

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Cedar Pointe Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Cottonwood Creek Trail Cedar Park, TX 78613	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 ensure residents who were unable to carry out activities of daily living received the necessary services timely to maintain good grooming and personal hygiene for 5 of 10 residents (Resident #35, and Resident #48, Resident #107, Resident #114, and Resident #117) reviewed for ADLs. The facility failed to ensure Resident #35, Resident #48, Resident #107, Resident #114, and Resident #117 briefs were changed timely. This failure could place residents at risk of not receiving care services, diminished quality of life, and decreased self-esteem. Findings included: Record review of Resident #35's Face Sheet, dated 01/07/2026, reflected an [AGE] year-old female, admitted [DATE] with diagnoses that included need for assistance with personal care, cognitive communication deficit (a condition that affects how individuals think and communicate), lack of Coordination (refers to difficulty in executing controlled, purposeful movements), muscle wasting and atrophy (wasting or thinning of muscle mass), and paroxysmal atrial fibrillation (a type of irregular heartbeat). Record review of Resident #35's quarterly MDS dated [DATE], reflected a BIMS Score of 12, which indicated cognitively intact. Record review of Resident #35's Care Plan, dated 09/12/2025, reflected Resident #35 required supervision and modified independence with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #35 to maintain current level of function with assistance in his daily living care needs. Record review of Resident #48's Face Sheet, dated 01/07/2026, reflected an [AGE] year-old female, admitted [DATE] with diagnoses that included need for assistance with personal care, muscle wasting and atrophy (wasting or thinning of muscle mass), atrial fibrillation (a type of irregular heartbeat), and glaucoma (many diseases involving eye pressure increases that lead to permanent vision loss and blindness). Record review of Resident #48's quarterly MDS dated [DATE], reflected a BIMS Score of 15, which indicated cognitively intact. Record review of Resident #48's Care Plan, dated 01/07/2026, reflected Resident #48 required modified independence with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #48 to maintain current level of function with assistance in his daily living care needs. Record review of Resident #107's Face Sheet, dated 01/07/2026, reflected an [AGE] year-old male, admitted [DATE] with diagnoses that included need for assistance with personal care, cognitive communication deficit (a condition that affects how individuals think and communicate), lack of coordination (refers to difficulty in executing controlled, purposeful movements), muscle weakness (a lack of muscle strength), muscle wasting and atrophy (wasting or thinning of muscle mass), paroxysmal atrial fibrillation (a type of irregular heartbeat), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and retention of urine (inability to empty the bladder when urinating). Record review of Resident #107's quarterly MDS, dated [DATE], reflected a BIMS Score of 15, which indicated cognitively intact. Record review of Resident #107's Care Plan, dated 09/29/2025, reflected Resident #107 required supervision and modified independence with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #107 to maintain current level of function with assistance in his daily living care needs. Record review of (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #114's Face Sheet, dated 01/07/2026, reflected an [AGE] year-old female, admitted [DATE] with diagnoses that included need for assistance with personal care, muscle weakness (a lack of muscle strength), lack of coordination (refers to difficulty in executing controlled, purposeful movements), cognitive communication deficit (a condition that affects how individuals think and communicate), muscle wasting and atrophy (wasting or thinning of muscle mass), alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), and urinary tract infections (an infection in any part of the urinary system. The urinary system includes kidneys, ureters, bladder and urethra).Record review of Resident #114's quarterly MDS, dated [DATE], reflected a BIMS Score of 14, which indicated cognitively intact.Record review of Resident #114's Care Plan, dated 07/23/2025, reflected Resident #114 required modified independence with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #114 to maintain current level of function with assistance in his daily living care needs.Record review of Resident #117's Face Sheet, dated 01/07/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included lack of coordination (refers to difficulty in executing controlled, purposeful movements), muscle weakness (a lack of muscle strength), muscle wasting and atrophy (wasting or thinning of muscle mass), cerebrovascular disease (disease includes a variety of medical conditions that affect the blood vessels of the brain and the cerebral circulation), and peripheral vascular disease (a disorder of the blood vessels outside the heart that affects blood flow to the limbs).Record review of Resident #117's quarterly MDS, dated [DATE], reflected a BIMS Score of 15, which indicated cognitively intact.Record review of Resident #117's Care Plan, dated 10/13/2025, reflected Resident #117 required modified independence with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #117 to maintain current level of function with assistance in his daily living care needs.In an interview on 01/06/2026 at 10:26 a.m., Resident #114 stated she had not addressed the facility about this, but there have been times the staff took too long to check her to change her brief. Resident #114 stated if staff checked her brief, sometimes she had not wet the brief yet and a few minutes later she ended up going in the brief and had to wait for the next round in 2 hours to be checked by staff. Resident #114 stated she wanted it addressed to the facility. During an observation on 01/06/2026 at 10:26 a.m., Resident #114 appeared to be well groomed and clean. In an interview on 01/06/2026 at 10:30 a.m. Resident #35 stated sometimes staff had a lot to do with other residents requiring more assistance, but there were times staff took longer than every two hours to check briefs. Resident #35 stated to let the facility know.During an observation on 01/06/2026 at 10:30 a.m., Resident #35 appeared to be well groomed and clean. In an interview on 01/06/2026 at 11:18 a.m., Resident #48 stated the staff could do better by changing briefs on time. Resident #48 stated sometimes it was over three hours before her brief was changed. Resident #48 stated it did not make her feel good when her brief was not changed timely.During an observation on 01/06/2026 at 11:18 a.m., Resident #48 appeared to be well groomed and clean. In an interview on 01/07/2026 at 9:44 a.m., Resident #107 stated sometimes it could be within five minutes or over one hour he waited to have his brief changed and it was not consistent. Resident #107 stated he did not like wearing soiled brief. Resident #107 stated he wanted the facility to be notified of the delay in care. During an observation on 01/07/2026 at 9:44 a.m., Resident #107 appeared to be well groomed and clean. In an interview on 01/07/2026 at 11:00 a.m., Resident #117 stated sometimes he needs his brief change during shift changes, and the staff leave instead of changing him. Resident #117 stated it sometimes takes the oncoming shift a long time to make their rounds and change his brief. Resident #117 stated he felt staff waited for the next shift to change his brief. During an observation on 01/08/2026 at 11:13 a.m., CNA G and CNA H performed resident care for Resident #48. CNAs changed gloves and cleaned hands in between changing gloves. Resident #48's brief was moderately wet, peri (a hygiene practice involving the cleaning and maintenance of the genital and anal regions, known collectively as the perineum.) area (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to ensure ADL care and changing resident briefs timely is taking place by all nursing staff at the facility. The ADM stated if ADL care and changing resident briefs timely aren't taking place, it can affect and diminish the resident's quality of life by potentially causing physiological issues, skin breakdowns, and urinary tract infections. ADM stated it's ultimately the overall responsibility of the ADM to ensure ADL care and changing resident briefs are conducted timely by the facility staff. ADM stated it's his expectation that all staff are changing residents' briefs and ensuring they are helping residents' wellbeingRecord review of Resident #48's facility orders, dated 4/10/2025, reflected apply barrier cream with each brief change on every shift.Record review of facility in-service education for peri care with ADL's, dated 08/29/2025, reflected to have been provided and completed by all staff, including CNA A, CNA G, CNA H, LVN B. Record review of Nursing Services ADLs policy, dated 05/2007, reflected: Nursing service staff cares for its residents in manner and in an environment that promotes maintenance or enhancement of each residents' quality of life and promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents receive assistance as needed to manage their physical needs which includes personal hygiene grooming, dressing, toileting, transferring, ambulating and eating. Each Resident is assessed for their ability to perform ADLs and the assistance needed, and a plan of care is developed, and interventions are implemented based on their needs, goals of care and preferences.		

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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 one of one kitchen reviewed for nutrition services. 1.The facility failed to ensure sanitation practices (cleaning the ice machine).2. The facility failed to label and date all food items in the kitchen. These failures could place residents at risk of foodborne illness. Findings included: Observation on 1/6/26 at 9:09 am of the facility kitchen revealed the ice machine had black and brown mold appearing substance growing on the inside of the ice machine. Further observation revealed the ice machine maintenance log's last recorded maintenance was dated 12/25.Observation on 1/6/26 at 9:11 am of the facility kitchen revealed a tray with 13 bowls containing cream of wheat or grits next to the steam table serving line undated and unlabeled.Observation on 1/6/26 at 9:12 am of the facility kitchen revealed a saucepan with melted butter on stove with ladle in pan uncovered, undated, and unlabeled.Observation on 1/6/26 at 9:14 am of the facility kitchen's reach in refrigerator revealed:-tray of bowls of oatmeal with label dated 1/2/26 as prep date no discard date recorded -container of chicken salad dated 12/26/25; receipt date, open date, or discard date not indicated.-To Go container dated 1/6/26 with a name marked on it.-container of Pico de Gallo dated 1/4/26 receipt date, preparation/open date, or discard date not indicated. Observation on 1/6/26 at 9:19 a.m. of the facility kitchen walk-in cooler revealed:-Ziploc bag of waffles dated 1/3/26 preparation date or discard date not indicated.-Container of cheesy potatoes dated 1/5/26 preparation date or discard date not indicated.-Container of vegetable blend dated 1/2/26 preparation date or discard date not indicated.-Container of BBQ sauce dated 1/5/26 preparation date or discard date not indicated.-Container of beans dated 1/1/26 preparation date or discard date not indicated.Observation on 1/6/26 at 9:21 a.m. of facility kitchen walk-in freezer revealed - Ziploc bag of chicken tenders dated 1/2/26 preparation date or discard date not indicated.Observation on 1/6/26 at 9:30 a.m. of facility nourishment room on the long-term care side of the facility revealed signage on refrigerator door stating all food must be labeled and dated. Expired and unlabeled food will be disposed of. Opened food can only be stored in refrigerator for three days. Further observation revealed: -container of blue bell ice cream undated and unlabeled.-bag of popsicles and ice cream cones, undated and unlabeled, with one ice cream cone, packaging open. Observation on 1/6/26 at 12:30 p.m. of the facility nourishment room on the skilled side of the facility revealed: - To go glass with frozen liquid in freezer unlabeled and undated.Observation on 1/7/26 at 11:37 a.m. of kitchen reach in refrigerator revealed: -container of tuna salad dated 1/3/26 preparation date or discard date not indicated.-container of grits dated 1/3/26 preparation date or discard date not indicated.Observation on 1/7/26 at 11:47 a.m. of skilled side of facility nourishment room revealed: -Reusable shopping bag with to go container and plastic containers of food items unlabeled and undated.-Disposable shopping bag with one 20 oz bottle of soda and to go container of food unlabeled and undated.Interview on 1/8/26 at 4:30 p.m., DA E stated they were in their position for three months and received dietary aide training (basic job duties, meal types, kitchen cleaning, food preparation, basic kitchen maintenance, ANE, and Resident rights). DA E stated the process for labeling and dating food items was to use the FIFO method, food items were dated upon receipt, dated upon opening or preparation, dated with expiration or discard date. DA E stated the truck was received and items put away by the DM and the dietary staff are responsible for dating food items with the opening/preparation date and the discard/expiration date. DA E stated the ice machine was cleaned nightly by the dietary aides and it must be shut off, emptied, wiped clean with sanitizer, let it dry, then plugged in and it refilled. DA E stated there were daily and weekly cleaning lists completed. When asked if food items were not properly labeled and dated, how it could negatively affect a resident, DA E stated it could make residents sick. When asked if the ice machine was not properly cleaned how it could negatively affect a resident DA E stated it could be because of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	salmonella. Interview on 1/8/26 at 4:53 p.m., [NAME] F stated that she was in this position for five years. [NAME] F stated at this facility she received three days of training because she had prior experience cooking at a different facility. [NAME] F stated her training was to get familiar with this facility and their way of doing things. [NAME] F stated that all food items were labeled and dated and that it was the cook's responsibility to label and date all food items when they were prepared. [NAME] F stated for cleaning the ice machine that all the inside was cleaned and then cleaned all of the outside. [NAME] F stated that the dietary aides were responsible for cleaning the ice machine every day because the corners developed mold in them. [NAME] F stated the maintenance director cleaned the ice machine once a week. [NAME] F stated if food items were not properly labeled and dated and if the ice machine was not cleaned it could be a big problem for residents and they could have stomach issues. Interview on 1/8/26 at 3:37 p.m., CNA A stated she worked at the facility for seven years. CNA A stated she received ANE training roughly two weeks ago and Resident Rights training about two months ago. CNA A stated all food items should be labeled and dated daily for anything in the resident nourishment room refrigerator. CNA A stated it depended on if the food item comes from the kitchen, then the kitchen was responsible for labeling and dating but if the item was something the family brought in then the nursing staff was responsible for labeling and dating those items. CNA A stated it could negatively affect a resident if food items were not properly labeled and dated by the residents getting food poisoning. CNA A stated she thought the DM was responsible for assigning kitchen staff to clean the ice machine. CNA A stated it could negatively affect a resident if the ice machine was not properly cleaned by giving them diarrhea or vomiting if the ice was contaminated. Interview on 1/8/26 at 5:03 p.m., the DM stated he was in the position for 4 years and 3 months. DM stated food items must be labeled upon receipt and then again upon preparation and they are good for 72-96 hours depending on the food item. DM stated if foods were prepared or opened, then a discard or expiration date was needed. DM stated all kitchen staff were responsible for labeling and dating. DM stated his expectation from staff was that staff would date upon receipt, date as soon as prepared with preparation date and discard date. DM stated the kitchen staff clean the inside, outside, and filters of the ice machine daily and the MD does a deep clean monthly on the ice machine. DM stated the DAs are responsible for the daily cleaning of the machine and the MD is responsible for the monthly deep clean of the machine. DM stated it was his expectation that the ice machine needs to be spotless when the ice machine is cleaned and that he wants the machine to shine when the staff are done. DM stated if foods are not properly labeled and dated that it could absolutely affect the residents with foodborne illness. DM stated it could negatively affect the residents if the ice machine was not cleaned properly by causing the residents to become sick. Interview on 1/8/26 at 5:12 p.m., the DON stated she was employed with the facility for three years and 11 months. The DON stated food items were dated upon receipt. The DON stated the kitchen staff date the items from the kitchen and nursing staff date items the residents bring in. Items are good for only 3 days and ADON's check the refrigerators in the morning. DON stated staff should not be putting their items in the refrigerator as they have a break room. DON stated it was her expectation that all food items are labeled and dated when they are placed in the nourishment room refrigerators. DON stated if food items are not bad it will not hurt a resident but that all items should have a date on them. DON stated she was unsure of the process for cleaning the ice machine as that is something the DM and MS take care of. DON stated the MS, and the kitchen staff are responsible for cleaning the ice machine. The DON stated it could probably negatively affect a resident if the ice machine was not properly cleaned but she was unsure as to how besides that it would be gross. Interview on 1/8/26 at 5:41 p.m., the ADM stated all items should be labeled and dated upon receipt ASAP, when prepared. Unsure if a discard date is needed. The kitchen staff and the individual placing the items in the fridge for the nourishment rooms are responsible for labeling and dating food items. It is my expectation that food labeling and dating is done appropriately by policy. The ice machine is cleaned daily by kitchen staff and monthly by MS staff. The responsibility of the ice machine cleaning is the kitchen staff and (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodations to meet the needs and preferences for 1 of 4 residents (Resident #16) reviewed for accommodations. The facility failed to ensure Resident #16 had the call light button in reach while lying in bed. This failure could place residents at risk of injury, not receiving timely care or receiving nursing interventions to meet the resident's needs, and/or it could make the resident feel neglected affecting their mental health. Findings included: Record review of Resident #16's Face Sheet, dated 01/07/2026, reflected a [AGE] year-old male, admitted [DATE] with diagnoses that included need for assistance with personal care, cognitive communication deficit (a condition that affects how individuals think and communicate), lack of coordination (refers to difficulty in executing controlled, purposeful movements), abnormalities of gait and mobility (referred to the way an individual moved and walked), muscle weakness (a lack of muscle strength), and traumatic brain injury (a brain injury that was caused by an outside force). Record review of Resident #16's quarterly MDS, dated [DATE], reflected a BIMS score of 13, which indicated cognitively intact. Record review of Resident #16's Care Plan, dated 08/18/2025, reflected Resident #16 required supervision and modified independence with bed mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goal was for Resident #16 to maintain current level of functioning with assistance in his daily living care needs. Record review of Resident #16 Care Plan for call light, initiated on 08/18/2025, reflected for all facility staff to be sure the call light was within reach and encouraged Resident #16 to use it to call for assistance as needed. Record review of facility in-service education for call lights conducted on 09/26/2025 and 12/05/2025 reflected to have been provided and completed by all facility staff. During an observation on 01/06/2026 at 12:15 p.m., Resident #16's call light was on the floor out of his reach. Resident #16 was not able to reach it. Resident #16 appeared to struggle with getting the call light and was not able to get out of bed to grab the call light off the floor. Resident #16 appeared to be well taken care groomed and clean. In an interview on 01/06/2026 at 12:15 p.m. Resident #16 stated staff have not put the call light near him since moving to this new room. Resident #16 stated not having the call light button next to him would stop him from getting assistance with things he may need and did not want that to happen. Resident #16 stated he did not want to feel isolated by not having the call light button near him. In an interview on 01/08/2026 at 3:45 p.m., CNA A stated she worked at the facility for seven years. CNA A stated she received call light training a week ago. CNA A stated call light training went over response times and 20 minutes was too long. CNA A stated call light response times should be within three to five minutes but staff needed to respond as soon as possible, in case of an emergency. CNA A stated the positioning of call lights should be within easy reach of the residents such as, on their lap or on the bedside table. CNA A stated call light placements were monitored by all nursing staff members. CNA A stated rounds should be done every hour with checking on residents. CNA A stated it is the responsibility of nursing staff to ensure call lights were in resident's reach. CNA A stated if call lights were not placed near residents, it could affect the resident's quality of life by not receiving assistance when needed and potentially not helping them in an emergency situation, putting residents in danger if they were on the floor. CNA A stated it was ultimately the overall responsibility of the DON and ADM to make sure residents had access to call lights. In an interview on 01/08/2026 at 4:05 p.m., LVN B stated she worked at this facility for eight years. LVN B stated she received call light training. LVN B stated call light training went over not leaving the call lights unanswered for more than 15 minutes, and for staff to respond to call lights as soon as possible. LVN B stated call lights should be positioned on the side residents were able to reach with their hands. LVN B stated she did not remember the last time she received call light training, but it was talked about daily. LVN B stated call light placements were monitored by all nursing staff. LVN B stated it was the responsibility of nursing staff to ensure call (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Cedar Pointe Health and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Cottonwood Creek Trail Cedar Park, TX 78613	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lights were in resident's reach. LVN B stated the nursing station had a call light board which notified them when call lights were turned on. LVN B stated if call lights were not placed near residents, or on the floor, it could affect the resident's quality of life by not receiving assistance when needed, the resident may not be feeling good, or potentially not help them in an emergency situation that could be fatal. LVN B stated call lights needed to be within reach to call for assistance other than the staff doing rounds every two hours. LVN B stated it was ultimately the overall responsibility of the DON to make sure residents had access to call lights. In an interview on 01/08/2026 at 5:19 p.m. the DON stated she had worked at the facility for three years and 11 months. The DON stated she received call light training last month. DON stated call light training went over call light responses, not to just turn off the call light, and make sure the call light was within reach for the residents. The DON stated call light placements were monitored by all nursing staff such as CNAs, nurses, and the DON. The DON stated it was the responsibility of nursing staff to ensure that call lights were in resident's reach, and she was responsible overall as the DON. The DON stated if call lights were not placed near residents, it could affect the residents' quality of life without receiving assistance when needed. The DON stated it was ultimately the overall responsibility of the DON to make sure residents had access to call lights. In an interview on 01/08/2026 at 5:40 p.m., the ADM stated he has worked at the facility since August 2021. The ADM stated he received call light training two to three months ago. ADM stated call light training went over placing call lights in proximity near the residents, and for staff to not turn off call lights when needs were not met. The ADM stated call light placements were monitored by all staff in the facility. The ADM stated it is the responsibility of all facility staff to ensure call lights were in resident's reach or if it was moved to make sure it was put in reach. ADM stated if call lights were not placed near residents, it could affect the residents' quality of life by not receiving assistance when needed and potentially not helping residents with their needs in an emergency situation. The ADM stated if call lights were on the floor, the residents would not be able to signal for help. The ADM stated it was ultimately the responsibility of the ADM to make sure residents had access to call lights and that facility staff were ensuring residents had access to call lights. The ADM stated it was his expectation that if staff noticed the call lights were not near residents, to make sure to put them back, and if call lights had fallen on the floor, staff needed to put it back in reach of the residents. Record review of Call Light policy, dated 05/2007, reflected: It is the policy of this facility to provide the residents with a means of communication with nursing staff. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents remained free of any significant medication errors for 1 of 6 residents (Resident #63) reviewed for medication errors. The facility failed to ensure Resident #63 received unexpired insulin glargine (long-acting insulin) required for treating Type 1 Diabetes. This failure could place residents at risk of complications such as increased blood sugar and decline in health. Findings included: Record review of Resident #63's face sheet, dated 01/07/2026, revealed, an 85- years-old female admitted on [DATE] and readmitted on [DATE]. Resident #63's diagnoses included acute diastolic (congestive) heart failure (a sudden worsening of the chronic condition where the stiff left ventricle can't relax enough to fill properly, causing fluid backup (congestion) into the lungs/body, leading to severe shortness of breath, swelling, and fatigue), anxiety disorder (mental health conditions marked by intense, persistent, and excessive worry or fear about everyday situations, leading to significant distress and impairment in daily life), chronic obstructive pulmonary disease (a progressive lung condition making breathing difficult), and type 1 diabetes mellitus (a chronic autoimmune disease where the body mistakenly destroys insulin-producing cells in the pancreas, leading to insulin deficiency and high blood sugar). During an observation of the medication pass on 1/7/2026 at 8:12 a.m., LVN C checked the blood sugar of Resident #63 with results of 203 mg/dL (normal blood sugar range: 70-99 mg/dL) and administered insulin Glargine 10 units through subcutaneous injection (the injection was given in the fatty tissue, just under the skin) to Resident #63 without checking the expiration date of the medication. Per observation of the medication vial with insulin Glargine Solution 100 U/ML revealed the marked open date, 12/7/2025, which exceeded 28 days storage instructions for this medication on the nursing cart after opening. Per MAR review Resident #63 received 4 doses of expired medication. During an interview with LVN C on 1/7/2026 at 8:25 a.m., revealed she was trained in the last six months on the medication administration policy and was aware of checking an expiration date for each medication and each resident before administering medications. She stated she thought this insulin would expire after 30 days of opening and kept it unrefrigerated on the nursing cart. She stated that she was responsible for checking the expiration date of medication on her cart. She stated the potential risk for administering expired medication would be ineffectiveness of this medication to treat the residents' medical condition and could negatively affect their health. She stated Resident #63 was dependent on receiving insulin to control her blood sugar and this medication was very important for treating her health condition and it is essential to keep insulin potent. During observation of Resident #63 on 1/7/2026 at 8:35 a.m. she appeared well kept and without any signs of physical distress. Per interview of Resident #63 on 1/7/2026 at 8:37 a.m., she stated that she felt fine without any concerns to report. During an interview on 1/08/2026 at 3:05 p.m., the DON stated that nursing staff was responsible for checking expiration dates on medication carts every day and before administering medication. She stated the DON and ADONs spot checked the med carts for the expiration dates. She stated the pharmacist checked med carts monthly for expired meds and any other issues with medications. She stated all nurses had access to the medication expiration reference chart available on each nursing cart and nursing station to refer to in case they had questions regarding medication expiration times. She stated she provided in-services on medication errors (yesterday) and on as needed basis when they changed the pharmacy, and through computer training modules on an annual basis. She stated that the potential risk for residents if they received expired insulin would be uncontrolled blood sugar levels which could affect their BP, circulation and overall health due to ineffectiveness of the medication. She stated that med errors were documented, in-service was provided, and notifications were sent to the Medical Director, Administrator, and family of the residents. During an interview on 1/08/2026 at 3:45 p.m., the ADM revealed that nursing staff who administer medications were responsible for proper medication administration, and he relied on (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON to oversee in-services and to follow proper medication administration policy and procedure to avoid medication errors. He stated potential risk of administering expired medications, including insulin, would be ineffectiveness of those medications and worsening of residents' health. Record review of storage and expiration insulin policy, dated 5/2021, revealed that insulin vials of Lantus (insulin glargine) had 28 expiration days period after opening. Record review of medication orders for Resident #63, dated 08/09/2025, revealed the order for Insulin Glargine 100 unit/ml to inject 10 unit subcutaneously in the morning. Discard 28 days after 1st use. Record review of Resident #63's care plan, dated 09/28/2025, revealed Resident #67 was on insulin to manage her blood sugars, and she was at risk of impaired circulation related to Diabetes. Resident # 63 was at risk for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) with ordered treatment through diabetes medication with interventions in place: monitor/document for side effects and effectiveness. Record review of Resident #63's MDS, dated [DATE], revealed Resident's BIMS score was 13 indicating intact cognitive status. Record review of Medication error report, dated 1/7/2026, revealed that insulin glargine given to Resident #63 on 1/7/2026 and dated 12/07/2025 (open date) should be discarded after 28 days of being opened. Record review of an in-service, dated 01/07/2026 and provided by the DON, revealed an in-service on insulin: please ensure before giving insulin that you check the dates on bottle to ensure open day is still within range of how long insulin can remain out and open from refrigerator. If not within date, throw away, get new insulin, and order new from pharmacy signed by 13 nurses including LVN C. Per record review of in-services for last six months, no other in-services on Medication Administration signed by LVN C was available. Record review of undated Medication administration policy (9.3 on page 16), revealed that facility staff should take all measures required by Facility Policy, Applicable Law, and the State Operation Manual when administering medications. Medications are administered as prescribed in accordance with good nursing principles and practices. Record review of undated Med Pass Policy revealed one of the required steps during med pass was, Check drug dose and expiration on all medications.		