy curtain while she was connecting Resident #1's feeding formula. During an interview on 03/15/2026 at 2:06 PM, LVN E said she should have pulled the privacy curtain when she was connecting Resident #1's feeding formula because his roommate was in the room. She said she closed the door so that nobody from the hallway could see the treatment she was providing. She said she should have pulled the privacy curtain to (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide privacy from the Resident's roommate. During an observation and interview on 03/15/2026 at 2:12 PM revealed when Resident #1 was asked if it was okay that his roommate could see what treatment was being done to him, the resident did not reply. Record review of Resident #36's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness. Record review of Resident #36's Comprehensive MDS Assessment, dated 02/25/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated that the resident required maximal assistance for transfer. Record review of Resident #36's Comprehensive Care Plan, dated 03/01/2026, reflected the resident required assist with ADLs and one of the interventions was to provide level of support to complete transferring needs every shift. During an observation on 03/16/2026 at 2:26 PM revealed CNA J was about to transfer Resident #36 from wheelchair to bed. She ushered the resident to her room and positioned the resident parallel to the bed. She sanitized her hands and put on a pair of gloves. She then transferred the resident to her bed using the stand and pivot. It was observed that Resident #36's roommate was in her bed, awake. CNA J did not pull the privacy curtain and did not close the door while transferring the resident. During an interview on 03/16/2026 at 2:35 PM, CNA J said she should have pulled the privacy curtain and closed the door to provide privacy during Resident #36's transfer. She said she did not know why she forgot to close the door and pull the privacy curtain since the resident's roommate was inside the room. During an observation and interview on 03/16/2026 at 2:41 PM revealed when Resident #36 was asked if it was okay if she was being transferred with the door open, the resident shrugged her shoulders. Record review of Resident #69's Face Sheet, dated 03/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic pain and gastro-esophageal reflux disease (stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of Resident #69's Comprehensive MDS Assessment, dated 01/24/2026, reflected that the resident had moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 10. The Comprehensive MDS Assessment indicated that the resident had chronic pain and gastro-esophageal reflux disease. Record review of Resident #69's Comprehensive Care Plan, dated 03/01/2026, reflected the resident was on opioid (medication for pain) medication as part of pain management and the interventions were to administer opioid medication as prescribed by the physician and to monitor for constipation. The plan indicated that the resident was using an anticoagulant and one of the interventions was to monitor diarrhea. Record review of Resident #69's Physician Order, dated 02/24/2026, reflected Mylanta Maximum Strength Oral Suspension 400-400-40 MG/5ML (Alum & Mag Hydroxide-Simethicone) Give 15 ml by mouth every 4 hours as needed for GI UPSET Give 15ML (=1200-1200-120MG) Record review of Resident #69's Physician Order, dated 02/24/2026, reflected Senna Oral Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth every 24 hours as needed for CONSTIPATION. Record review of Resident #69's Physician Order, dated 02/24/2026, reflected Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug* Give 1 tablet by mouth every 8 hours as needed for pain. Record review of Resident #69's Physician Order, dated 02/24/2026, reflected Tylenol Tablet 325 MG (Acetaminophen). Give 2 tablets orally every 6 hours as needed for PAIN/ELEVATED TEMP Give 2tabs (=650MG) Document level of pain [0-10]. In progress note describe pain scale used and location of pain and any painbehaviors observed. DO NOT EXCEED 3,000MG/DAY OF ACETAMINOPHEN FROM ALL SOURCES UNLESS APPROVED BY MD. During an observation on 03/15/2026 at 9:17 AM revealed a cart was parked in a hallway. On top of the cart was a laptop with its screen open and displayed Resident #69's name, date of birth , name of his physician, location, code status, allergies, special instructions, her latest vital signs, her latest weight, her latest pain level, and some of her medications. The screen of the laptop was facing the hallway and was unattended. During an observation and interview on 03/15/2026 at 9:21 AM, LVN E said she went to check on a resident, that was why she left her cart. She said it was a HIPAA violation because the personal and medical information of Resident #69 was exposed. She (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the said information should be secure and confidential. Record review of Resident #75's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #75's Comprehensive MDS Assessment, dated 01/30/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had diabetes mellitus (high blood sugar). Record review of Resident #75's Comprehensive Care Plan, dated 02/12/2026, reflected the resident had diabetes mellitus and the intervention was to administer diabetic medications as ordered. Record review of Resident #75's Physician Order, dated 03/13/2026, reflected FINGERSTICK BLOOD SUGAR - AC & HS = Fingerstick blood sugar [BBG/FSBS] before meals and at bedtime. Document results. IF FSBS LESS THAN 69 ORGREATER THAN 400 AND UNRESOLVED, NOTIFY PHYSICIAN before meals and at bedtime. During an observation on 03/16/2026 at 11:40 AM revealed Resident #75 was in her bed, awake. It was observed that RN D was about to check the resident's blood sugar. It was also observed that the resident's roommate and the roommate's family member were inside the room. RN D told the resident and the roommate's family member that she needed to pull the privacy curtain because she needed to check Resident #75's blood sugar. During an interview on 03/16/2026 at 11:55 AM, RN D said getting the blood sugar of Resident #75 was a medical treatment and should not be disclosed to anybody that did not have anything to do with resident care. She said she should be mindful before talking about a resident's medical condition or treatment because their medical information should be confidential. During an interview on 03/16/2026 at 12:03 PM, Resident #75 said she was not aware about it was not right to share with anybody about one's medical information. During an interview on 03/17/2026 at 7:02 AM, ADON A said the staff should close the door and/or pull the privacy curtain when they were providing treatment and care to the residents. She said the staff needed to get used to providing privacy during treatment and care so that individuals that did not have anything to do with the residents' care would not see it. She said it did not matter if the residents mind or not, but the expectation was for the staff should be sensible enough that if they were in the residents' position, they might want their door closed or the privacy curtain pulled during treatment. She said checking the blood sugar was a medical procedure and should not be disclosed to anyone. She said disclosing a medical procedure to somebody that had nothing to do with the resident's care could be a HIPAA violation. She said, aside from disclosing medical information, leaving the laptop open with resident's medical information open could also be a HIPAA violation because the medications and the vital signs of the resident were exposed. She said the expectation was that residents were given privacy during care and treatment and that the staff would secure the residents' personal and medical information. She said the DON had already initiated an in-service about privacy and confidentiality of medical information. During an interview on 03/17/2026 at 7:41 AM, the DON said personal and medical information about a resident should not be disclosed to anybody that had nothing to do with the resident's care because it was a HIPAA violation. She said leaving the computer open with a resident's medical information exposed was also a HIPAA violation. She said the medical information of a resident should be protected and could not be shared without the permission of the resident or the resident's responsible party. She said the door should be closed every time the staff provided care or treatment to give privacy and prevent improper exposure of any body part. She said if somebody else was inside the room, the privacy curtain should be pulled for the same reason. She said other individuals, like non-clinical personnel, visitors, and other residents, would see the treatments being done and might cause embarrassment. 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 and confidentiality of information for all residents. The DON stated she had already started an in-service about privacy during care and treatment and about confidentiality of medical information. During an interview on 03/17/2026 at 8:12 AM, the Administrator said the staff should not disclose any medical information about a resident to another resident or to their family member because it was a HIPAA violation. She said leaving the computer (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	open, with exposed medical information about a resident, was also a HIPAA violation. She said medical information should be secured because it was confidential. She said the staff must make sure that the residents were provided privacy during treatment and transfer to avoid any discomfort or embarrassment. She said the expectation was for the staff to be mindful about privacy when providing treatment and secure all the medical information. She said the DON already started an inservice about HIPAA and providing privacy to the residents during care and treatment, but she would monitor closely if the staff understood the in-service. Record review of the facility's policy, Resident Rights Policy Operational/Resident Care Policies, undated reflected Privacy and Confidentiality . Residents' personal and clinical records are protected to assure confidentiality . Personal privacy will be provided for . medical treatment . personal care. Record review of the facility's in-service Privacy, dated 03/15/2026, reflected Remember to provide privacy to residents by pulling the curtain or closing the door. Record review of the facility's In-Service HIPAA, dated 03/16/2026, reflected Remember when performing cares or administering medications to residents, be mindful of HIPAA rules when the roommate is present. Record review of the facility's in-service HIPAA, dated 03/17/2026, reflected If you walk away from your computer, be sure to close or turn off your screen.

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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 five of eighteen residents (Residents #4, #17, #38, #51, and #67) reviewed for medication storage. 1. The facility failed to ensure an antifungal powder was not inside Resident #4's room and his medication was not left with him to take unattended on 03/15/2026.2. The facility failed to secure Resident #4's TUMS when it was left inside his room on 03/15/2026. 3. The facility failed to ensure an eyedrop was not inside Resident #17's room on 03/15/2026. 4. The facility failed to ensure an antifungal powder and a wound cleanser were not inside Resident #38's room on 03/15/2026. 5. The facility failed to ensure a cup of barrier cream was not inside Resident #51's room on 03/15/2026. 6. The facility failed to ensure an antifungal powder was inside Resident #67's room on 03/15/2026. 7. The facility failed to ensure the Treatment Nurse did not leave the dressing with medication inside the Resident #38's room on 03/16/2026. 8. The facility failed to ensure that the treatment cart was locked when left unattended on 03/15/2026. 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 #4's Face Sheet, dated 03/15/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dementia. Record review of Resident #4's Comprehensive MDS Assessment, dated 03/07/2026, reflected the resident had severe impairment in cognition with a BIMS score of 05. The Comprehensive MDS Assessment indicated the resident had dementia. The assessment did not indicate that the resident had a skin issue. Record review of Resident #4's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had impaired cognitive function and one of the interventions was to monitor any changes in cognitive function. During an observation on 03/15/2026 at 10:38 AM revealed Resident #4 was not inside his room. It was observed that there was a container of anti-fungal powder on top of the resident's drawer. During an observation and interview on 03/15/2026 at 10:46 AM, ADON A said antifungal powder should not be inside the residents' rooms and should be stored inside the carts. She said the medications should be secured so the residents, especially the confused resident, would not get a hold of them and misuse them. She said the staff should be mindful that no medications were inside the rooms. She said this was not only applicable for the nurses, but the CNAs must report to the nurse if they saw any. She went inside Resident #4's room and saw the anti-fungal powder on top of the resident's drawer. She took the anti-fungal powder and said she would put it inside a plastic bag and put the resident's name on it. During an interview on 03/17/2026 at 10:59 AM, Resident #4 said he did not have any rashes, so he did not know why there was an antifungal powder inside his room.2. Record review of Resident #4's Face Sheet, dated 03/15/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastro-esophageal reflux disease and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #4's Comprehensive MDS Assessment, dated 03/07/2026, reflected the resident had severe impairment in cognition with a BIMS 05. The Comprehensive MDS Assessment indicated the resident had gastro-esophageal reflux disease and dementia. Record review of Resident #4's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had impaired cognitive function and one of the interventions was to monitor any changes in cognitive function. Record review of Resident #4's Physician's Order, dated 02/23/2026, reflected Calcium Carbonate Tablet Chewable 500 MG Give 2 tablet by mouth every 12 hours as needed for indigestion AND Give 1 tablet by mouth three times a day for phosphorus binder (medication that prevents high level of phosphorus in the blood) give with (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meals. Record review on 03/15/2026 of Resident #4's Assessment Notes reflected that the resident did not have an assessment for self-administration of medication. During an observation on 03/15/2026 at 10:38 AM revealed Resident #4 was not inside his room. It was observed that there was a small plastic cup with a pill on top of the resident's drawer. During an observation and interview on 03/15/2026 at 10:48 AM, MA F said during medication administration, the staff administering the medications should stay with the resident to make sure that the resident took the medications. She went inside Resident #4's room and saw the medication that was inside a small cup. She said the medication was TUMS and was given three times a day. She said she gave the resident morning medication, including his TUMS, and the resident took all his morning medications. She said she did not notice the TUMS on top of the resident's drawers, and she did not know who left the medication with the resident to take unattended. She said medications should be secured inside the cart. she said if the resident did not take the medication, then it should have been discarded. She said the resident might take it with the next dose that could lead to overdosing. She took the cup with TUMS in it and discarded it. During an interview on 03/16/2026 at 7:01 AM, RN E said she would sometimes help in passing medications if needed. She said she did not pass medication prior to Sunday, 03/15/2026. She said medications should not be inside the residents' room but locked inside the cart because residents might use them inappropriately.During an interview on 03/15/2026 at 10:46 AM, ADON A said Resident #4's TUMS should not be inside the room but inside the cart. she said if the resident did not take it, then it should have been disposed. She said the resident might take them more that what was recommended or someone else might, like another resident or a visitor. She said the resident might aspirate or choke while taking the medications, and nobody would know. She said the DON had already started an in-service about not leaving the medications with the residents. 3. Record review of Resident #17's Face Sheet, dated 03/16/2026, 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). Record review of Resident #17's Comprehensive MDS Assessment, dated 03/05/2026, 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 had depression. Record review of Resident #17's Comprehensive Care Plan, dated 01/18/2026, reflected that the resident was using an anti-depressant and one of the interventions was to administer medications as ordered. Record review on 03/16/2026 of Resident #17's Physician's Order reflected no order for eyedrops. During an observation and interview on 03/15/2026 at 10:53 AM revealed that Resident #17 was in her bed, awake. It was observed that a container of eye drops was on her windowpane. The resident said she did not know if the staff knew about the eyedrops being inside her room, but it had always been in her windowpane. She said she was not using the eyedrops. During an observation and interview on 03/15/2026 at 10:58 AM, ADON A said, just like the anti-fungal powder, the residents could not have eye drops inside their rooms because the staff were the ones administering the eye drops. She said she was not even sure if the resident had an order for the eyedrops. She went inside Resident #17's room and talked to the resident regarding the eyedrops. She told the resident that she would put the eyedrops in the cart and request an order for it. 4. Record review of Resident #38's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dementia and a non-pressure ulcer (wound not caused by pressure) of the left foot. Record review of Resident 38's Comprehensive MDS Assessment, dated 03/05/2026, reflected that the resident had severe impairment in cognition with a BIMS score of 04. The Comprehensive MDS Assessment indicated the resident had dementia and non-pressure ulcer of the left foot. Record review of Resident #38's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had impaired cognitive function and one of the interventions was to administer medications as ordered. Record review of Resident #38's Physician's Order, dated 02/09/2026, reflected Clean abrasions/skin tears with normal saline. Apply steri-strips as needed. Apply protective dressing as needed. Change daily and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prn. Monitor until healed. During an observation and interview on 03/15/2026 at 9:07 AM revealed Resident #38 was in his bed, awake. It was observed that a container of anti-fungal powder and wound cleanser were on top of his shelf. When asked about the anti-fungal powder and wound cleanser, the resident shrugged his shoulders. During an interview on 03/16/2026 at 9:00 AM, the Treatment Nurse said she was using normal saline for the Resident #38's wound care, so she did not know who used a wound cleanser for wound care. 5. Record review of Resident #51's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dementia and muscle weakness. Record review of Resident #51's Comprehensive MDS Assessment, dated 02/13/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment indicated the resident was incontinent (unable to control) for bladder and bowel. Record review of Resident #51's Comprehensive Care Plan, dated 02/24/2026, reflected that the resident was incontinent for bladder and bowel and one of the interventions was to do perineal (area between the thighs) care after each incontinent episode. Record review of Resident #51's Physician's Order, dated 02/09/2026, reflected May apply skin protectant/barrier cream to affected/reddened areas every shift and/or prn as preventative. During an observation and interview on 03/15/2026 at 9:11 AM revealed Resident #51 was in his bed awake. It was observed that a small cup with white cream was on top of the resident's side table. The resident said the staff used the cream when they cleaned and changed him. He said he did not know who left the cup of cream on his side table. During an observation and interview on 03/15/2026 at 9:29 AM, LVN E said the antifungal powder and the wound cleanser should not be inside Resident #38's room because the resident might use them inappropriately or might use them more than the recommended. She said confused residents might consume them as well; that could result in upset stomach and nausea. She said she knew the resident had a wound that was being treated, but she said she was not sure why the resident had an anti-fungal powder inside his room. She went inside the room and took the anti-fungal powder and the wound cleanser and said she would put them in the treatment cart. During an observation and interview on 03/15/2026 at 9:32 AM, LVN E then went to Resident #38's room and saw the cup of white cream on top of Resident #51's side table. She said, most probably, it was barrier cream that was used when the resident was being changed. She took the cup of barrier cream and disposed of it. She said the barrier cream should not be also inside the residents' rooms for the same reason as the antifungal powder and wound cleanser. 6. Record review of Resident #67's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia. Record review of Resident #67s Comprehensive MDS Assessment, dated 02/15/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had moisture associated with skin damage. Record review of Resident #67's Comprehensive Care Plan, dated 02/24/2026, reflected that the resident had a rash under left breast related to moisture and one of the interventions was to administer nystatin powder as ordered. Record review of Resident #67's Physician's Order, dated 07/23/2025, reflected Nystatin Powder (Nystatin (Bulk)) Apply to Under Left Breast topically one time a day for yeast. During an observation, an interview on 03/15/2026 at 12:23 PM revealed Resident #67 was in her bed, awake. It was observed that she had a small white cart at the bedside. On the second tier of the cart was a container of an antifungal powder. The resident said the staff were using the powder for the rash under her breast. She said after the staff use the antifungal powder; they would return it to her cart. During an interview on 03/16/2026 at 8:55 AM, CNA I said she was not aware there was an anti-fungal powder inside Resident #67's room. She said the powder should be in the cart of the nurses. She said the residents might use them inappropriately, or confused residents might use them to powder their faces. She said she would go to the resident's room and would check if the anti-fungal powder was still inside the room. She said the barrier creams should not be inside the rooms of the residents for the same reason. 7. Record review of Resident #38's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old male admitted to the facility on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farmersville Health and Rehabilitation	205 Beech St Farmersville, TX 75442

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE]. The resident was diagnosed with a non-pressure chronic ulcer on the left foot. Record review of Resident 38's Comprehensive MDS Assessment, dated 03/05/2026, reflected that the resident had severe impairment in cognition with a BIMS score 04. The Comprehensive MDS Assessment indicated the resident had a non-pressure chronic ulcer of the left foot. Record review of Resident #38's Comprehensive Care Plan, dated 03/12/2026, reflected that the resident had a chronic venous/stasis ulcer of the left lower leg r/t PVD and one of the interventions was to treat the wound as ordered. Record review of Resident #38's Physician's Order, dated 02/09/2026, reflected LEFT LOWER EXTREM - VASCULAR WOUND - Cleanse with NORMAL SALINE, pat dry with GAUZE, apply MUPIROCIN, apply CALCIUM ALGINATE, cover with, DRY DRESSING secure with ROLLED GAUZE, and ELASTIC COMPRESSION WRAP one time a day for wound care. During an observation on 03/16/2026 at 9:15 AM revealed the Treatment Nurse was about to do Resident #38's wound care. She sanitized her hands and put on a pair of gloves. She then sanitized the resident's overbed table. She took off her gloves, sanitized her hands, and put on a pair of gloves. She then prepared some normal saline, mupirocin ointment, calcium alginate, some gauze, and a dry dressing. She placed the things needed for wound care on top of the resident's overbed table. She then put the mupirocin ointment on top of the dressing. She pushed the resident's overbed table and placed it at the bedside. When she was about to start wound care, she asked the resident if he was in pain; the resident said he was in pain with a pain scale of 8/10. She told the resident that she would ask the nurse to give him a pain medication. She went to the nurse's station and left the dressing with medication at bedside. During an interview on 03/16/2026 at 9:31 AM, the Treatment Nurse said she should have not left the dressing with medication on it when she went out of Resident #38's room to call the call at the nurse's station. She said the resident, if confused, might consume it. She said she should have flagged a staff to call the nurse, or she should have discarded the dressing with medication and prepared another one once the pain medication was administered. 8. During an observation on 03/15/2026 at 9:17 AM revealed a cart parked in the hallway was not locked. It was observed that there were two tubes of topical antibiotics on the first drawer of the cart. The cart was facing the hallway and was unattended. It was observed that several residents were passing-by the unlocked cart During an observation and interview on 03/15/2026 at 9:21 AM, LVN E said the carts should be locked when left unattended because the residents could open the drawers and could get medications from the drawer and consume them. She said she did not know who left the treatment cart open. She then locked the cart. During an interview on 03/17/2026 at 7:02 AM, ADON A said the Treatment Nurse should have pushed the call light so that she could let somebody tell the nurse that the resident needed a pain pill. She said she could have called from outside the room, with the dressing with medication still within her vision. She said any cart should be left unlocked because the resident might be able to open the drawers and get medications that they do not need. She said the DON already started an in-service about not having any medications inside the rooms of the resident and not leaving the carts unlocked. She said the in-service was for the CNAs also because the CNAs must report to the nurse if they saw any medication inside the rooms of the residents. She said the DON had already started an in-service about medication storage. During an interview on 03/17/2026 at 7:41 AM, the DON said medications, of any form, should not be stored inside the residents' rooms. She said nasal antifungal powder, eye drops, and barrier creams should be inside the carts to secure them. She said the staff should be the one administering them if the residents had orders for the said medications. She said the residents might use them inappropriately that could result in adverse reactions. She said the Treatment Nurse should have called somebody to call the nurse for the pain pill instead of leaving the medicated dressing inside the room unattended. She said all the carts should be locked when the staff were not using the carts because the residents and visitors could get medications from the drawers. She said residents might consume the medication they took from the cart that they were allergic to. She said the expectation was there would be no medications inside the rooms of the residents, that staff should scan the room for any medications, and the carts would be (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	locked when the staff were not using them. She said she already started an in-service about medication storage and not locking the carts. During an interview on 03/17/2026 at 8:12 AM, the Administrator said that the expectation was for the staff to make sure there was no medications inside the rooms of the residents because the residents might consume the medications or use them inappropriately. She said the carts should be locked before the staff left the carts unattended. She said the DON already started an in-service about not storing medications inside the rooms of the residents and to lock the carts always. Record review of the facility's policy, Medication Cart, reflected Procedure . 16. If the cart is left at any time . it must be locked. Record review of the facility's policy, Storage of Drugs Operational/Resident Care Policies, undated, reflected All drugs and biologicals are stored in locked compartments . Only authorized personnel are permitted to have access to the medication keys. Record review of the facility' policy, Drug Security Operational/Resident Care Policies, undated, reflected A drug distribution cart is used by the facility and when not in use it will be locked. Record review of the facility' policy, Drug Orders Operational/Resident Care Policies, undated, reflected All drugs must be prescribed by the resident's physician or consulting physician.

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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 one of one kitchen reviewed for food and nutrition services. The facility failed to ensure dietary staff properly labeled and dated stored food received by vendors.The facility failed to ensure the ice machine was thoroughly cleaned and/or sanitized.The facility failed to ensure the serving table had the appropriate amount of sanitizer in the container (red bucket) for sanitization.The facility failed to ensure the deep fryer was properly cleaned.The facility failed to ensure expired food in the refrigerator was discarded. These failures could place residents at risk of exposure to food contamination and illness. Findings included:Observations on 03/15/26 from 9:05 a.m. to 9:16 a.m. in the facility's only kitchen revealed: The deep fryer in the kitchen area had extremely dark grease and built-up brownish stain along the inside walls of the fryer. One plastic bag of sliced cheeses, located in the refrigerator, was dated 2/16/26 and another date of 3/10/26. One silver container labeled sandwiches, located in the refrigerator, was dated 3/11/26 to 3/14/26. Item should have been discarded. One large bag with a yellow substance (later identified as scrambled eggs), located in the refrigerator, was not labeled and dated. One large container of frozen apple streusel coffee cake, located in the freezer, was dated with a stored date of 9/03/25. An ice machine, located in the kitchen had reddish stains along the inside white panel wall of the ice machine and white stains along the inside of the opening door.During an interview and observation on 03/16/26 at 11:34 p.m., the DM and [NAME] O tested the Red bucket, which was supposed to contain sanitizer solution to sanitize the serving table during lunch. The DM used a test strip to test the PPM and the test indicated no sanitizer fluid was present. [NAME] O stated she had tested the solution during the breakfast serving and it tested at 200 PPM, she stated she was not sure why it tested at 0 PPM for the lunch serving. The DM stated they tested the solution in the Red bucket every meal prior to serving the meals. She stated if the solution did not have the appropriate amount of sanitizer fluid in the solution, it would not decontaminate the surface.During an interview on 03/16/26 at 12:34 p.m., the DM was shown photos of the concerns observed in the kitchen area on 03/15/26. She stated she had spoken with her staff later that day and was informed of some of the concerns. She stated she cleaned the fryer every two weeks, but the cooks forgot to strain the grease daily. She stated she had cleaned the deep fryer on 03/15/26. She stated she had observed some of the foods not labeled and dated and had since labeled and dated the foods. She stated she had someone clean the ice machine. She stated she was unsure of the expiration date for the food when there was no expiration date on them and would have to research it. She stated the concerns observed could result in food contamination and residents getting sick.During an interview on 03/17/26 at 12:00 p.m., the Administrator was informed of the concerns observed in the kitchen area. She stated she had spoken with the DM and was informed of the findings. She stated she expected her kitchen to meet guidelines to avoid infection and food contamination. Record Review of the Facility's policy titled Proper labeling and dating, undated, revealed, Food must be labeled and dated. Why labeling and dating is important. Protects residents from foodborne illnesses. Maintains food quality and freshness. Ensures proper food rotation. Required during state and health inspections. Foods that must be labeled. All foods must be labeled when stored in refrigerators, freezers, or dry storage. Ready to eat food must be discarded after 7 days. Food must be discarded if past discard date. It is the policy of this facility that the food services shall be maintained in a clean and sanitary manner. 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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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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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 6 residents (Resident #20) reviewed for care plan. The facility failed to ensure Resident #20's care plan reflected a plan of care for the resident's use of a Nebulizer. This failure could place the resident at risk of not receiving the necessary care and services.Findings included:Record review of Resident #20's Face Sheet, dated 03/16/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 had a diagnosis of COPD (lung disease).Record review of Resident #20's Quarterly MDS Assessment, dated 02/10/26, reflected Resident #20's BIMS (11) indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnosis of COPD.Record review of Resident #20's Physician orders, dated 03/16/26, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/ML 1 vial inhale every 6 hours for COPD. Nebulizer - Clean and change tubing every week on Sunday. Record review of Resident #20's Comprehensive Care Plan, dated 01/25/26, did not reflect a plan of care for the use of the Nebulizer. During an observation on 03/15/26 at 10:29 a.m., Resident #20 had a nebulizer mask sitting on top of her nightstand unbagged.During an interview on 03/17/26 at 09:15 a.m., the DON was informed of Resident #20 not being care planned for the use of a nebulizer. She stated it was the MDS nurse's responsibility to ensure care plans were updated with the resident's plan of care because they had orders for the use of a nebulizer. She stated not care planning the use of the nebulizer could result in missed care.During an interview on 03/17/26 at 09:30 a.m., the MDS nurse was informed of Resident #20 not being care planned for the use of a nebulizer. She stated she thought the intervention of the resident using the broad term of the resident's use of an aerosol/bronchodilator was sufficient. She was informed Resident #20 had physician orders for an aerosol/bronchodilator medication; however, it was orders for a different form of medication, and the resident's care plan was not specific to the referencing the resident's use of the nebulizer. She stated the intervention should include the use of the nebulizer because it was part of her plan of care.During an interview on 03/17/26 at 10:20 a.m., ADON B was informed of Resident #20 not being care planned for the use of a nebulizer. She stated it was the MDS nurse's responsibility to ensure care plans were updated with the resident's plan of care. She stated not care planning the use of the nebulizer could result in the resident not receiving the care needed. She stated as a nurse it should have been care planned. Record review of the facility's policy, Comprehensive Person-Centered Care Planning, undated, reflected The facility will develop and implement a Comprehensive Care plan in place of the baseline care plan for each resident that includes instructions needed to provide effective person-centered care of the resident that meet professional standards of quality of care. The care plan will include the minimum healthcare information necessary to properly care for a resident including, but not limited to, B. Physician Orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one of two residents (Resident #2) reviewed for feeding tube management. The facility failed to ensure LVN E flushed Resident #2's g-tube before administering the resident's bolus feeding on 03/15/2026. This failure could place residents with g-tubes at risk for tube displacement, clogging, aspiration, and discomfort.Findings included: Record review of Resident #2's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #2's Comprehensive MDS Assessment, dated 01/06/2026, reflected that the resident had moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #2's Quarterly Care Plan, dated 01/14/2026, reflected that the resident required a PEG and one of the interventions was to check for tube placement and gastric residual (food, liquid, and secretions remaining in the stomach) before initiating feeding. Record review of Resident #2's Physician Order, dated 03/11/2026, reflected every 4 hours G-TUBE - FLUSH [routine] = Flush g-tube w/ 200cc of water Q 4 hours. HOB elevated 30-45 degrees at all times. Check tube placement prior to each feeding, meds and fluids per auscultation (listening to the sounds produced within a body using a stethoscope) and residual (food, liquid and secretions remaining in the stomach) Q shift. If 100cc, HOLD feeding. During an observation on 03/15/2026 at 1:44 PM revealed LVN E was about to give Resident #2's bolus feeding (giving large doses of formula through g-tube several times a day) via g-tube. She sanitized her hands, prepared one big cup of water and four small cups of water, and placed the cups of water on a tray. She went inside the room and placed the tray on the resident's overbed table. She took a small box of feeding formulas and a 60 ml piston syringe and placed them on the tray. She sanitized her hands and put on a gown. She checked for placement and gastric residuals. After checking the placement and the gastric residual, she pulled the plunger out of the syringe and attached it to the g-tube. After attaching the syringe to the g-tube, she took the feeding formula from the tray and poured some into the barrel of the syringe attached to the g-tube. She did not flush the g-tube prior to pouring the formula. She then poured 30 ml of water into the formula inside the syringe. She did it twice. She continued to pour the formula until the box was empty. After the formula was consumed, she flushed the g-tube with 30 ml of water and detached the syringe. During an interview on 03/15/2026 at 2:06 PM, LVN E said she brought a big cup of water because she needed to flush the g-tube that was flushed every four hours. She said she did not know why she forgot to flush the g-tube before pouring the formula. She said the g-tube should be flushed prior to giving the formula to make sure the g-tube was working and not obstructed. During an interview on 03/15/2026 at 2:14 PM, when asked how he was doing after the bolus feeding, Resident #2 gave a thumb up. During an interview on 03/17/2026 at 7:02 AM, ADON A said the best practice was to flush the g-tube before giving the feeding formula to make sure the g-tube was functioning well and had no issues. She said, especially for bolus feeding, because the staff needed to give the formula at a certain time. She said sometimes some formulas were left in the tube causing it to be clogged if not flushed. She said the g-tube should be flushed before and after bolus feeding. She said the expectation was for the staff not to forget to flush the g-tube before giving the bolus. She said she would coordinate with the DON on what to do about the issue. During an interview on 03/17/2026 at 7:41 AM, the DON said the purpose of flushing the g-tube before giving the formula was to verify if the tube was not blocked before giving the formula. She said flushing before bolus feeding was to ensure that the tube was working properly and to clear out the tube from an old formula that could cause blockage. She said it would be a mess when the staff would only realize that the g-tube was clogged once the formula was (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	already poured. She said flushing should be done before bolus feeding and before medication administration. She said the expectation was to use the water that was prepared to flush the g-tube. She said she already did a one-on-one in-service with LVN E regarding not flushing the g-tube prior to giving the feeding formula. She said she would also do an in-service to all the staff on using the g-tube for formula and medications. During an interview on 03/17/2026 at 8:12 AM, the Administrator said she was not a clinician, and she would let the DON be the lead about the issue. She said the expectation was for the staff to follow the right procedure regarding g-tube. Record review of the facility's policy G-tube Medication Administration undated, reflected, 18. Check for placement and residual . 19. Flush with warm water by gravity flow . 20. Administer dissolved medication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that residents, who needed respiratory care, were provided 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 #20) reviewed for respiratory care.The facility failed to ensure Resident #20's Nebulizer mask was properly stored in a bag when not in use on 03/15/26. This failure could place the resident at risk for respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #20's Face Sheet, dated 03/16/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 had a diagnosis of COPD (lung disease).Record review of Resident #20's Quarterly MDS Assessment, dated 02/10/26, reflected Resident #20's BIMS (11) indicated a moderate cognitive impairment. The Quarterly MDS Assessment reflected the resident had active diagnosis of COPD.Record review of Resident #20's Physician orders, dated 03/16/26, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/ML 1 vial inhale every 6 hours for COPD. Nebulizer - Clean and change tubing every week on Sunday.During an observation on 03/15/26 at 10:29 a.m., Resident #20 had a nebulizer mask sitting on top of her nightstand unbagged.During an Interview and observation on 03/15/26 at 10:32 a.m., RN D was shown by the Surveyor Resident #20's nebulizer mask sitting on top of her nightstand unbagged. She stated they try to ensure all masks and nasal cannulas were bagged when not in use to avoid them from getting contaminated. She stated it was the nurse's responsibility to ensure the devices were bagged.During an interview on 03/17/26 at 09:15 a.m., the DON was informed by the Surveyor of Resident #20's nebulizer mask sitting on top of her nightstand unbagged. She stated the breathing devices should be bagged when not in use to avoid them from getting contaminated. She stated it was the nurse's responsibility to ensure the devices were bagged. She stated she in-serviced her nursing staff on the importance of properly bagging masks and nasal cannulas when not in use on 03/16/26.During an interview on 03/17/26 at 10:20 a.m., ADON was informed by the Surveyor of Resident #20's nebulizer mask sitting on top of her nightstand unbagged. She stated the breathing devices should be bagged when not in use to avoid the resident getting an infection. She stated it was the nurse's responsibility to ensure the devices were bagged when not in use.Record review of the facility's policy Oxygen Concentrator, revised 11/01/2025, reflected POLICY: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner . PROCEDURES . 1. Oxygen Tanks, Connectors and Concentrators . E. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms . 2. Nebulizer Equipment Procedures . F. Store, clean, and dry until next use.

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	676424	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farmersville Health and Rehabilitation	205 Beech St Farmersville, TX 75442

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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 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 assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one of eighteen residents (Resident #4) reviewed for pharmaceutical services. The facility failed to ensure Resident #4's medication was not left with the resident to take unattended on 03/15/2026. This failure could place residents at risk of not receiving medications as ordered, taking medications without a self-administration assessment, potential overdose, and adverse effect.Findings included: Record review of Resident #4's Face Sheet, dated 03/15/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastro-esophageal reflux disease and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #4's Comprehensive MDS Assessment, dated 03/07/2026, reflected the resident had severe impairment in cognition with a BIMS 05. The Comprehensive MDS Assessment indicated the resident had gastro-esophageal reflux disease and dementia. Record review of Resident #4's Comprehensive Care Plan, dated 03/01/2026, reflected that the resident had impaired cognitive function and one of the interventions was to monitor any changes in cognitive function. Record review of Resident #4's Physician's Order, dated 02/23/2026, reflected Calcium Carbonate Tablet Chewable 500 MG Give 2 tablet by mouth every 12 hours as needed for indigestion AND Give 1 tablet by mouth three times a day for phosphorus binder (medication that prevents high level of phosphorus in the blood) give with meals. Record review on 03/15/2026 of Resident #4's Assessment Notes reflected that the resident did not have an assessment for self-administration of medication. During an observation on 03/15/2026 at 10:38 AM revealed Resident #4 was not inside his room. It was observed that there was a small plastic cup with a pill on top of the resident's drawer. During an observation and interview on 03/15/2026 at 10:48 AM, MA F said during medication administration, the staff administering the medications should stay with the resident to make sure that the resident took the medications. She went inside Resident #4's room and saw the medication that was inside a small cup. She said the medication was TUMS and was given three times a day. She said she gave the resident morning medication, including his TUMS, and the resident took all his morning medications. She said she did not notice the TUMS on top of the resident's drawers, and she did not know who left the medication with the resident to take unattended. She said leaving medications with the resident to take later without anybody supervising could lead to the resident not taking the medication, underdosing, overdosing, or misuse of medications. She said the resident might choke on the medication, and nobody would know. She also said other residents who wandered around might take the medication that she did not need. She took the cup with TUMS in it and discarded it. During an interview on 03/16/2026 at 7:01 AM, RN E said she would sometimes help in passing medications if needed. She said she did not pass medication prior to Sunday, 03/15/2026. She said medications should never be left with the residents to take later, unattended because the best practice was to give the medications and wait until the resident took them before leaving the room. She said the resident might not take the medication and might take it with the next pill and might overdose. During an interview on 03/15/2026 at 10:46 AM, ADON A said staff should not leave any medications with the residents for the residents to take unsupervised. She said the staff administering the medications should stay with the resident until the resident was done with the medications. She said the resident might not take them, or someone else might, like another resident or a visitor. She said the resident might aspirate or choke while taking the medications, and nobody would know. She said the residents could not take medications by themselves except if they were assessed that they could self-administer. She asked around, but nobody knew who left the medication inside Resident #4's (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. She said the DON had already started an in-service about not leaving the medications with the residents. During an interview on 03/17/2026 at 7:41 AM, the DON said staff should never leave the medications at the bedside for the resident to take later. She said the staff must ensure the resident took all his medications before leaving the room. She said so much could go wrong like the resident could hoard or hide the pills to avoid taking them, could overdose on hoarded pills, and could choke without anybody to help the resident. She said another resident could get hold of it and take the medication that was the resident allergic to. She said the expectation was that no residents were administering their medications without proper assessment. She said if the resident refused the medication, the staff should discard it and document that the resident refused the medication. The DON said she had already started an in-service about medication administration. During an interview on 03/17/2026 at 8:12 AM, the Administrator said she was not a clinician and she would let the DON be the lead about the issue. She said the expectation was if leaving the medication with the resident could cause probable harm, then the staff should not do it. During an interview on 03/17/2026 at 10:59 AM, Resident #4 said he was taking TUMS because of his indigestion. He said staff would bring the medication to him and would tell him to take if wanted to or not. Record review of the facility's policy, Medication Administration undated, reflected 12. Residents observed to ensure medications are swallowed .14. Medications are not left on top of the cart or at resident's bedside.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based 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 two of eighteen resident (Resident #1 and Resident #2) reviewed for infection control. 1. The facility failed to ensure LVN E performed hand hygiene and changed her gloves while preparing Resident #1's formula for g-tube on 03/15/2026. 2. The facility failed to ensure LVN E sanitized the tray she used between Resident #1 and Resident #2 during g-tube management on 03/15/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1. Record review of Resident #1's Face Sheet, dated 03/16/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support). Record review of Resident #1's Quarterly MDS Assessment, dated 02/24/2026, reflected that the resident had severe impairment with a BIMS score of 03. The Quarterly MDS Assessment indicated that the resident had a feeding tube. Record review of Resident #1's Comprehensive Care Plan, dated 03/05/2026, reflected that the resident required a PEG tube and one of the interventions was to check for placement and residuals. Record review of Resident #1's Physician Order, dated 02/09/2026, reflected Enteral Feed Order every shift G-TUBE - ENTERAL FORMULA [CONTINUOUS] = Enteral Formula: NUTREN 2.0 @ 50 cc for 22 hours/day via g-tube and pump. Head of bed elevated 30-45 degrees at all times. During an observation on 03/15/2026 at 1:04 PM revealed LVN E was about to connect Resident #1's enteral feeding formula to his g-tube. She prepared the bag of pre-filled enteral formula, a tray, a flush bag, water for the flush bag, two cups of water, a syringe, and some tubings inside an open plastic bag. She sanitized her hands and put on a gown. She went inside the resident's room and hung the pre-filled enteral formula on one of the hooks of the IV pole with a feeding pump attached to it. She placed the other things that she prepared on the tray and placed the tray on the resident's side table. She then pulled the trash can near her using her gloved right hand. After pulling the trash can, she started to pour water on the flush bag. She did not sanitize her hands and change her gloves after touching the trash can. After pouring water into the flush bag, she hung the flush bag on the other hook of the IV pole. She then removed the cap of the pre-filled formula and connected the tube. She connected the tubes of both bags to the pump and started to prime the feeding set pointing the ends of the tubes towards the trash can. After priming the formula set, she hung the tubings to one of the hooks of the IV pole. After hanging out the tubes, she checked the placement of the g-tube and gastric residuals. After checking the placement of the g-tube and the gastric residual, she connected the formula to the resident's g-tube. She did not change her gloves after touching the trash and all through the process of connecting the formula bag. 2. Record review of Resident #2's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing). Record review of Resident #2's Comprehensive MDS Assessment, dated 01/06/2026, reflected that the resident had moderate impairment in cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated the resident had a feeding tube. Record review of Resident #2's Quarterly Care Plan, dated 01/14/2026, reflected that the resident required a PEG and one of the interventions was to check for tube placement and feeding before initiating feeding. Record review of Resident #2's Physician Order, dated 03/11/2026, reflected every 4 hours G-TUBE - FLUSH [routine] = Flush g-tube w/ 200 cc of water Q 4 hours. HOBelevated 30-45 degrees at all times. Check tube placement prior to each feeding, meds and fluids per auscultation and residual Q shift. If 100 cc, HOLD feeding. During an observation on 03/15/2026 starting at 1:04 PM revealed LVN E was about to connect Resident #1's feeding formula to his g-tube. She prepared the bag of pre-filled enteral formula, a tray, (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a flush bag, water for the flush bag, two cups of water, a syringe, and some tubings inside an open plastic bag. She sanitized her hands and put on a gown. She went inside the resident's room and hung the pre-filled enteral formula on one of the hooks the IV pole with a feeding pump attached to it. She placed the other things that she prepared on the tray and placed the tray on Resident #1's side table and proceeded to connect the feeding formula. After connecting Resident #1's feeding formula, she went back to her cart and placed the tray on top of her cart. She did not sanitize the bottom of the tray that she placed on Resident #1's side table before putting it on top of her cart. She then went to the sink with the tray, placed the tray at the side of the sink, and washed her hands and the syringe that she used for Resident #1. After washing the syringe, she went back to her cart and put the tray on top of her cart. She then went to Resident #2's room and prepared to give Resident #2's bolus feeding (method of delivering enteral nutrition through a feeding tube, providing large doses several times a day). She prepared one big cup of water and four small cups of water. She placed the cups of water on the tray that she used for Resident #1. She went inside the room and placed the tray on Resident #2's overbed table and proceeded to give Resident #2's bolus feeding. After giving the bolus formula to Resident #2, she returned to her cart and put the tray on top of her cart. She then went to the sink to wash her hands and the syringe she used for Resident #2. She went back to her cart and placed the tray back to the top of her cart. She did not sanitize the bottom of the tray after she used it from one resident to another and after she placed it on the Resident #1's side table and Resident #2's overbed table. During an interview on 03/15/2026 at 2:06 PM, LVN E said she should have used her foot to pull the trash can be closer to her or she should have changed her gloves after touching the trash can. She said she was taught to use a tray if she needed to bring the things she needed for treatment inside, but it did not occur to her to sanitize the bottom of the tray after it had contact with the residents' side table and overbed table. She said she did not know what probable microorganisms were on top of the table, and she could have brought them to her cart and to the sink. She said her actions could result in cross contamination and probable infection of any kind. During an interview on 03/17/2026 at 7:02 AM, ADON A said the staff should be mindful that they were not causing any spread of infection in the facility. She said when the staff touched something dirty, like the trash can, the staff should have sanitized her hands and changed her gloves. She said since the tray that was used for Resident #1 touched his side table, then the tray should have been sanitized inside and outside. She said both incidents could cause cross contamination and probable spread of infection. She said the DON already started an in-service about hand hygiene and sanitizing re-usable items used for the residents. During an interview on 03/17/2026 at 7:41 AM, the DON said that hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should have sanitized her hands and changed her gloves after touching the trash can and before connecting the resident's feeding formula. She said the staff should sanitize the tray she used for the things she needed for g-tube because if there were microorganisms in the resident's tables, then it would be also on top of the cart and on the side of the sink. She said the expectation was for the staff to be mindful that they were not causing cross contamination and could lead to development of infections. She said she did a one-on-one in-service with LVN E and in-service for all the staff about infection control and disinfecting reusable equipment. During an interview on 03/17/2026 at 8:12 AM, the Administrator said they always remind the staff to be vigilant with hand hygiene. She said after touching something dirty, the staff should sanitize their hands and change their gloves to make sure their gloves were clean while doing any treatment. She said the tray used should have been sanitized to prevent cross contamination. She said the DON already started an inservice but she would closely monitor if the staff understood the in-service provided. Record review of the facility's policy Infection Control Operational/Resident Care Policies, undated, reflected All employees are required to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice . Staff performances will be monitored to ascertain that proper procedures are followed . environmental waste . Routine cleaning and disinfection of resident care equipment including equipment shared among residents id also implemented.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for one of three direct care staff (RN D) reviewed for other environmental conditions. The facility failed to ensure that RN D did not leave a container of germicidal wipes on top of the nurse's cart unattended on 03/16/2026. This failure could prevent the residents from having an environment that was safe for the residents, staff, and public. Findings included: Record review of Resident #75's Face Sheet, dated 03/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #75's Comprehensive MDS Assessment, dated 01/30/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had diabetes mellitus. Record review of Resident #75's Comprehensive Care Plan, dated 02/12/2026, reflected the resident had diabetes mellitus and one of the interventions was to administer diabetic medications as ordered. Record review of Resident #75's Physician Order, dated 03/13/2026, reflected FINGERSTICK BLOOD SUGAR - AC & HS = Fingerstick blood sugar [BBG/FSBS] before meals and at bedtime. Document results. IF FSBS LESS THAN 69 OR GREATER THAN 400 AND UNRESOLVED, NOTIFY PHYSICIAN before meals and at bedtime. During an observation on 03/16/2026 at 11:40 AM revealed RN D was about to check Resident #75's blood sugar. She prepared the glucometer, alcohol wipes, test strips, and the push-button safety lancets. Before going inside the room, she took a container of germicidal wipes from the last drawer of the cart she was using, opened it, pulled a wipe, and cleaned the glucometer. After cleaning the glucometer, she went inside the resident's room and brought with her the glucometer, alcohol wipes, some test strips, and some push button safety lancets and placed them on top of the resident's overbed table with a parchment paper on it. She closed the door and left the opened container of germicidal wipes on top of her cart. When she was about to start checking the blood sugar, she remembered that she forgot to prepare some gauze. She went to her cart to get some gauze, went back inside the room, and closed the door, leaving the opened container of germicidal wipes again. It was observed that some wipes were peeking out from the opening of the container and several residents were walking in the hallway. During an observation and interview on 03/16/2026 at 11:55 AM, RN D said she used the germicidal wipes to clean the glucometer that she was about to use. She said she should put it back inside the cart because residents might take some and use them to wipe their face. She closed the container of the germicidal wipes and put it back inside her cart. During an interview on 03/17/2026 at 7:02 AM, ADON A said the germicidal wipes should be stored inside the cart for safety reasons. She said residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, and skin. She said it might cause irritation and toxicity. She said anything that indicated Keep out of reach of children should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. She said the DON already started an in-service about not leaving the germicidal wipes on top of the carts unattended. During an interview on 03/17/2026 at 7:41 AM, the DON said the germicidal wipes should be locked inside the carts and not left on top of the carts unattended. She said it should be secured inside the carts so that the residents would not be able to access the wipes that had chemicals on them. She said confused residents might get hold of the wipes, wipe their face, and body that could result to irritations. She said the expectation was for the staff to be mindful and never leave the germicidal wipes on top of the carts unattended. She said she already did an in-service about not leaving the germicidal wipes unattended. During an interview on 03/17/2026 at 8:12 AM, the Administrator said the germicidal wipes should not be placed somewhere accessible to the residents because the wipes had chemicals in them that could be harmful when consumed or had contact with (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the eyes. She said the DON already started an in-service about germicidal wipes, and she would monitor closely if the staff understood the in-service. In an interview on 03/17/2026 at 9:38 AM, the Dietary and Housekeeping Manager said the germicidal wipes should not be within reach of the resident because they could cause adverse reactions such as irritation. She said the wipes were usually locked inside the cart. She said the nurses used gloves when they use the wipes because it could cause irritation to the skin. Record review of the facility's policy Housekeeping Services Operational/Resident Care Policies, undated, reflected The facility provides a safe, functional, sanitary, and comfortable environment for all residents, staff, and the public . All poisonous items and or other items with cautionary labels are kept secured and are only accessible to employees.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 34 (Room numbers 2, 3, 4, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39) out of 34 multiple-resident bedrooms, measured at least 80 square feet per resident. The facility failed to ensure multiple resident Room numbers 2, 3, 4, 6, 7, 8, 10, 18, 20, 24, 25, 26, 27, 28, 29, 30, 32, 33, 34, 35, 37 and 39 met the required minimum of 80 square feet per resident. The facility failed to ensure all resident rooms had the required minimum of 80 square feet per resident in rooms occupied by multiple residents. This failure could place residents who reside in these rooms at-risk for a limitation in their ability to move around the room and a decreased quality of life. Findings included: During the survey entrance conference on 03/14/26 at 9:25 AM, the ADM revealed the facility had a room size waiver in place for the bedrooms measuring less than the required square footage. She also advised nothing has changed in the past years regarding resident's room square footage. Review of Form DADS 3740 (Bed Classifications Form), completed by the facility on 03/15/2026, revealed all 37 bedrooms in the facility had two beds and were classified as Medicare and Medicaid. Review of the facility's license on 03/15/2026 at 10:30 AM revealed the facility was licensed for 74 beds. Review of the resident bedroom measurements listing, undated provided by the ADM on 03/16/2026 revealed the following: 1) Resident Rooms 2, 3 and 4 measured 127 square feet. 2) Resident Rooms 6, 8 and 10 measured 132 square feet 3) Resident room [ROOM NUMBER] measured 146 square feet 4) Resident rooms [ROOM NUMBERS] measured 147 square feet 5) Resident Rooms 12, 14, 15, 16, 17 and 19 measured 156 square feet 6) Resident room [ROOM NUMBER] measured 159 square feet 7) Resident Rooms 20, 22, 24, 26 and 28 measured 151 square feet 8) Resident Rooms 23, 25, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37 and 39 measured 153 square feet. During an interview on 03/16/2026 at 1:30 PM ADM provided a copy of a signed Form 3762-Room Size Waiver request form. ADM stated the facility would be requesting that the same room size waiver be continued for the next year. The ADM stated there had been no change in the number or size dimensions of the affected rooms requested for waiver consideration. ADM stated the facility did not have a policy regarding the room size waiver.No policy was provided prior to exit.