STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676466	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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 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 seven of twenty residents (Residents #14, #36, #51, #101, #102, #126, and #150) reviewed for privacy and confidentiality. 1.The facility failed to ensure CNA F closed the door and pulled the privacy curtain while doing Resident #126's incontinent care on [DATE]. 2.The facility failed to ensure LVN C secured Residents #14, #36, #51, #101, #102, and #150's medical information before leaving his cart on [DATE]. 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 care and having their personal and medical record exposed to unauthorized individuals.Findings included: 1.Record review of Resident #126's Face Sheet, dated [DATE], reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #126's Comprehensive MDS Assessment, dated [DATE], reflected that the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 14. The Comprehensive MDS Assessment indicated that the resident was incontinent (unable to control) for bladder and bowel. Record review of Resident #126's Comprehensive Care Plan, dated [DATE], reflected that the resident required assistance with ADLs and one of the interventions was to provide level of support to complete toilet use and personal hygiene. During an observation on [DATE] at 9:24 a.m., CNA F was about to do Resident #126's incontinent care. He went inside the resident's room, put on a pair of gloves, and proceeded with incontinent care. He did not close the door nor pull the privacy curtain. During an interview on [DATE] at 9:33 a.m., CNA F said the door should be closed when performing incontinent care because somebody might walk inside and would see the care being done. He said the privacy curtain should be closed as well because the roommate or the roommate's family member might go inside the room and see the resident without any brief on. She said the door should be closed, and the privacy curtain should be pulled to provide privacy. 2.Record review of Resident #14's Face Sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was on DNR (Do Not Resuscitate: refuse CPR if the heart or breathing stops) and was admitted to hospice. Record review of Resident #36's Face Sheet, dated [DATE], reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with cerebral infarction (stroke, insufficient oxygen in the brain), polyarthritis (inflammation of five or more joints), and hypertension (high blood pressure). The Face Sheet indicated the resident was on full code (life-saving measures would be provided if the heart stops). Record review of Resident #36's Progress Note, dated [DATE], reflected Appointment Date and Time: [DATE] at 6:30 am . NPO (nothing by mouth) at midnight . hold Eliquis 2 days . hold losartan 24 hr prior. Record review of Resident #36's Physician Order, dated [DATE], reflected BiPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs) = Resident to wear BiPAP at Bedtime. Record review of Resident #36's Physician Order, dated [DATE], reflected Hydrocodone-Acetaminophen Oral Tablet (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	10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain. Record review of Resident #51's Face Sheet, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason) and anxiety (intense or excessive fear or worry). The Face Sheet indicated the resident was on DNR. Record review of Resident #51's Physician Order, dated [DATE], reflected Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 1 ml by mouth every 4 hours related to UNSPECIFIED DEMENTIA, UNSPECIFIED . AND ANXIETY. Record review of Resident #51's Physician Order, dated [DATE], Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 1 ml by mouth every 4 hours for ANXIETY/AGITATION (restlessness). Record review of Resident #101's Face Sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE]. The Face Sheet indicated the resident was on full code. Record review of Resident #102's Face Sheet, dated [DATE], reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep) and was on full code. Record review on Resident #102's Physician Order, dated [DATE], reflected CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) = Resident to wear CPAP QHS, set at PS (additional pressure applied during inspiration) 8 QHS. Check placement, setting, and functioning daily. every night shift. Record review on Resident #102's Physician Order, dated [DATE], reflected MID-LINE (a long and thin tube inserted into a large vein in the upper arm used for medication administration) STAT. Record review of Resident #102's vital signs, dated [DATE], reflected blood pressure: 126/65; temperature: 97.2; pulse: 76; respiration: 16; and oxygen saturation: 96%. Record review of Resident #102's Progress Note, dated [DATE], reflected nursing interventions: . new midline placed [DATE] LUA. Record review of Resident #150's Face Sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was on full code. During an observation on [DATE] at 10:55 a.m. revealed LVN C was called to attend to one of the residents. He locked his cart and went inside the resident's room. He left his cart in the middle of the hall with an untitled piece of paper left on top of the cart. On the piece of paper was written Resident #36's name, advance directive and was on hospice; Resident #36's name, appointment date, when he needed to be on NPO, what medications were to be held before the appointment, the resident was using a BiPAP, that the resident was on pain management, and the resident was full code; Resident #51's name, was receiving morphine and lorazepam, and was on DNR; Resident #101's name and was full code; Resident #102's name, had a midline to LUA, used a CPAP, and was on full code; Resident #150's name and was on full code. During an interview on [DATE] at 11:08 a.m., LVN C said he was already inside the resident's room when he realized he did not flip over the shift report on top of his cart. He said he should have turned the paper over before leaving his cart because what was written on the piece of paper was some of the residents' medical information and should be kept confidential. He said the paper should have been secured to prevent HIPAA violations. During an interview on [DATE] at 9:03 a.m., ADON A said staff should always close the door and pull the privacy curtain everytime they provide care to provide privacy. She said residents and family members could step inside the room and might see the resident being changed, or the people in the hallway might see the care being done. She said the staff should always provide privacy during care. She said the piece of paper was the nurses' 24-hour report and had some medical information that was supposed to be confidential. She said the report should have been left in the nurses' station. She said there was a binder in the station for the shift reports. She said if the nurse preferred to bring the report with them, they could put it inside the drawer or under the laptop before leaving the cart. She said she would coordinate with the DON regarding privacy and securing confidential information. During an interview on [DATE] at 9:15 a.m., the DON said what was written on the shift report was confidential information and should not be left exposed. She said the paper should have been turned over, placed inside the cart, or placed under the computer. She said there (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a binder in the nurses' station where the nurses could put the report. She said doors should be closed, and privacy curtains should be pulled everytime the staff perform care to provide privacy. She said she would start an inservice about privacy and confidentiality of records. During an interview on [DATE] at 9:41 a.m., the Administrator said the resident's medical information should be protected and could be a HIPAA violation when exposed. She said residents should be given privacy for all the care provided. She said she would coordinate with the DON regarding the issues discussed. She said she would personally monitor that the staff understood the in-service and not make the same mistake again. Record review of the facility's policy, Privacy and Confidentiality Operational/Resident Care Policies, undated, reflected Residents' personal and clinical records are protected to assure confidentiality . Personal privacy will be provided for . personal care . A nursing home resident has the right to personal privacy of not only his/her own physical body, but also . personal care . All information that contains personal identification or descriptions which would uniquely identify an individual resident or a provider of health care is considered to be personal and private and will be kept confidential.

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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 observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for four of eighteen residents (Residents #14, #23, #95, and #131) reviewed for medication storage. 1.The facility failed to ensure that Resident #14's zinc oxide was not on top of the resident's side table on 06/14/2026. 2.The facility failed to ensure that Resident #23's zinc oxide was not on top of the resident's side table on 06/14/2026. 3.The facility failed to ensure that Resident #131's zinc oxide was not on top of the resident's side table on 06/14/2026. 4.The facility failed to ensure that Resident #95 did not have a tube of Estradiol Vaginal Cream and a container of pain relief cream inside her room on 06/14/2026. These failures could place the residents at risk of misuse of medications and possible adverse reactions.Findings included: 1.Record review of Resident #14's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #14's Comprehensive MDS Assessment, dated 05/13/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #14's Comprehensive Care Plan, dated 05/27/2026, reflected the resident was incontinent for bladder and bowel and one of the interventions was to apply moisture barrier every shift as preventive measure. Record review of Resident #14's Clinical Assessment List, dated 06/14/2026, reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 06/14/2026 at 9:02 a.m., Resident #14 was in his bed, awake. It was observed that a sachet of zinc oxide (medicated cream used to prevent skin irritation) cream was on top of the resident's side table. The cream was on plain view and was easily accessible. The resident said the staff use the cream everytime they change his brief. 2.Record review of Resident #23's Face Sheet, dated 06/16/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia. Record review of Resident #23's Comprehensive MDS Assessment, dated 04/27/2025, reflected the resident had severe impairment in cognition with a BIMS score of 03. The Comprehensive MDS Assessment indicated the resident was incontinent for bowel and bladder. Record review of Resident #23's Comprehensive Care Plan, dated 01/06/2025, reflected that the resident was incontinent and one of the interventions was to provide incontinent care. Record review of Resident #23's Clinical Assessment List, dated 06/14/2026, reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 06/16/2026 at 9:14 a.m., Resident #23 was in her bed, awake. A tube of zinc oxide cream was observed on the resident's side table. The cream was in plain view and could be easily accessible. The resident said the staff would use it every time they changed her. She said she was not sure who left the skin barrier on her side table. 3.Record review of Resident #131's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia and reflux uropathy (urine flows backward from the bladder into the kidneys). Record review of Resident #131's Quarterly MDS Assessment, dated 06/02/2026, reflected the resident had a severe impairment in cognition with a BIMS score of 07. The Quarterly MDS Assessment indicated that the resident was incontinent. Record review of Resident #131's Comprehensive Care Plan, dated 04/15/2026, reflected the resident required assistance with ADLs and one of the interventions was to provide level of support for toilet use. Record review of Resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#131's Clinical Assessment List, dated 06/14/2026, reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. During an observation and interview on 06/14/2026 at 9:17 a.m., Resident #131 was in her bed, awake. A tube of zinc oxide cream was on top of her side table. She said she did not know what the cream was for, but she would always see it on her side table. The cream was in plain view and could be easily accessible. During an observation and interview on 06/14/2026 at 11:18 a.m., CNA E said zinc oxides should not be inside the residents' rooms because confused residents might accidentally consume them, thinking that the cream was something edible. She went inside the rooms of Residents #14, #23, and #131 and took the zinc oxides from inside the rooms. She said she did not know who left the zinc oxides inside the rooms of the residents. She said there would be residents who would wander around the facility that might go inside other residents' rooms and might take the zinc oxides with them. During an interview on 06/16/2026 at 9:03 a.m., ADON A said zinc oxide was a form of medicated cream because it had ingredients that would prevent skin issues. She said zinc oxides should not be inside the residents' rooms and should be in the carts and should be secured so the residents, especially the confused residents, would not get a hold of them. She said residents with poor eyesight could mistakenly think that zinc oxides were sauce and put them on their food or mistakenly use as toothpaste. She said the cream, when consumed, might cause adverse reactions. She said she would coordinate with the DON about the zinc oxides inside the rooms of the residents. During an interview on 06/16/2026 at 9:15 a.m., the DON said zinc oxide should not be within reach of the residents because residents might use them inappropriately and could result in adverse reactions. She said zinc oxide was applied topically and could be harmful when ingested. She said the expectation was for the staff not to leave the zinc oxides accessible to the residents. She said she would start an in-service about medication storage. During an interview on 06/16/2026 at 9:41 a.m., the Administrator said the expectation was for the staff to make sure there was no zinc oxides on the side tables of the residents because the residents might consume the medications or use them inappropriately. She said the facility had a population of confused residents and those who wandered around that might be able to grab the zinc oxides. She said she would coordinate with the DON about the issue. She said she would personally monitor that the staff understood the in-service and not make the same mistake again. 4.Record review of Resident #95's face sheet dated 06/16/2026 reflected a [AGE] year-old female admitted on [DATE]. Her diagnosis included acute kidney failure (kidneys stop working), depression (persistent feeling of sadness or loss of interest) and hypertension, (high blood pressure). Record review of Resident #95's MDS assessment dated [DATE] revealed a BIMS score of 11 indicating she was moderately cognitively impaired. Record review of Resident #95's comprehensive care plan dated 06/08/2026 reflected that she used an anti-depressant and one of the interventions was to monitor for side effects and effectiveness. Record review on 06/16/2026 of Resident #95's Physician Orders reflected an order for the vaginal cream to be administered by a nurse. There was no order for the pain cream. Record review of Resident #95's Clinical Assessment Notes, dated 06/16/2026, reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications. In an observation and interview on 06/14/2026 at 9:52 a.m. Resident #95 had a tube of Estradiol Vaginal Cream (Estradiol (estrogen) is a female hormone used to help alleviate symptoms of menopause, including vaginal dryness and burning) on the over bed table, when asked what that was, she stated she had forgotten to use it last night. She stated she had not yet used the pain cream that was on the nightstand. In an interview on 06/15/2026 at 11:51 a.m. with LVN I revealed she was not aware that Resident #95 had any medications at bedside. She stated those should not be in the room and the risk to the resident was it could be used for the wrong reason or the wrong amount used. In an interview on 06/16/2026 at 1:35 p.m., the DON stated that no medication should be at the resident's bedside, and she expected her staff to remove items that are not allowed. She stated the risk to the residents is that the medication could not be administered correctly. Record review of the facility's policy, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Storage of Drug Operational/Resident Care Policies, undated, reflected, All drugs and biologicals are stored in locked compartments.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 three of eighteen residents (Resident #44, #126, and #137) reviewed for infection control. 1.The facility failed to ensure CNA F performed hand hygiene, changed her gloves, and wore a gown during Resident #126's incontinent care on 06/14/2026. 2.The facility failed to ensure CNA F and CNA G wore gowns when Resident #126, who was on enhanced barrier precautions due to pressure ulcer, was repositioned on 06/14/2026. 3.The facility failed to ensure MA D sanitized the blood pressure cuff when used between Resident #44 and Resident #137 on 06/14/2026. These failures could place residents at risk of cross-contamination and development of infections.Findings included: 1.Record review of Resident #126's Face Sheet, dated 06/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #126's Comprehensive MDS Assessment, dated 05/08/2026, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident was incontinent and was at risk of pressure ulcer (wound on the skin caused by prolonged pressure to specific areas of the body). Record review of Resident #126's Comprehensive Care Plan, dated 06/04/2026, reflected the resident required assistance with ADLs and had a stage four pressure ulcer to left lateral malleolus. The interventions were to provide support with toilet use and to provide wound care. Record review of Resident #126's Physician Order, dated 06/12/2026, reflected LEFT LATERAL (from the sides) MALLEOULUS (bone in the ankle): STAGE 4 Clean wound bed with wound cleanser or normal saline, pat dry, cover with Foam dressing one time a day. The order indicated that the resident had the pressure ulcer since 05/29/2026 and was edited on 06/12/2026. During an observation on 06/14/2026 at 9:24 a.m., CNA F was about to do Resident #126's incontinent care, who had a pressure ulcer to left ankle. He went inside the room and put on a pair of gloves. He did not wash his hands before putting on his gloves. He also did not wear a gown before doing incontinent care. He took a brief from a plastic bag, opened it, and placed it on the resident's side. He unfastened the soiled brief, tucked it between the resident's legs, and rolled the resident to his side. He then cleaned the resident's bottom. After cleaning the resident's bottom, he applied some cream to the resident's bottom using the same gloves used in cleaning the resident's bottom. After applying the cream, he changed his gloves but did not sanitize his hands before putting on a new pair of gloves. He then pulled the soiled brief and threw it on the trash can. He took the opened brief from the resident's side, placed it under the resident, and fixed it under. He did not change his gloves after touching the soiled brief. After fixing the brief, he rolled back the resident, cleaned the resident's perineal area (area between the legs) with the same gloves that touched the soiled brief, and fastened the brief. It was observed that during the process of incontinent care, CNA F was leaning on the resident's bed. After he was done with incontinent care, he took off his gloves and told the resident that he would call somebody to help him reposition the resident. He went out of the room but did not wash his hands before leaving the room. There was a sign outside the resident's room that stated the resident was on EBP, and a gown was required when changing the brief. The sign also indicated to clean the hands before entering and when leaving the room. 2.During an observation on 06/14/2026 at 9:34 a.m. revealed CNA F and CNA G were about to reposition Resident #126. CNA F put on a pair of gloves but did not wash his hands before putting on a pair of gloves. CNA G went to the bathroom, washed her hands, put on a pair of gloves, and proceeded to reposition the resident. Both CNAs did not have a gown, and both CNAs were leaning on the resident's bed. There was a sign observed outside the resident's room that the resident was on EBP, and a gown was required during transfer. The sign also (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated to clean the hands before entering and when leaving the room. During an interview on 06/14/2026 at 9:37 a.m., CNA F said he should wash his hands before incontinent care and repositioning the resident, before putting on a pair of gloves, should have sanitized his hands when he changed his gloves, and changed his gloves after pulling the soiled brief. He said the purposes of the procedures mentioned were to prevent cross contamination and spread of infection. He said he was not aware Resident #126 was on EBP. He said he saw the sign but did not bother to check for whom the sign was for. He said since the resident was on EBP, then PPE was required for the same reason. He said he was trained in infection control but did not know why he forgot to practice them when he did incontinent care and repositioning. During an interview on 06/14/2026 at 9:40 a.m., CNA G said she was not aware Resident #126 was on EBP. She said she thought the EBP sign was for Resident #126's roommate. She looked at the EBP sign and realized the sign was for Resident #126. She said if a resident required EBP, a gown should be worn even when repositioning the resident because it was a high contact activity. She said a gown should have been worn to prevent cross contamination. 3.Record review of Resident #44's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #44's Comprehensive MDS Assessment, dated 04/08/2026, reflected the resident had a severe impairment with cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had hypertension. Record review of Resident #98's Comprehensive Care Plan, dated 05/28/2026, reflected the resident had hypertension and one of the interventions was to administer medication as ordered. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Losartan Potassium 50 MG Tablet Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD If SBP less than 100 or DBP less than 60 **IF SBP > 180 or DBP > 110 NOTIFY NURSE/PHYSICIAN. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Metoprolol Succinate ER Oral Tablet Extended-Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD If SBP less than 100 or DBP less than 60 OR PULSE less than 60. IF SBP > 180 or DBP > 110 NOTIFY NURSE/PHYSICIAN. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #137's Face Sheet, dated 06/16/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with hypertension. Record review of Resident #137's Comprehensive MDS Assessment, dated 05/22/2026, reflected the resident had a moderate (resident may need additional support and monitoring) impairment with cognition with a BIMS score of 08. The Comprehensive MDS Assessment indicated that the resident had hypertension. Record review of Resident #137's Comprehensive Care Plan, dated 05/28/2026, reflected the resident had hypertension and one of the interventions was to administer medication as ordered. Record review of Resident #137's Physician Order, dated 07/27/2025, reflected Carvedilol Oral Tablet 12.5 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN HOLD FOR SBP <100 OR DBP < 60 OR PULSE < 60. During an observation on 06/14/2026 starting at 11:29 a.m. revealed MA D went inside Resident #137's room with a bp cuff. She then came out of Resident #137's room holding a bp cuff and placed it on top of the medication cart, prepared Resident #137's medication, and gave the medications to Resident #137. She did not sanitize the blood pressure cuff after use. She then went to Resident #44's room to check the resident's blood pressure. She picked up the blood pressure cuff from the medication cart and went inside the resident's room and placed the blood pressure cuff on the resident's arm. After the blood pressure reading was completed, MA D placed the blood pressure cuff on top of the medication cart, prepared the medications, and gave the medications to Residents #44. She did not sanitize the blood pressure cuff after use. During an interview on 06/14/2026 at 11:57 a.m., MA D said the facility protocol was to sanitize the bp cuff in between use to prevent cross contamination. She said one resident might have a skin issue and might be transferred to another resident because the bp cuff was not sanitized. During an interview on 06/16/2026 at 9:03 a.m., ADON (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A said the staff should be mindful they were not causing any spread of infection in the facility and one way to do that was to do hand hygiene before, after, and during any care. She said the staff should change their gloves after cleaning the resident's bottom to make sure the staff were not using soiled gloves when they touched the new brief and should sanitize the hands before putting on a new pair of gloves. She said another way to prevent the spread of infection was to wear PPE when residents were on EBP. She said residents with pressure ulcers were on EBP to prevent any microorganism from the residents from clinging to the clothes of the staff. She said the purpose of EBP was to prevent the spread of MDRO (Multi-Drug-Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics). She said, during incontinent care, the procedure would always be from clean to dirty, meaning gloves should have been changed before touching the new brief. She said the bp cuff should have been sanitized in between use for the same reason. She said the blood pressure cuff should be sanitized in-between use also to prevent cross contamination. She said she would coordinate with the DON about the issues discussed. During an interview on 06/16/2026 at 9:15 a.m., the DON said hand hygiene was the most effective way to prevent cross contamination and spread of infection. She said staff should do hand hygiene before and after any care, said gloves should be changed after cleaning the resident's bottom and before touching the new brief, said hands should be sanitized before putting on a new pair of gloves, and a gown should have been worn if the resident was on EBP. She said the blood pressure cuff should be sanitized after using it. She said not following the policies and procedures of infection control could contribute to cross contamination, development of infection, and spread of infection. She said the expectation was for the staff to adhere to the policies and procedures of infection control. She said she would start an in-service about infection control. During an interview on 06/16/2026 at 9:41 a.m., the Administrator said the expectation was for the staff to wash their hands before and after any care, change their gloves and sanitize their hands when needed, sanitize their hands and bp cuff when required, and put on a gown when the residents were on EBP. She said the blood pressure cuff should be cleaned before using it on another resident. She said the concerns discussed could attribute to the development and spread of infection. She said she would coordinate with the DON regarding the issues discussed. She said she would personally monitor that the staff understood the in-service and not make the same mistake again. Record review of the facility's policy Hand Washing undated, reflected Policy: Hand washing is required before and after a procedure that involves direct or indirect contact with a resident, after contact with any wastes or contaminated materials. Record review of the facility's policy Infection Prevention and Control Program undated, reflected Policies and procedures . Appropriate cleaning, storage, disinfecting, disposal of equipment . Low level disinfection is used for non-critical equipment. Record review of the facility's policy Enhanced Barrier Precaution Infection Prevention and Control Program, undated, reflected Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities . EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi-Drug-Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics) to staff hands and clothing. EBP are indicated for residents with any of the following . Wounds . Wounds generally include . pressure ulcers.

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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 observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one of eighteen residents (Resident #24) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #24's room was in a position that was accessible to the resident on 06/14/2026. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Record review of Resident #24's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). Record review of Resident #24's Comprehensive MDS Assessment (assessment used to determine functional capabilities and health needs), dated 05/26/2026, reflected the resident had a severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS (screening tool used to assess cognitive status) score of 03. The Comprehensive MDS Assessment indicated the resident was dependent on staff for transfer, toileting, hygiene, shower, and dressing. Record review of Resident #24's Comprehensive Care Plan, dated 03/23/2026, reflected the resident had a history of falling and was at increased risk of falling and one of the interventions was to be sure the resident's call light was within reach. During an observation and interview on 06/14/2026 at 9:08 a.m., Resident #24 was in his bed, awake. It was observed that the resident's call light was on the floor. When asked what he used when he needed assistance, the resident shrugged his shoulders. During an observation and interview on 06/14/2026 at 9:10 a.m., CNA E said call lights should always be within reach of the residents because that was how they called the staff if they needed something. She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. She went inside Residents #24's room and saw the call light on the floor. She pulled the call light from the floor and put it where the resident could reach it. She said, maybe, the call light fell when the resident was repositioned. She said the staff who repositioned him should have made sure the call light was within the resident's reach before leaving the resident's room. During an interview on 06/15/2026 at 8:46 a.m., LVN C said he heard about Resident #24's call light. He said he did not notice that the resident's call light was on the floor. He said staff should always make sure the call lights were with the resident before leaving the room so that they could call the staff if they needed anything. During an interview on 06/16/2026 at 9:03 a.m., ADON A said the call lights should always be with the residents or within reach of the residents. She said the staff should make sure that the call lights were with the residents before they leave the room. She said the call lights were for all residents, regardless of whether they were dependent or independent. She said all the staff were responsible in making sure the call lights were with the residents. She said the expectation was for the staff to make sure that all the call lights were within reach of the residents. She said she would coordinate with the DON regarding the call lights. During an interview on 06/16/2026 at 9:15 a.m., the DON said call lights were inside the residents' rooms so they can call the staff for assistance, a glass of water, pain medication, or if they needed to be changed. She said if the call lights were not within reach, their needs would not be met. She said the call lights were for all the residents, and all the staff were responsible for the call lights. She said the expectation was for the staff to scan the residents' rooms when they did their rounds and ensure the call lights were within reach of the residents before they left the rooms. She said she would start an in-service about call light placement. During an interview on 06/16/2026 at 9:41 a.m., the Administrator said call lights should always be within the reach of the residents. She said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. She said the residents might fall trying to get up to get what they needed. She said she would collaborate with the DON about the issue (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding call lights. Record review of facility's policy Call Lights undated, reflected Purpose: To respond to a resident's call light for their needs . 9. The call light must always be within resident's reach before you leave the room.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure assessments accurately reflected the resident's status for one of eight residents (Residents #13) reviewed for accuracy of assessments. The facility failed to ensure Resident #13's Comprehensive MDS Assessment, dated 05/01/2026, accurately reflected that the resident was receiving insulin. This failure could place the resident at risk for not receiving care and services to meet their needs, diminished function of health, and regression in their overall health.Findings included: Record review of Resident #13's Face Sheet, dated 06/16/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus (high blood sugar). Record review of Resident #13's Comprehensive MDS Assessment, dated 05/01/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus but did not indicate that the resident was receiving insulin. Record review of Resident #13's Comprehensive Care Plan, dated 04/14/2026, reflected that the resident had diabetes mellitus and one of the interventions was to administer diabetes medication as ordered. Record review of Resident #13's Physician Order, dated 05/08/2026, reflected Trulicity Subcutaneous Solution Autoinjector 0.75 MG/0.5ML (Dulaglutide) Inject 0.75 mg subcutaneously (administer under the skin) one time a day every Fri related to . TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. During an observation and interview on 06/16/2026 at 8:57 a.m., MDS Nurse H said if a resident was receiving insulin, then the resident should be coded that she was receiving hypoglycemic (medications used to lower high blood sugar) medications. She went to Resident #13's MDS and saw that the resident was not coded for hypoglycemic medications. She then changed the code, so the MDS would reflect that the resident was on hypoglycemic medication. She said it was an oversight on her part. She said the MDS captures the care that a resident needed. She said the MDS was a form of a clinical assessment to determine the needs of the residents. She said if the assessment was not accurate, then there could be a probability that the needs would not be met. She said she would also audit the MDS of the other residents. During an interview on 06/16/2026 at 9:03 a.m., ADON A said she was not familiar with the MDS but if the MDS needed to reflect that residents were being administered hypoglycemic medications, then it should be in the MDS. During an interview on 06/16/2026 at 9:15 a.m., the DON said the MDS painted the picture of the needs of the residents so that appropriate care could be implemented. She said the MDS could also be used to do the care plan. She said she would coordinate with the MDS Nurse to do an audit. During an interview on 06/16/2026 at 9:41 a.m., the Administrator said she was not familiar with MDS and would coordinate with the MDS Nurse and the DON about the issue. Record review of the facility's policy Resident Assessment Operational/Resident Care Policies, undated, reflected It is the policy of this facility to conduct and document, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of a resident's functional capacity on all residents admitted to the facility . This will provide the facility with the information necessary to develop a care plan and to provide appropriate care and services for each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that the residents' environment remained free of hazards as was possible for 2 (Resident # 96 and Resident #95) of 10 residents reviewed for accident and hazards. 1.The facility failed to ensure a bottle of rubbing alcohol was not left on Resident #96's nightstand next to her bed on 06/14/2026. 2.The facility failed to ensure Resident # 95 did not have a can of aerosol hairspray on the overbed table next to her bed on 06/14/2026.3. The facility failed to ensure medications and biologicals were stored in a secure manner by leaving Micro-Kill wipes unattended on a medication cart without staff supervision. These failures could place residents at risk of injuries and exposure to toxic chemicals.Finding included:Record review of Resident #96's face sheet dated 06/16/2026 reflected a [AGE] year-old female admitted on [DATE]. Her diagnosis included osteomyelitis of vertebra, thoracic region (a localized infection of the bones in the mid to upper back), unspecified dementia (a clinical diagnosis used when a patient clearly has symptoms of cognitive decline or memory loss) and mood disorder. Record review of Resident #96's PPS (Prospective Payment System) Scheduled Assessment for Medicare Part A Stay MDS assessment dated [DATE] revealed a BIMS of 12, indicating she was moderately cognitively intact.On 6/14/26 at 9:11 AM, the surveyor observed a container of Micro-Kill wipes on an unattended medication cart located in front of room [ROOM NUMBER]. No nursing staff were present with or monitoring the medication cart at the time of the observation.During an observation and interview on 06/14/2026 at 9:17 a.m. revealed a plastic container of rubbing alcohol that was sitting on the nightstand next to Resident #96's bed. She stated she did not know why it was there or how long it had been there. On the back of the container there was a note that said, Keep out of reach of children.During an interview on 06/15/2026 at 9:42 a.m., RN A stated she was not aware the alcohol was in the room and said it should not be there, she stated the risk to the resident was that it could be ingested by someone who didn't know what it was. Record review of the facility's undated policy Operational/Resident Care Polices stated in part . All poisonous items and or other items with cautionary labels are kept secured and are only accessible to employees. Record review of Resident #95's face sheet dated 06/16/2026 reflected a [AGE] year-old female admitted on [DATE]. Her diagnosis included acute kidney failure, depression and hypertension, (high blood pressure). Record review of Resident #95's MDS assessment dated [DATE]revelaed a BIMS of 11 indicating she was moderately cognitively intact.During an observation and interview on 06/14/2026 at 9:50 a.m. revealed a can of aerosol hairspray that she stated her daughter had brought her. She was not aware she was not supposed to have that in her room. In an interview on 06/15/2026 @ 12:06 p.m., LVN B stated she was not aware that Resident # 95 had aerosol hairspray, she stated the risk was that someone who was confused could get a hold of it.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for two of ten residents (Resident #44 and Resident #113) reviewed for medication administration. 1.The facility failed to ensure MA D administered Resident #44's medication on time on 06/14/2026. 2.The facility failed to dispose of Resident #113's expired insulin on 06/15/2026. These failures could place residents at risk of not receiving the full therapeutic benefits of the medications and not receiving medications as ordered resulting to adverse effects.Findings included: 1.Record review of Resident #44's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason), pleural effusion (collection of fluid around the lungs), drug induced constipation (problem with passing stool), GERD (stomach acid flows back into the tube connecting your mouth and stomach), rheumatoid arthritis (inflammation of the joints), hypertension (high blood pressure) and anxiety (intense or excessive fear or worry). Record review of Resident #44's Comprehensive MDS Assessment, dated 04/08/2026, reflected the resident had a severe impairment with cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had medically complex conditions. Record review of Resident #44's Comprehensive Care Plan, dated 05/28/2026, reflected the resident was at risk of complications and one of the interventions was administer medications at the same time of the day.Record review of Resident #44's Physician Order, dated 04/25/2026, reflected Famotidine Oral Tablet 20 MG (Famotidine) Give 1 tablet by mouth one time a day for GERD. The medication was scheduled to be administered at 9:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for Edema (swelling caused by fluid trapped in the tissues of the body). The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Lidocaine External Patch 4 % (Lidocaine) Apply to AFFECTED AREA topically one time a day for Pain and remove per schedule. The patch was scheduled to be applied at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Losartan Potassium 50 MG Tablet Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION . HOLD If SBP less than 100 or DBP less than 60 IF SBP > 180 or DBP > 110 NOTIFY NURSE/PHYSICIAN. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Metoprolol Succinate ER Oral Tablet Extended-Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION . HOLD If SBP less than 100 or DBP less than 60 OR PULSE less than 60. IF SBP > 180 or DBP > 110 NOTIFY NURSE/PHYSICIAN. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Miralax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350). Give 17 grams by mouth one time a day for STOOL SOFTENER. Give 1 scoop (=17gm) mixed in 6-8 oz of fluid. Document amount taken. The Miralax was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 04/25/2026, reflected Paroxetine HCl Oral Tablet 30 MG (Paroxetine HCl) Give 1 tablet by mouth one time a day related to OTHER SPECIFIED DEPRESSIVE (persistent feeling of sadness or loss of interest) EPISODES. The medication was scheduled to be given at 9:00 a.m. Record review of Resident #44's Physician Order, dated 04/29/2026, reflected Hydroxychloroquine Sulfate Tablet 200 MG Give 1 tablet by mouth two times a day related to RHEUMATOID ARTHRITIS, UNSPECIFIED . for 90 Days. The medication was scheduled to be given at 9:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Senna Oral (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tablet 8.6 - 50 MG (Sennosides-Docusate Sodium) Give 1 tablet by mouth two times a day for Constipation. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/16/2026, reflected Ipratropium Bromide Nasal Solution 0.06% (Ipratropium Bromide [Nasal]) 2 sprays in both nostrils three times a day for Rhinorrhea (runny nose). The medication was scheduled to be given at 8:00 a.m. During an observation and interview on 06/14/2026 at 11:37 a.m., revealed MA D was passing medications in hall 100. She went inside Resident #44's room and took the resident's blood pressure. After taking the resident's blood pressure, she started to prepare the resident's medications. When asked if she was preparing the resident's noon medication, she said she was preparing the resident's morning medication. She said she was late for her medications. It was also observed that the resident's eMAR was red. During an interview on 06/14/2026 at 11:57 a.m., MA D said aside from the residents' complaining that their medications were late, it might affect the overall health of the residents because the medications were late. She said the right procedure for passing medications was to administer them one hour before and one hour after. She said the resident's eMAR was red implying that the medications were late. During an interview on 06/15/2026 at 8:46 a.m., LVN C said he was not aware that MA D was late for the medications. He said he had no idea why she was late. He said he passed some of the residents' medication in hall 100. He said the health of the residents might be affected like their condition was not improving because of the late medication. During an interview on 06/15/2026 at 8:51 a.m., the DON said she was not aware that MA D was late with her medications. She said she would talk to MA D and assess Resident #44. 2.Record review of Resident #113's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with diabetes mellitus. Record review of Resident #113's Comprehensive MDS Assessment, dated 05/06/2026, reflected the resident had severe impairment in cognition with a BIMS score of 04. The Comprehensive MDS Assessment indicated the resident had diabetes mellitus and was receiving insulin. Record review of Resident #113's Comprehensive Care Plan, dated 05/04/2026, reflected the resident had diabetes mellitus and one of the interventions was administering diabetes medication as ordered. Record review of Resident #113's Physician Order, dated 02/26/2026, reflected Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 180 = 0 units < 70 give OJ; 181 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units > 401. give 12 units and call MD, recheck in 15 minutes, subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. During an observation on 06/16/2026 at 12:28 p.m. revealed Resident #113's insulin was inside the medication room's refrigerator, along with the other insulins. The insulin was opened on 05/15/2026. During an interview on 06/16/2026 at 12:29 p.m., RN B said the insulin was already expired because the shelf life for Humalog was 28 days. She said she did not know who left the expired insulin inside the refrigerator. She said the insulin should have been disposed of and not left inside the refrigerator along with the other insulin because somebody might have used the expired insulin accidentally. She said expired medications could be less effective or more toxic. During an interview on 06/16/2026 at 9:03 a.m., ADON A said there should not be expired medication inside the medication room's refrigerator because expired medications could be less potent and would not be able to provide the full benefit of the medications. She said the nurses were responsible for ensuring there were no expired medications in the refrigerator. She said, maybe a nurse took a new insulin but was not able to dispose of the expired one. She said medications could be administered one hour before and one hour after. She said medications should be administered on time to meet the needs of the residents. She said she would coordinate with the DON about the issue. During an interview on 06/16/2026 at 9:15 a.m., the DON said they inspected all the carts and medication rooms the night before. She said she did not know why there was an expired insulin inside the medication room. She said, maybe a nurse was getting a new insulin and accidentally left the expired insulin. She said the expired insulin should have been disposed of. She said there was a time frame for each hall (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676466	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheyenne Medical Lodge	750 Highway 352 Mesquite, TX 75149

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to administer the medications. She said some of the residents were assigned to the nurses to ease the load of the MAs, so she could not understand why the medications were administered very late. She said she will do an in-service about making sure there were no expired medications and medication administration. During an interview on 06/16/2026 at 9:41 a.m., the Administrator said she was not a clinician and would let the DON take the lead about the expired medication and late medication administration. Record review of the facility's policy Pharmacy Services Operational/Resident Care Policies, undated, reflected The facility provides routine and emergency drugs and biologicals to residents . The facility uses an automated dispensing machine called Omnicell to ensure the safe, and accurate dispensing of medications . The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of the resident . When pharmacy services are provided . the facility assumes responsibility for obtaining services that meet professional standards, principles, and timeliness of the service. Record review of the facility's policy, Drug Security Operational/Resident Care Policies, undated, reflected, The facility establishes procedures for storing and disposing of drugs and biological . Medications . medications which have passed the expiration date . will be stored separately under lock andkey in the director of nurses' office and in the medication room. Policy for insulin shelf life requested on 06/16/2026 at 12:55 p.m. via email to the Administrator. The Administrator replied, via email, they do not have a policy regarding the shelf life of insulins but would follow the manufacturer's guideline.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, the facility failed to ensure that the medication error rate was not five percent or greater. Eleven medication administration errors were identified out of 25 opportunities, yielding a 44.4% error rate for one of five residents (Resident #44) reviewed for medication errors. The facility failed to ensure MA D did not give Resident #44's eight o'clock and nine o'clock medications at 11:30 a.m. on 06/14/2026. This failure could place the residents at risk for treatment failure, disease progression, reduced effectiveness, and adverse reactions.Findings included: Record review of Resident #44's Face Sheet, dated 06/16/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia, pleural effusion, drug-induced constipation, GERD, rheumatoid arthritis, hypertension, and anxiety. Record review of Resident #44's Comprehensive MDS Assessment, dated 04/08/2026, reflected the resident had a severe impairment with cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated the resident had medically complex conditions. Record review of Resident #44's Comprehensive Care Plan, dated 05/28/2026, reflected the resident was at risk of complications and one of the interventions was administer medications at the same time of the day. Record review of Resident #44's Physician Order, dated 04/25/2026, reflected Famotidine Oral Tablet 20 MG (Famotidine) Give 1 tablet by mouth one time a day for GERD. The medication was scheduled to be administered at 9:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for Edema. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Lidocaine External Patch 4 % (Lidocaine) Apply to AFFECTED AREA topically one time a day for Pain and remove per schedule. The patch was scheduled to be applied at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Losartan Potassium 50 MG Tablet Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD If SBP less than 100 or DBP less than 60 **IF SBP > 180 or DBP > 110 NOTIFY NURSE/PHYSICIAN. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Metoprolol Succinate ER Oral Tablet Extended-Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD If SBP less than 100 or DBP less than 60 OR PULSE less than 60. IF SBP > 180 or DBP > 110 NOTIFY NURSE/PHYSICIAN. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Miralax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350). Give 17 grams by mouth one time a day for STOOL SOFTENER. Give 1 scoop (=17gm) mixed in 6-8oz of fluid. Document amount taken. The Miralax was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 04/25/2026, reflected Paroxetine HCl Oral Tablet 30 MG (Paroxetine HCl) Give 1 tablet by mouth one time a day related to OTHER SPECIFIED DEPRESSIVE EPISODES. The medication was scheduled to be given at 9:00 a.m. Record review of Resident #44's Physician Order, dated 04/29/2026, reflected Hydroxychloroquine Sulfate Tablet 200 MG Give 1 tablet by mouth two times a day related to RHEUMATOID ARTHRITIS, UNSPECIFIED (M06.9) for 90 Days. The medication was scheduled to be given at 9:00 a.m. Record review of Resident #44's Physician Order, dated 03/17/2026, reflected Senna S Oral Tablet 8.6 - 50 MG (Sennosides-Docusate Sodium) Give 1 tablet by mouth two times a day for Constipation. The medication was scheduled to be given at 8:00 a.m. Record review of Resident #44's Physician Order, dated 03/16/2026, reflected Ipratropium Bromide Nasal Solution 0.06 % (Ipratropium Bromide [Nasal]) 2 sprays in both nostrils three times a day for Rhinorrhea. The medication was scheduled to be given at 8:00 a.m. During an observation and interview on 06/14/2026 at 11:37 a.m., revealed MA D was passing medications in hall 100. She prepared a total of eleven medications for Resident #44 and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered them. When asked if she was preparing the resident's noon medication, she said she was preparing the resident's morning medication. She said she was late for her medications. It was observed that the medications she was preparing were due at 8:00 a.m. and 9:00 a.m. It was also observed that the resident's eMAR was in red. During an interview on 06/14/2026 at 11:57 a.m., MA D said since Resident #44's medications were late, it could be considered a medication error. She said the resident's eMAR was red implying that the medications were late. During an interview on 06/15/2026 at 8:51 a.m., the DON said she already talked to MA D to ask her why the medications were late and assessed Resident #44. She said the resident was stable and did not have any adverse reactions from the late medications. During an interview on 06/16/2026 at 9:03 a.m., ADON A said she expected all medications to be given within the two-hour window of when the medication is due. For a medication due at 8:00 a.m., it should be given between 7:00 a.m. and 9:00 a.m. For medications scheduled at 9:00 a.m., it should be given between 8:00 a.m. and 10:00 a.m. She said not giving the medications within the time frame would result to medication errors. During an interview on 06/16/2026 at 9:15 a.m., the DON said since the medications were given late, there was a medication error. She said a medication error of 44.4% was a big one and should be corrected. She said medication errors should be prevented to ensure the safety of the residents. She said medication errors, such as wrong time, could cause adverse reactions and worsening of the existing conditions. She said she would find out the root cause of the medication error to identify the causes and implement a fix to the issue observed. She said the expectation was that there was no medication error that would occur. During an interview on 06/16/2026 at 9:41 a.m., the Administrator said medications should be given an hour before or an hour after their due time to prevent medication error. She said medications that were due at 8:00 a.m. and 9:00 a.m. and were given at almost noon were unacceptable. She said she would coordinate with the DON about the issue. Record review of the facility's policy Drug Administration Operational/Resident Care Policies, undated, reflected The facility will ensure that medication error rates are not 5 percent or greater and the residents are free of any significant medication errors . All drug errors and adverse drug reactions will be reported to the resident's physician in a timely manner, as warranted by an assessment of the resident's condition, and recorded in the resident's record . Drug administration in error can occur in several instances . the drug is administered at the wrong time. Record review of the facility's policy Medication Errors and Drug Reactions undated, reflected Purpose . 5. To report when a drug is not given at the correct time.