| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676440 | A. Building<br>B. Wing | 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ignite Medical Resort Round Rock, LLC | 16219 Ranch Road 620 North<br>Austin, TX 78717 |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a resident or family group with private space for 1 of 1 resident council meetings reviewed for resident rightsThe facility failed to provide a private space for residents to meet during resident council meetings, exposing residents to loss of privacy.This failure could affect place residents by placing them at risk for loss of privacy and dignity. the Findings included:Record review of previous Resident Council Meetings Minutes, dated 10/23/2025,11/20/2025, 11/23/2025 revealed that Resident council meetings were regularly held in the facilities dining room.During an interview on 01/13/2026 at 10:00 AM revealed AD F had been trained in Resident Rights and in Abuse, Neglect, and Exploitation. AD F stated, Per the State of Texas Constitution, residents will not be denied their rights and residents should be able to make choices. AD F stated the topics previously addressed in past resident council meetings included: Protecting and valuing residents' private space, right to be free of reprisal from the facility, right to Respect and Dignity. AD F stated she was responsible for ensuring residents had a private place to meet.During a follow up interview and record review on 01/13/2026 at 11:35 a.m., AD F stated she was not aware of the privacy requirement for residents during resident council meetings. She stated, Now that you have highlighted the aspect of privacy, the dining room may not have been the best place to hold resident council meetings. She stated, I was thinking that the dining room was my only option. She stated, she understood that residents should be able to afford privacy while expressing their thoughts about the facility, and she believed the meetings should take place in the privacy of the conference room from then on.An interview on 01/15/2026 at 2:24 p.m. revealed the ADM's expectations for resident privacy was that they should have privacy to make complaints when attending the resident council meetings. The ADM stated the average length of stay for residents was 14 days, and the residents have other interests.During an interview on 01/15/2026 at 2:04 p.m., it was revealed that VPCO was trained in resident rights and the right of a resident to have privacy. She stated the policy was Residents are allowed to meet without staff present. She stated, if uninvited staff were walking through a room while residents were in a resident council meeting, they may not be as candid with their comments, complaints, or input at the meeting. She stated residents were allowed to present grievances to the facility, and resident council meetings should try to be held in a private place.Review of the facility's policy Resident Rights dated November 2021 Reflected, Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States.Includes:Dignity and RespectFreedom of Choice You have the right to:Make your own choices regarding personal affairs, care, benefits, and services.Privacy and Confidentiality You have the right to:Privacy, including privacy during visits, phone calls and while attending to personal needs.Complaints You have the right to:Organize or participate in any group that presents residents' concerns to the administrator of the facility.Your rights may be restricted only to the extent necessary to protect you or others, or to protect the rights of others, particularly those rights relating to privacy and confidentiality.Policy: [facility] Resident Rights dated April 2022.Purpose: To ensure<br>(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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | each resident is treated with dignity and respect. This includes providing activities and interactions from staff, temporary agencies or volunteers that is focused on assisting in maintaining and enhancing self- esteem, self- worth, individualizing goals, preferences, and choices. Care and services respect individuality while both honoring and valuing input.GuidelineOur facility environment encourages self-selection of individualized needs, care, and routines in a dignified and [NAME] way to respect preferences and full exercises of rights. Our residents have rights to a dignified existence, self - determination, and communication with and access to persons and services inside and outside the facility.Respect and Dignity.Protecting and valuing residents' private space:Knocking on doors and requesting permissions before entering and closing doors as requested. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 5 of 8 residents (Resident #31, Resident #57, Resident #76, Resident #93, and Resident #94) reviewed for quality of life.1. The facility failed to ensure Resident #57, Resident #76, Resident #93, and Resident #94 received regular showers.2. The facility failed to ensure Resident #31, and Resident #94 were offered to have their facial hair removed.These failures placed residents at risk of having poor hygiene.Findings included:1. A record review of Resident #31's face sheet dated 1/14/2026 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of congestive heart failure (end-stage heart disease), atrial fibrillation (abnormal heartbeat), chronic kidney disease, anxiety disorder, need for assistance with personal care, hypothyroidism (underactive thyroid), hypertension (high blood pressure), depression, hyperlipidemia and (high cholesterol), vascular dementia (cognitive disorder). A record review of Resident #31's MDS assessment dated [DATE] reflected a BIMS score of 7, which indicated moderately impaired cognition. Resident #31's MDS assessment reflected that she required moderate assistance with bathing and supervision or touching assistance with personal hygiene. A record review of Resident #31's care plan last revised on 1/13/2026 reflected that she had ADL self-care performance deficits and limitations in physical mobility. A record review of Resident #31's progress notes dated 1/02/2026-1/13/2026 reflected no documented refusals of care. A record review of Resident #31's POC Response History for bathing dated 1/14/2026 with a 30-day lookback period reflected no data.A record review of Resident #31's shower sheets reflected that she refused a shower on 1/02/2026, 1/06/2026, and 1/13/2026. Resident #31's shower sheets reflected that she received a shower on 1/03/2026 and 1/09/2026. During an observation and interview on 1/13/2026 at 12:43 PM, Resident #31 was observed sitting in her room. Resident #31 was observed to have a few wispy chin hairs about 0.5 inches in length. Resident #31 stated she had several chin hairs that she had not plucked yet. Resident #31 stated it would be nice if someone offered to help her with that.2. A record review of Resident #57's face sheet dated 1/14/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of acute kidney failure, anemia, morbid (extreme) obesity, hypertension (high blood pressure), nonalcoholic steatohepatitis (fatty liver disease), type 2 diabetes (uncontrolled blood sugar), hyperlipidemia (high blood pressure), and glaucoma (eye disease). A record review of Resident #57's MDS assessment dated [DATE] reflected a BIMS score of 15, which reflected intact cognition. Resident #57's MDS assessment did not reflect data on her functional abilities. A record review of Resident #57's care plan last revised on 1/13/2026 reflected that she had ADL self-care performance deficits and limitations in physical mobility. Resident #57's care plan reflected she required substantial/maximal assistance with bathing and personal hygiene. A record review of Resident #57's progress notes dated 1/02/2026-1/14/2026 reflected no documented refusals of care. A record review of Resident #57's shower sheets reflected she refused a shower on 1/05/2026 and 1/12/2026. There was no documentation of showers offered during that period.During an observation and interview on 1/13/2026 at 10:45 AM, Resident #57 was observed sitting in her wheelchair in her room. Resident #57 stated she arrived at the facility on 1/02/2026 and it took the facility 7 days to bathe her. Resident #57 stated her family member had to come to the facility and intervened so that she could receive a shower. Resident #57 stated she refused a shower one time because it was 9:00 PM and she was already lying in bed comfortably for the night. Resident #57 stated she asked if she could have a shower the next day, and staff told her it would be 2-3 days until she could get one. Resident #57 was not sure which nurse stated this. Resident #57 stated she was due for a bath the day prior, on 1/12/2026, but no one came.3. A record review of Resident #76's face sheet dated 1/14/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of displaced subtrochanteric<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | fracture of left femur (broken leg), unspecified dementia (cognitive disorder), anxiety disorder, insomnia (inability to sleep), gastro-esophageal reflux disease (acid reflux), dysphagia (difficulty swallowing), and severe protein-calorie malnutrition. A record review of Resident #76's MDS assessment dated [DATE] did not reflect a BIMS score or data on her functional abilities. A record review of Resident #76's care plan last revised on 1/13/2026 reflected that she had ADL self-care performance deficits and limitations in physical mobility. Resident #76's care plan reflected that she required partial/moderate assistance with bathing and supervision or touching assistance with personal hygiene. A record review of Resident #76's progress notes dated 1/09/2026-1/14/2026 reflected no documented refusals of care. A record review of Resident #76's POC Response History for bathing dated 1/15/2026 with a 30-day lookback period reflected No Data Found. A record review of Resident #76's shower sheets reflected she refused a shower on 1/13/2026. There was no documentation of showers offered on other days.During an interview and observation on 1/13/2026 at 9:56 AM, Resident#76 was observed lying in bed. Resident #76's hair appeared oily. Resident #76 stated she wanted a shower and wondered when she would get one. Resident #76 stated she had not received a shower since arriving at the facility. Resident #76 stated she had not asked for a shower. 4. A record review of Resident #93's face sheet dated 1/15/2026 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of metabolic encephalopathy (condition that causes brain dysfunction), unspecified dementia, hypertension (high blood pressure), fracture of left femur (leg), pubis (hip) and sacrum (spine), hyperlipidemia (high cholesterol), Alzheimer's disease (cognitive disease), and protein-calorie malnutrition.A record review of Resident #93's MDS assessment dated [DATE] reflected a BIMS score of 00, which indicated severe cognitive impairment. Resident #93's MDS assessment did not reflect data on her functional abilities. A record review of Resident #93's care plan last revised on 1/13/2026 reflected that she had ADL self-care performance deficits and limitations in physical mobility. Resident #93's care plan reflected she was dependent on staff for bathing and required substantial/maximal assistance with personal hygiene.A record review of Resident #93's progress notes dated 1/06/2026-1/15/2026 reflected no refusals of baths or showers. A record review of Resident #93's POC Response History for baths/showers dated 1/15/2026 with a 30-day lookback period reflected No Data Found.A record review of Resident #93's shower sheets reflected that she was given a shower on 1/08/2026. Resident #93's shower sheet dated 1/10/2026 reflected that she refused a shower and it was noted on her shower sheet that she liked day showers. Resident #93's shower sheet dated 1/15/2026 reflected she refused a shower.During an observation and interview on 1/13/2026 at 11:31 AM, Resident #93 was observed lying in bed. Resident #93 was non-interviewable. Resident #93's family member was present and stated that staff instructed her that Resident #93 would be a night shower but Resident #93 preferred day showers. Resident #93's family member stated she had requested several times that Resident #93 receive a shower during the day instead of at night since she had sundown syndrome. Resident #93's family members stated staff told her they would try to get Resident #93 on the schedule for day showers. Resident #93's family member stated that Resident #93 had only received one shower since arriving at the facility, and that was four days ago. Resident #93's family member stated she had requested a shower for Resident #93 the day prior, but Resident #93 had not received one. 5. A record review of Resident #94's face sheet dated 1/14/2026 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of congestive heart failure (end-stage heart disease), type 2 diabetes (uncontrolled blood sugar), depression, anxiety, chronic kidney disease, lymphedema (swelling), and spinal stenosis (narrowing of spinal canal). A record review of Resident #94's MDS assessment dated [DATE] did not reflect a BIMS score or data on her functional abilities. A record review of Resident #94's care plan last revised on 1/10/2026 reflected that she had ADL self-care performance deficits and limitations in physical mobility. Resident #94's care plan reflected she required substantial/maximal assistance with bathing and partial/moderate assistance with personal hygiene. A record review of Resident #94's progress notes dated 1/09/2026-1/14/2026 reflected no documented refusals of baths or<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | showers.A record review of Resident #94's POC Response History for showers/baths dated 1/14/2026 with a 30-day lookback period reflected No Data Found.A record review of Resident #94's shower sheet dated 1/09/2026 reflected that she refused a shower.Resident #94's shower sheets from January 2026 were requested on 1/15/2026 at 12:45 PM but were not provided prior to exit.During an observation and interview on 1/13/2026 at 12:04 PM, Resident #94 was observed in her room. Resident #94 stated she had not received a shower since she arrived at the facility (last Thursday). Resident #94 was observed to have facial hair on her chin. Resident #94 stated she used to tweeze her chin hair when she was at home. Resident #94 stated staff had not offered to help her groom her facial hair.During an interview on 1/14/2026 at 3:42 PM, LVN I stated showers were documented on sheets and electronically. During an interview on 1/14/2026 at 3:48 PM, LVN I stated when residents refused showers, the CNA would notify the nurse, and the nurse would ask the resident why they were refusing. LVN, I stated the nurse would then make a progress note in the resident's chart and notify the social worker. During an observation and interview on 1/15/2026 at 10:46 AM, CNA J stated that each CNA gave three showers a day and she stated CNAs went by a chart. CNA J then displayed the facility's shower schedule, which was organized by room number. CNA J stated residents were offered showers at least twice a week, but she would give them an extra shower if they needed one. CNA J stated that the facility's policy on grooming women with facial hair included shaving them any time they needed it. CNA J stated CNAs were responsible for bathing and grooming residents. CNA J stated, we do a lot of training. CNA J stated she was not sure when the last time Resident #76 had a shower, but that SC A oversaw the shower sheets and could look up when the resident's last shower was. CNA J stated she had not worked on Tuesday, but that Resident #76 would get a bath tomorrow. CNA J stated Resident #76's shower schedule was Tuesday and Friday nights. CNA J stated that Resident #31's shower days were Tuesday and Friday nights. An observation revealed CNA J walked into Resident #31's room, examined Resident #31's face, and then stated, I noticed some hairs there that I need to trim up today. CNA J stated she had not offered to remove Resident #31's facial hair in the past and she did not know whether other staff had offered. CNA J stated Resident #94's shower days were during the day on Mondays and Thursdays. CNA J stated she did not know the last time was Resident #94 was bathed, but that she was scheduled for one that same day. CNA J stated Resident #31 did not have a history of refusing baths. CNA J stated she had not offered to remove Resident #94's facial hair. An observation revealed CNA J walked into Resident #94's room, examined the resident, and said, she needs to be shaved today and that it was a little bunchy. CNA J stated Resident #57's showers were on Monday and Thursday evenings. CNA J stated she was not sure whether Resident #57 had refused showers in the past and she would have to look it up with [SC A] to see when Resident #57's last shower was. During an interview on 1/15/2026 at 12:31 PM, RN B stated she was not sure when Resident #93's last shower was, but that Resident #93 had been requesting showers during the day since it was cold at night. RN B stated refusals were documented on shower sheets and showers should be documented, but sometimes they don't document. RN B provided a sheet which reflected that Resident #93 had refused a shower on 1/10/2026. When asked if Resident #93 had been offered a shower since the 10th, RN B stated, yes. An observation revealed that RN B pulled up Resident #93 POC Response History for baths and it reflected no data. RN B stated Resident #93 may have been given a shower even if it was not documented. During an interview on 1/15/2026 at 12:45 PM, SC A stated that she was the CNA staffing coordinator and that she oversaw shower sheets. SC A stated CNAs were supposed to document showers in PCC and on the shower sheets. SC A stated, if it's not written, it didn't happen. SC A stated CNAs were supposed to ask three times if residents were refusing showers, then a nurse would need to sign the shower sheet if the resident still refused. During an interview on 1/15/2026 at 2:06 PM, the VPCO stated CNAs provided showers and tried to keep residents on a schedule. The VPCO stated grooming facial hair on women could be done during the shower depending on the patient. The VPCO stated we can offer that and it would be a shave. The VPCO stated CNAs were (continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | responsible for bathing and grooming residents at least twice a week. The VPCO stated we need to be documenting refusals and following up with the nurse. The VPCO stated nurses would sign shower sheets and try to get to the root cause as to why a resident did not want a shower. The VPCO stated showers were documented on PCC and on shower sheets, but there was no place in PCC to document grooming of facial hair. The VPCO stated that all staff had been trained upon hire and yearly through checkoffs and competencies. The VPCO stated that charge nurses monitored CNAs to ensure showers were being done. When asked what a potential negative outcome was if female residents had unwanted facial hair, the VPCO stated, they could be upset. When asked what a potential outcome was for residents if they did not receive regular showers/baths, the VPCO stated they could get upset or it could affect their progress.During an interview on 1/15/2026 at 2:26 PM, the ADM stated CNAs provide showers to residents twice a week either in the morning or in the afternoon. The ADM stated if residents wanted showers more frequently, staff should accommodate. The ADM stated she would try to find out if there was a policy on grooming facial hair on women. The ADM stated she expected staff to take note of facial hair on females, and it should be part of their ADL care. The ADM stated that staff were monitored to ensure showers and grooming were being done through leadership rounding with residents. The ADM stated showers were documented on sheets and she thought they documented in PCC. The ADM stated refusals were noted on the shower sheets. The ADM stated that all CNAs were trained as a part of their licensure and that it was addressed through orientation and in-services. The ADM stated residents with unwanted facial hair might feel embarrassed and we all feel better when we take a shower.Record review of the facility's policy titled ADL Policy dated November 2020 reflected the following: This facility will provide each resident with care, treatment, and services according to the resident's individualized care plan. Based on the individual resident's comprehensive assessment, facility staff will ensure that each resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that the decline was unavoidable, including: Bathing. GroomingA record review of the facility's policy titled Resident Dignity dated November 2018 reflected the following: Policy: This facility will promote care for residents of the facility in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of the resident's individuality.Procedure:ˆ Residents will be groomed as they wish including hair care and styled, facial hair shaved/trimmed as the resident wishes, nail care as the resident chooses. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to prepare and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen and food sanitation.1. The facility failed to ensure the [NAME] used proper hand sanitation while preparing pureed foods. 2. The facility failed to ensure the DA D used proper hand sanitation prior to distributing food to residents' rooms. These failures could place residents, who receive food from the kitchen, at risk for food contamination and foodborne illness.Findings Included:An observation and interview on 01/13/2026 at 11:25 a.m., revealed the [NAME] cleaned and disinfected the robot coup blender after finishing a puree of Tamale pie. The [NAME] failed to wash her hands before putting clean gloves on. [NAME] completed a puree of refried beans, removed her gloves, and cleaned and sanitized the robot coup. [NAME] did not wash her hands between cleaning of robot coup and puree of rice. The [NAME] put gloves on and pureed rice and no handwashing after rice was pureed and gloves were removed. [NAME] stated she had training in food preparation and sanitation procedures. [NAME] stated the policy is to wash hands between kitchen and food preparation tasks.Observation/ interview on 01/15/2026 at 1:16 p.m., revealed DA D has been trained in food safety and sanitation. DA D stated he worked at the facility since August of 2025. He stated handwashing is to be performed before he leaves the kitchen to deliver food trays to the halls. Observed DA D failed to wash his hands prior to removing the food tray-cart from the kitchen to deliver food trays to the 100 hall. DA D stated the policy requires they sanitize our hands between tray delivery. During an interview on 01/14/2026 at 11:52 a.m., the RD stated her title is Dietary Specialist. She stated her responsibility is to meet with nursing staff and update residents' charts with new or changed nutritional and dietary needs. She stated she performs a kitchen sanitation audit 1 time per month, and she submits the findings to the facility staff. RD stated the policy for handwashing is posted at the designated wash sinks and it is her expectation that staff would wash hands between kitchen tasks, and before and after food preparation. She stated handwashing is essential for preventing food borne illness. During an interview on 01/14/2026 at 5:36 p.m., DM H (Corporate Dietary Manager) stated he was trained in culinary arts, dietary management, sanitation, and handwashing. He stated that the AC is the facility's Administrator. DM H explained that handwashing is to be done by all staff, and those who enter the kitchen, to prevent food borne illness. During an interview on 01/15/2026 at 2:04 p.m., the VPCO stated she was trained on kitchen sanitation and handwashing. She stated handwashing should be done when entering the kitchen and between tasks, using the soap dispenser and designated hand washing sinks in the kitchen. She stated there was no reason someone should not wash their hands per the handwashing policy. She stated if staff members do not wash hands between kitchen tasks, there could be cross contamination. Record Review of an in-service training on 10/15/2025 regarding Handwashing and Sanitation: proper Dishwashing & Storage and sanitation buckets.Record Review of kitchen staff certifications revealed. DM H Certified Dietary Manager and Certified Food Protection Professional. The [NAME] - Texas Food Service Handler certificationDA D - Texas Food Service Handler certification Review of the facility's policy for Food & Nutrition Services Sanitation & Food Safety Handwashing Policy reflected,Food and Nutrition services employees will practice safe food handling to prevent foodborne illness.Procedure: Food and nutrition services employees will thoroughly wash their hands and exposed areas of their arms with soap and water in the designated hand-washing sink at the following times: Upon entering the kitchen at the beginning of the shift Before engaging in food preparation. After touching anything unsanitary (garbage, dirty dishes) After touching bare human body parts other than clean hands and arms (example adjusting one's hairnet)Between removing gloves or aprons and before putting on new gloves or aprons.When switching between working with raw food and working with ready-to-eat food.Use of GlovesFood and nutrition service employees wear disposable gloves to avoid bare- hand contact with food.Use of disposable gloves shall be preceded by thorough hand washing with soap and water. |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observations, interviews, 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 reviewed for infection control.DA D did not sanitize his hands between each resident when passing meal trays for lunch. This failure could place the residents at risk of transmission of disease and infection.Findings included:Observation on 01/13/2026 at 12:50 PM of staff passing lunch trays to the resident rooms on the 100 Hall revealed DA D did not hand hygiene when leaving Resident #59's room. He took a tray from the cart to Resident #26's room, and no hand hygiene was conducted. DA D then returned to the cart and took a tray to Resident #38's room, and no hand hygiene was conducted. He returned to the cart and took a tray to Resident 67's room, and no hand hygiene was conducted. An interview on 01/13/2026 at 1:14 PM with DA D, who stated he had been trained to clean his hands with hand sanitizer between each resident when passing their lunch trays but stated he had been moving fast and had forgotten to sanitize his hands. DA D further stated he received training on hand hygiene and passing resident trays. DA D stated not conducting hand hygiene between each resident when passing meal trays could lead to infection. Interview on 01/15/26 at 1:53 PM with the VPCO revealed she was the infection preventionist for the facility. She also stated that normally the ADON and wound care nurse would also be the infection preventionist. The DON stated the policy for conducting handwashing/hand hygiene when providing care/passing meal trays included all staff were to be using hand sanitizer between each meal pass unless something happened and they needed to wash their hands. stated a negative outcome to the resident could be cross contamination. The DON stated Nurse leadership and herself were responsible for monitoring to ensure staff were conducting hand hygiene. The DON further stated the facility conducted monitoring to ensure staff were washing their hands by conducting spot checks, in-services, and checkoffs. She stated she did not know why the staff member did not conduct hand hygiene between each resident when passing meal trays. Review of the facility's Policy & Procedures on Hand Hygiene dated April 2023 reflected, Policy: All staff members will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, as effective hand hygiene reduces the incidence of healthcare-associated infections (HAIs)Handwashing may also be used for routinely decontaminating hands in the following clinical situations: Before and after contact with inanimate objects including medical equipment in the immediate vicinity of the resident Indications for Alcohol-Based Hand Rub (ABHR):If hands are not visibly soiled, an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situations: Before and after having direct contact with residents Before and after contact with inanimate objects including medical equipment in the immediate vicinity of the resident Before and after assisting a resident with eating |

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|---|---|---|---|
| | 676440 | A. Building<br>B. Wing | 01/15/2026 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 2 of 15 residents (Resident #22 and Resident #71) reviewed for resident rights. The facility failed to ensure Resident #22 and Resident #71's rooms were clean.This deficient practice could place residents at risk of feelings dissatisfaction.The findings were:Record review of Resident #22's face sheet, dated 01/14/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #22 had diagnoses which included embolism and thrombosis (blood clots in blood vessels), atrial fibrillation (abnormal heart rhythm), dementia (memory, thinking, difficulty), need for assistance with personal care, muscle weakness, history of falls and unsteadiness on feet. Record review of Resident #22's MDS assessment, dated 01/05/2026, revealed Resident #22 had a BIMS score of 13 which indicated intact cognitive responses. Record review of Resident #22's admission care plan dated 12/31/2026 revealed [Resident #22] was at risk for falls related to history of falls and decreased mobility. The goal was [Resident #22] would remain free from injury related to falls. Interventions were when [Resident #22] attempts to stand, ask what they would like to do and then assist them to complete the task.Record review of Resident #71's face sheet, dated 01/14/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. [Resident #71] had diagnoses which included anxiety (feeling of uneasiness or worry), morbid (severe) obesity, need for assistance with personal care, difficulty in walking, pain due to trauma, and person injured in collision between other specified motor vehicles. Record review of [Resident #71]'s MDS, dated [DATE], revealed Resident #71 had a BIMS score of 15 which indicated intact cognitive responses. Record review of [Resident #71]'s admission care plan dated 12/24/2026 revealed [Resident #71] was at risk for falls related to impaired mobility, fractures, pain and post-surgical state. The goal was [Resident #71] would remain free from injury related to falls. An intervention was educating Resident #71 and family on need to call for assistance when transferring in and out of chair.Observation of [Resident #71]'s room on 01/13/2026 at 9:53 a.m., revealed the resident's room had paper on the floor, dirty socks on the floor, an empty medication cup under the bed and the bathroom had hair on the wall of the shower. Observation of [Resident #22]'s room on 01/13/2026 at 2:26 p.m., revealed there was a paper towel on the floor, small pieces of paper on the floor, and two spoons on the floor under her bed.Observation of [Resident #71]'s room on 01/13/2026 at 2:29 p.m., revealed her room still had paper on the floor, dirty socks on the floor, an empty medication cup under the bed and the bathroom still had hair on the wall of the shower. Observation of [Resident #71]'s room on 01/14/2026 at 8:22 a.m., revealed her room still had paper on the floor, dirty socks on the floor, an empty medication cup under the bed and the bathroom still had hair on the wall of the shower. An interview with [Resident #71] on 01/13/2026 at 9:56 a.m., she stated she did not know the last time housekeeping had come into her room to clean. She said housekeeping had not come in to sweep, mop, or clean her bathroom. She also said that her visitors would comment on how dirty her room was. She said she wanted housekeeping to come clean her room daily. An interview with [Resident #22] on 01/13/2026 at 2:29 p.m., revealed that her room was dirty because housekeeping had already come. She said housekeeping only cleaned the room once a day. She said that staff would not pick up anything and left it for housekeeping. An interview with the HKS on 01/15/2026 at 11:27 a.m., revealed she had been trained in resident rights. She said the housekeeping policy was if a room had a resident in it, staff were not to touch the bed. She said the housekeeping staff would take out the trash, clean the bathroom, sweep, mop and fill up the soap dispensers. She said housekeeping was responsible for cleaning the resident's rooms once a day. She said if housekeeping knew a resident dropped things often, the housekeeping staff would go back and retouch up the room. She said when housekeeping was not there, the staff should pick up<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | trash on the floor. She also said depending on what the mess was, the staff would call housekeeping to come in and disinfect. She said if the residents' rooms were not cleaned, it could cause the resident to get sicker and cause germs in the room. She said the HKS was responsible for monitoring to ensure the residents' rooms were clean. She said the HKS monitored it by walking around and checking the resident's rooms to ensure they were clean. She said [Resident #22] and [Resident #71]'s rooms were probably dirty because the facility only had one housekeeper because the other housekeeper was out sick.An interview with the VPCO on 01/15/2026 at 2:07 p.m., revealed that she had been trained on resident rights. She said the housekeeping policy for cleaning the residents' rooms was the housekeeper had a spreadsheet of things they were to clean the residents' rooms. She said the rooms were cleaned daily. She said housekeeping was responsible for cleaning the resident's rooms. She also said CNAs could help pick up trash and keep the residents' rooms clean. She said a resident may get upset if their room was not cleaned or if their room was cluttered. She said the housekeeping supervisor monitored to ensure the residents' rooms were getting cleaned. She said the housekeeping supervisor monitored through an audit system. She said she did not know why [Resident #22] and [Resident #71]'s rooms had not been cleaned. During an interview with the ADM on 01/15/2026 at 2:27 p.m., she said the housekeeping policy was that the residents' rooms should be cleaned daily. She said the housekeeping staff were responsible for cleaning the resident's rooms. She said the nursing staff should be helping keep the residents' rooms tidy when housekeeping was not there. She said it depended on the resident on how it might affect them. She said some may not care, but it was standard that the staff had to keep the rooms clean. She said the housekeeping supervisor and the director of environmental services monitored to ensure the rooms were cleaned. She said the housekeeping supervisor and the director of environmental services monitored by doing rounds. She said she knew that residents' had been refusing things, but she was not sure if [Resident #22] or [Resident #71] had refused to let staff clean their rooms. Record review of the facility's Safe, Clean, Comfortable, Homelike Environment Policy dated 07/2025, revealed Management and Environmental Service staff provide homelike surroundings with access to personal living space. Staff will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, functional, and comfortable interior. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed to ensure drugs are stored properly and only authorized persons have access for 1 of 2 medication carts (TC #1) reviewed for pharmacy services.The facility failed to ensure TC #1 was locked, medications secured, and not accessible to other staff, residents, or visitors.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings included:An initial walkthrough observation of the facility on 01/13/2026 at 09:01 a.m., revealed TC#1 was unlocked and unattended outside of a resident's room. A nurse was inside a resident's room with her back turned away from the treatment cart. The resident's door was cracked open about two inches. Residents were walking by the unlocked treatment cart. TC #1 contained residents prescribed creams. On top of the treatment cart was a bottle of wound cleaner solution and two packages of black foam wound dressings. One foam dressing was opened. LVN C came out of the room, introduced herself, went back into the room, closed the door all the way and did not lock the treatment cart. An interview with LVN C on 01/15/2026 at 10:26 a.m., revealed that she had been trained on medication storage. She said the medication/treatment cart policy was staff must lock the treatment cart anytime they walked away. She said the person who was working on the treatment cart was responsible for locking the cart. She said the treatment cart should be locked immediately after removing the medication from the cart and before walking away from the cart. She said if the treatment cart was left unlocked and unattended someone could get into the treatment cart and take medication from the cart. She said the clinical supervisor monitored by doing rounds and in-services. She said she left the medication cart unlocked because she walked in to talk to the resident. She said she locked it the second time when she came out of the resident's room. She said that the cart should have been locked when she walked back into the resident's room. An interview with the VPCO on 01/15/2026 at 2:07 p.m., revealed she had been trained on medication storage. She said the medication/treatment cart policy was staff must lock the cart any time the staff member was not using the cart. She said the team member who was assigned to the cart was responsible for ensuring the cart was locked. She said the treatment cart should always be locked outside when staff were in the cart providing care. She said if the treatment cart was left unlocked and unattended, someone might get some band aids out of the cart. She said nurse leaders monitored to ensure that staff were locking the medication/treatment carts. She said nurse leaders monitored by doing spot checks and rounds. She said LVN C left the treatment cart unlocked and unattended because she was dealing with a disgruntled resident and forgot.An interview with the ADM on 01/15/2026 at 2:22 p.m., revealed she had been trained on medication storage. She said the medication/treatment cart policy was that the cart should always be locked if the staff member was not in the cart or in sight of the cart. She said the medication aide or nurse on the medication/treatment cart was responsible for locking the cart. She said if the medication/treatment cart was left unlocked and unattended, it left items accessible to people who were not licensed to give medications. She said that the ADM and VPCO monitored to ensure staff were locking the medication/treatment carts. She said the ADM and VPCO monitored by doing rounds. She said that she did not know why LVN C left the treatment cart unlocked. During an interview with the ADM on 01/14/2026 at 1:29 p.m., the medication storage policy was requested.Record review of the facility's Medication Labeling and Storage policy dated January 2026, revealed the policy provided did not cover medication storage. The medication storage policy was not provided upon exit. |