STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676487	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Parmer	13800 N Fm 620 Rd Sb Austin, TX 78717

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 sampled residents (R#68). The facility failed to develop a care plan that described the respiratory care/services R#68 would receive for her shortness of breath per her physician's orders made on 10/25/25. This failure could place residents at risk of receiving the wrong oxygen flow, interruptions in therapy, delayed emergency response, respiratory distress, life-threatening hypoxia or complications from oxygenation. Review of R#68's admission record, dated 01/29/26, showed she was admitted to the facility on [DATE] with medical diagnosis that included shortness of breath.Review of R#68's admission MDS, dated [DATE], showed she had a BIMS score of 13/15, which indicated she was cognitively intact. Section O reflected that she required oxygen therapy on admission and while she was a resident. Review of R#68's order summary report, dated 01/28/26, reflected a verbal order made on 10/25/25 to change nebulizer mask and oxygen tubing every Sunday HS and PRN, oxygen to be on at (1-5) liters per minute continuously, delivered through NC, may titrate to greater than or equal to 88% every shift and PRN, okay for therapy to titrate PRN for SOB/decreased O2 saturation or every shift for SOB. The order started on 10/26/25. Review of R#68's care plan, completed 01/17/26, showed she would get shortness of breath. There were no interventions documented regarding her verbal order made on 10/25/25. During an observation of and interview with R#68 on 01/28/26 at 11:18 a.m., her oxygen machine was on in her room. Her NC was on her lap. She stated she was receiving oxygen therapy for her shortness of breath at the time of the interview, every shift and daily. She stated she did not observe and did not know if staff changed her oxygen tubing and nebulizer masks when she did not use the equipment. During an interview with CNA E on 01/30/26 at 1:34 p.m., she stated the NP reviewed and revised residents' care plans.During an interview with CNA F on 01/30/26 at 1:58p.m., she stated the Case Manager reviewed and revised residents' care plans. During an interview with CNA G on 01/30/26 at 2:23 p.m., CNA O on 01/30/26 at 3:09 p.m. and LPN L on 01/30/26 at 4:03 p.m., they stated they did not know who reviewed and revised residents' care plans. During an interview with LVN H on 01/30/26 at 2:51 p.m., she stated the nurses and IDT team reviewed and revised residents' care plans. She also stated she did not know who oversaw and ensured the nurses and IDT team reviewed and revised residents' care plans. During an interview with the Weekend Supervisor on 01/30/26 at 3:24 p.m., she stated the case manager and IDT team reviewed and revised residents' care plans.During an interview with LPN J on 01/30/26 at 3:51 p.m., she stated the ADON and DON reviewed and revised residents' care plans.During a interview with RN M on 01/30/26 at 4:12 p.m., she stated nurses reviewed and revised care plans. She also stated the ADON and DON oversaw and ensured nurses reviewed and revised residents' care plans.During an interview with the DON on 01/30/26 at 4:43 p.m., she stated MDS Coordinator C and D reviewed and revised residents' care plans. She also stated her or the ADON (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oversaw and ensured MDS Coordinator reviewed and revised residents' care plans by reviewing orders and 24 hour reports. The surveyor attempted to call MDS Coordinator C on 01/30/26 at 5:05 p.m The surveyor left a voicemail and call back number. MDS Coordinator C did not return the surveyor's call before exit. During an interview with MDS Coordinator D on 01/30/26 at 5:07 p.m., she stated the IDT team reviewed and revised residents' care plans. She stated she knew it was important to review and revise residents' care plans and said, Because the plan of care could change. Resident could be at risk of death, risk of falls, injuries, metabolic, cardiac, endo, kidney, etc. During an interview with the ADM on 01/30/26 at 5:17 p.m., he stated the IDT team reviewed and revised residents' care plans. He also stated he knew it was important to review and revise residents' care plans and said, It keeps residents health status up to date and what their status is. Review of the facility's care plan policy and procedure, revised 02/08/21, reflected, Policy: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan and manage resident care as evidenced by documentation from admission through discharge for each resident.The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the patient's strengths, limitations, and goals. The care plan will be specific and appropriate to the individual needs for each resident. The interdisciplinary care plan will be developed through collaborative efforts of the IDT and other health care professionals. The care plan will be patient centered emphasizing the resident's and/or family's goals.Procedure:The facility will develop, implement, and provide care in accordance with a comprehensive person-centered care plan for the resident consistent with regulatory requirements. The care plan is to include measurable objectives and timeframes to meet a resident's medical, nursing, psycho-social, and functional needs identified with completion of the comprehensive assessment.The interdisciplinary team members will contribute towards the interventions and approaches needed to obtain the resident's desired and expected outcomes.The care plans will be modified when needed to meet the resident's current needs, problems, and goals. Any revision, additions, or deletion to the plan of care will be dated.Revisions involving the care of other disciplines are done through consultative and collaborative efforts.All residents are discussed with the Interdisciplinary Team to provide continued updates, revisions, and discontinuation of interventions based on the resident's goals, care needs, and discharge planning.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 8 sampled residents (R#63). The facility failed to revise R#63's care plan to reflect all fall risk interventions recommended by the PCP after his unwitnessed fall on 01/13/26. This failure could place residents at risk of falls, injuries or hospitalization. Review of R#63's admission record, dated 01/29/26, showed he was admitted to the facility on [DATE] with medical diagnoses including wedge compression fracture, low back pain and altered mental status. Review of R#63's 5-Day MDS assessment, dated 01/15/26, showed he had a BIMS score of 7/15, which indicated he had severe cognitive impairment. Section J reflected he had no falls since admission/reentry. Review of R#63's progress notes showed RN K created a note on 01/13/26 at 8:00 a.m. that reflected she notified the PCP of his change in condition evaluation for fall on 01/13/26. The PCP recommended increasing frequent monitoring, place fall mats, educate him on importance of using call light to prevent falls and keeping his bed low to the ground after fall. Review of R#63's care plan, initiated 01/09/26, showed he was a high risk faller and had a fall on 01/13/26. Interventions include call don't fall signs in his room to remind him to call for assistance, safety rounds by all staff, fall mats at bedside, have adequate lighting, and transfer and change positions slowly. Interventions did not include the PCP's recommendation of lowering bed to the ground. During an observation and interview of R#63 on 01/28/26 at 11:47 a.m., he was lying in bed with FAM sitting next to him. Fall mats were on each side of his bed. Call don't fall sign was in his room. There was adequate lighting. A female CNA left his room after finishing resident care on him. The female CNA did not lower his bed to the ground before leaving his room. The surveyor attempted to interview R#63, but he did not answer any of the surveyor's questions. R#63's FAM stated he fell on the ground at the facility. They also stated staff did not lower his bed to the ground before leaving his room and they often had to remind staff. During an interview with CNA E on 01/30/26 at 1:34 p.m., she stated the NP reviewed and revised residents' care plans. During an interview with CNA F on 01/30/26 at 1:58 p.m., she stated the Case Manager reviewed and revised residents' care plans. During an interview with CNA G on 01/30/26 at 2:23 p.m., she stated she did not know who reviewed and revised residents' care plans. During an interview with LVN H on 01/30/26 at 2:51 p.m., she stated the nurses and IDT team reviewed and revised residents' care plans. She stated she did not know who oversaw and ensured the nurses and IDT team reviewed and revised residents' care plans. During an interview with CNA O on 01/30/26 at 3:09 p.m., she stated she did not know who reviewed and revised residents' care plans. During an interview with the Weekend Supervisor on 01/30/26 at 3:24 p.m., she stated the Case Manager and IDT team reviewed and revised residents' care plans. During an interview with LPN J on 01/30/26 at 3:51 p.m., she stated the ADON and DON reviewed and revised residents' care plans. During an interview with LPN L on 01/30/26 at 4:03 p.m., she stated she did not know who reviewed and revised residents' care plans. During an interview with RN M on 01/30/26 at 4:12 p.m., she stated the nurses reviewed and revised residents' care plans. She also stated the ADON and DON oversaw and ensured residents' care plans were reviewed and revised. During an interview with the DON on 01/30/26 at 4:43 p.m., she stated MDS Coordinator C and D reviewed and revised residents' care plans. She also stated she or the ADON oversaw and ensured residents' care plans were reviewed and revised by reviewing residents' orders and 24 hour reports. The surveyor attempted to call MDS Coordinator C on 01/30/26 at 5:05 p.m the surveyor left a voicemail and call back number. MDS Coordinator C did not return the surveyor's call before exit. During an interview with MDS Coordinator D on 01/30/26 at 5:07 p.m., she stated she, MDS Coordinator C and the IDT team were responsible for reviewing and revising residents' care plans. She also stated she knew it was important to review and revise residents' care plans and said, Because the plan of care could change. Resident could be at (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of death, falls, injuries, metabolic, cardiac, endo, kidney, etc. During an interview with the ADM on 01/30/26 at 5:17 p.m., he stated the IDT team reviewed and revised residents' care plans. He stated he knew it was important to review and revise residents' care plans and said, It keeps residents health status up to date and what their status is. Review of the facility's care plan policy and procedure, revised 02/08/21, reflected, Policy: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan and manage resident care as evidenced by documentation from admission through discharge for each resident.The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the patient's strengths, limitations, and goals. The care plan will be specific and appropriate to the individual needs for each resident. The interdisciplinary care plan will be developed through collaborative efforts of the IDT and other health care professionals. The care plan will be patient centered emphasizing the resident's and/or family's goals.Procedure:The facility will develop, implement, and provide care in accordance with a comprehensive person-centered care plan for the resident consistent with regulatory requirements. The care plan is to include measurable objectives and timeframes to meet a resident's medical, nursing, psycho-social, and functional needs identified with completion of the comprehensive assessment.The interdisciplinary team members will contribute towards the interventions and approaches needed to obtain the resident's desired and expected outcomes.The care plans will be modified when needed to meet the resident's current needs, problems, and goals. Any revision, additions, or deletion to the plan of care will be dated.Revisions involving the care of other disciplines are done through consultative and collaborative efforts.All residents are discussed with the Interdisciplinary Team to provide continued updates, revisions, and discontinuation of interventions based on the resident's goals, care needs, and discharge planning. Review of the facility's fall prevention policy, revised 07/24/23, reflected, PROCEDURE:Any patient deemed to be high risk by nursing and/or therapy staff will have the following interventions at least considered: .Low bed (or lower our standard bed to its lowest position).Post fall Procedure::.Determine what interventions need to be implemented to prevent further falls. Complete orders and/or tasks for fall prevention and for skin injuries if indicated.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 8 sampled residents (R#63). The facility failed to conduct neurological monitoring for R#63 after his unwitnessed fall on 01/13/26. These failures could place residents at risk of delayed treatment adjustments or potential health complications. Review of R#63's admission record, dated 01/29/26, showed he was admitted to the facility on [DATE] with medical diagnoses including wedge compression fracture, low back pain and altered mental status. Review of R#63's 5-Day MDS assessment, dated 01/15/26, showed he had a BIMS score of 7/15, which indicated he had severe cognitive impairment. Section J reflected he had no falls since admission/reentry. Review of R#63's care plan, initiated 01/09/26, showed he was a high risk faller and had a fall on 01/13/26. Interventions include call don't fall signs in his room to remind him to call for assistance, safety rounds by all staff, fall mats at bedside, have adequate lighting, and transfer and change positions slowly. Review of R#63's progress notes showed:- RN K created a note on 01/13/26 at 8:00 a.m. that reflected she notified the PCP of his change in condition evaluation for fall on 01/13/26. The PCP recommended increasing frequent monitoring, place fall mats, educate him on importance of using call light to prevent falls and keeping his bed low to the ground after fall.-Physician A signed an encounter note on 01/15/26 at 10:08 p.m. that reflected, Chief Complaint / Nature of Presenting Problem: Staff reports patient had a fall. History Of Present Illness: .Patient seen and examined at bedside. According to the staff patient was found on the floor at bedside this morning. Patient says he was trying to get out of bed independently and landed on his back. Denies any pain, and no signs of injury noted. Neurologically at his baseline. Denies nausea, HA, vision changes. Will continue to monitor. Stable vitals. Labs reviewed with family.Review of R#63's Change in Condition Evaluation, dated 01/13/26 at 8:00 a.m. showed he had a fall on 01/13/26 in the morning time, had previous falls at home and surgical interventions, notified his PCP and FAM on 01/13/26 at 8:00 a.m. and the PCP recommended increase frequent monitoring, place fall mats, educate patient on importance of using call light to prevent falls and keep the bed low to the ground.Review of R#63's Post-Fall Evaluation, created by RN K on 01/13/26 at 3:18 p.m., showed he had an unwitnessed fall in his room on 01/13/26, was found lying on his back directly next to the bed, had no new skin issues, bleeding or bumps, denied complaints of pain to his head and having used his call light at the time, his call light was not on at the time, and stated he was trying to go out to his lawn to walk, hit his head during the fall and did have pain regarding his chronic back pain. Neurological checks were initiated per facility protocol. Review of R#63's evaluations showed there was no record of neurological evaluations completed after his unwitnessed fall on 01/13/26. Review of R#63's documents showed there was no record of neurological evaluations completed after his unwitnessed fall on 01/13/26. During an observation and interview of R#63 on 01/28/26 at 11:47 a.m., he was lying in bed with FAM sitting next to him. Fall mats were on each side of his bed. Call don't fall sign was in his room. There was adequate lighting. A female CNA left his room after finishing resident care on him. The female CNA did not lower his bed to the ground before leaving his room. The surveyor attempted to interview R#63, but he did not answer any of the surveyor's questions. R#63's FAM stated he fell on the ground at the facility. They also stated staff did not lower his bed to the ground before leaving his room and they often had to remind staff. The surveyor attempted to call MD R on 01/29/26 at 4:05p.m. The surveyor left a voicemail and call back number. MD R did not return the surveyor's call before exit. During an interview with MD Q on 01/29/26 at 4:06 p.m., he stated he worked with R#63. He stated he expected staff to notify the MD, assess the resident for injury, determine if there was a head injury, review residents' medications to determine if any brain bleed and would send the resident out to the hospital if a resident had an unwitnessed fall. He stated he (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would expect staff to initiate neurological monitoring within the first 24 hours if there was a suspected head injury and medications the resident took that could cause brain bleed. He stated he knew it was important to initiate neurological monitoring after an unwitnessed fall and said, Well because if there were any changes after a fall, it could attribute to an intercranial bleed if there was a head injury. The surveyor attempted to call RN K on 01/30/26 at 4:01 p.m The surveyor left a voicemail and call back number. RN K did not return the surveyor's call before exit. During an interview with the DON on 01/30/26 at 4:43 p.m., she stated she expected the frequency of neurological monitoring to take place in accordance with the neurological flow sheet form she provided the surveyor. She stated the nurses documented neurological monitoring on the flow sheets form and uploaded it to residents' electronic health records later on. She stated she oversaw and ensured nurses conducted neurological monitoring. She knew it was important to initiate neurological monitoring after an unwitnessed fall and said, To make sure there was not a change in condition or to make sure the neurological status did not change. Residents could be at risk of a lot of things. During an interview with the ADM on 01/30/26 at 5:17 p.m., he stated he expected staff perform neurological monitoring immediately after an unwitnessed fall and follow the frequency. He stated the nurses documented neurological monitoring on the flow sheet forms and uploaded it to residents' electronic health records later on. He stated the DON oversaw and ensured nurses conducted neurological monitoring. He stated he knew it was important to initiate neurological monitoring after an unwitnessed fall and said, To check for any change in condition of the residents and to see what the next immediate step would be. Residents could be at risk of having a change of condition missed. Review of the facility's neurological flow sheet form reflected staff were required to check on level of consciousness, range of motion, hand grasp, speech and pupil reaction once every 15 minutes x4, once every 30 minutes x2, once every hour x4, once every four hours x6, and once every shift x4. Review of the facility's fall prevention policy, revised 07/24/23, reflected, Post fall Procedure::If unwitnessed fall, perform neurological assessment using the neurological flow sheet.Determine what interventions need to be implemented to prevent further falls. Complete orders and/or tasks for fall prevention and for skin injuries if indicated.The surveyor requested the DON and ADM provide a copy of the facility's quality of care policy and procedure on 01/30/26 at 2:39 p.m. and was not provided with the record before exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 8 sampled residents (R#11 and R#68). 1.The facility failed to bag R#11 and R#68's NCs, CPAP masks, and tubing when not in use.2. The facility failed to document oxygen liters in R#11 and R#68's TARs per their physician's orders. This failure could place residents at risk of respiratory infection. Review of R#11's admission record, dated 01/28/26, showed she was admitted to the facility on [DATE] with medical diagnoses including acute respiratory failure, asthma, pneumonia and COVID-19. Review of R#11's admission MDS, dated [DATE], showed she had a BIMS score of 13/15, which indicated she was cognitively intact. Section O reflected that she also required oxygen therapy while a resident. Review of R#11's care plan, completed 01/19/26, showed staff were required to administer oxygen as ordered and PRN, monitor pulse every shift if less than 88%, start oxygen at 1-5 liters per minute continuously, deliver oxygen through NC, may titrate oxygen to greater than or equal to 88% every shift and prn, and okay for therapy to titrate.Review of R#11's order summary report, dated 01/29/26, showed she had a verbal order for oxygen to be on at (1-5) liters per minute (continuously), delivered through (NC) may titrate to greater than or equal to 88% every shift and PRN and okay for therapy to titrate every shift and PRN for SOB/decreased saturation started on 12/26/25. Review of R#11's MAR/TAR for January 2026 showed staff did not document liters she received per minute on the night of 01/02/26, morning and night of 01/16/26, night of 01/17/26, 01/21/26 and 01/22/26, morning and night of 01/24/26, 01/26/26 and 01/27/26 and the morning of 01/28/26, which indicated there were 13 entries that were not documented with the amount of liters she received during those shifts. Review of R#11's progress notes reviewed on 01/28/26 showed no notes related to amount of liters not documented in MAR/TAR. Review of R#68's admission record, dated 01/29/26, showed she was admitted to the facility on [DATE] with medical diagnosis including shortness of breath. Review of R#68's admission MDS, dated [DATE], showed Section C reflected she had a BIMS score of 13/15, which indicated she was cognitively intact. Section O reflected she required oxygen therapy on and while admitted at the facility. Review of R#68's care plan, completed 01/17/26, reflected she had shortness of breath. No interventions documented related to oxygen use orders. Review of R#68's order summary report, dated 01/29/26, showed she had a verbal order for oxygen to be on at (1-5)liters per minute (continuously), delivered through (NC) may titrate to greater than or equal to 88% every shift and PRN and okay for therapy to titrate every shift and PRN for SOB/decreased saturation started on 10/25/25.Review of R#68's MAR/TAR for January 2026 showed staff did not document liters she received per minute on the morning and night of 01/01/26 through 01/15/26 and 01/17/26 through 01/28/26 and the morning of 01/16/26 and 01/29/26, which indicated there were 56 entries that were not documented with the amount of liters she received during those shifts. Review of R#68's progress notes reviewed on 01/29/26 showed no notes related to amount of liters not documented in MAR/TAR. During an observation and interview of R#68 on 01/28/26 at 11:18 a.m., she was lying in her bed in her room. Her NC was sitting on her lap. The oxygen machine was on. She stated she was receiving oxygen every shift daily and PRN for her shortness of breath. She stated she did not observe and did not know if staff changed or bagged her tubing and NC when she did not use them. During an observation and interview of R#11 on 01/28/26 at 11:26 a.m., she was lying in her bed in her room. Her NC was on the ground and the oxygen machine was on. Her CPAP mask was on her night stand next to her and the machine was off. Her NC was hanging on her wheelchair back support and the oxygen tank was off. She stated she was receiving oxygen every shift daily and PRN for her shortness of breath. She stated staff did not bag her NC and CPAP masks whenever her respiratory equipment was not in use. During an interview with CNA E on 01/30/26 at 1:34 p.m., she (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the CNAs and nurses were responsible for bagging oxygen tubing and equipment when not in use and said, If we leave it out, someone could trip. She stated she rounded and stayed on the floor to ensure oxygen equipment was stored away when not in use. She stated the nurses oversaw and ensured the CNAs stored away oxygen equipment when not in use. She stated she knew it was important to properly store away oxygen equipment when not in use and said, Because it's important, what if it falls and causes a fire or resident gets hurt. Residents could be at risk of respiratory infection. She also stated the nurses documented amount of oxygen liters in residents' TAR. She also stated the DON and management team oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, Because that's how you determine how much you need. If they don't get the appropriate amount, they might not be able to breathe right. During an interview with CNA F on 01/30/26 at 1:58 p.m., she stated the CNAs checked and ensured oxygen equipment was stored away when not in use every morning and notified the nurse when oxygen equipment was not in use. She also stated the nurses were responsible for bagging oxygen tubing and equipment when not in use. She stated the maintenance staff and nurses oversaw and ensured oxygen equipment was properly stored away when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, Because we need to make sure the tubing is not damaged because sometimes it happens. She did not know what residents could be at risk of if oxygen equipment was not properly stored away when not in use. She also stated the nurses documented amount of oxygen liters in residents' TAR. She stated the ADON or DON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, To make sure residents have enough to breathe. She did not know what residents could be at risk of if staff did not document amount of oxygen liters in residents' TAR.During an interview with CNA G on 01/30/26 at 2:23 p.m., she stated the CNAs or nurses were responsible for bagging oxygen tubing and equipment when not in use. She stated the CNAs and nurses checked all the time to ensure oxygen equipment was stored away when not in use and said, To make sure residents don't fall or get hurt. She stated the nurses oversaw and ensured oxygen equipment was properly stored away when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, So it's not contaminated. Residents could be at risk of infection. She also stated the nurses documented amount of oxygen liters in residents' TAR. She also stated that the ADON or DON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, To make sure residents were getting right amount of oxygen they need. Residents could be at risk of suffocation. During an interview with LVN H on 01/30/26 at 2:51 p.m., she stated the nurses bagged oxygen NC and equipment when not in use and every time treatment is finished. She stated the ADON oversaw and ensured nurses stored and bagged oxygen equipment and NC when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, It could get dirty and cause an infection. She also stated the nurses documented amount of oxygen liters in residents' TAR. She also stated that the ADON or DON oversaw and ensured amount of oxygen liters were documented in residents' TAR. She stated she knew it was important to ensure oxygen liters were documented in TAR and said, Just to monitor where residents are at and might need to titrate due to oxygen orders. Residents could be at risk of getting the wrong amount of oxygen and inconsistent or lack of continuity of care. During an interview with CNA I on 01/30/26 at 3:09 p.m., she stated the CNAs or nurses were responsible for bagging oxygen tubing when not in use. She stated the CNAs and nurses checked and ensured oxygen equipment was stored away when not in use at least every two hours. She stated the HR oversaw and ensured oxygen equipment was properly stored away when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, Because it could get bacteria and residents could catch and infection. She also stated the nurses documented amount of oxygen liters in residents' TAR. She stated the MDS (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinators oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, Because they might end up getting too much of what they were supposed to have. During an interview with the Weekend Supervisor on 01/30/26 at 3:24 p.m., she stated the CNAs, therapy or nurses were responsible for bagging oxygen tubing when not in use. She stated she checked whenever she did room rounds, which were at least throughout the shift, and ensured oxygen equipment was stored away when not in use. She stated all staff and night time staff oversaw and ensured oxygen equipment was properly stored away when not in use during night shifts and angel rounds. She stated she knew it was important to store away oxygen equipment when not in use and said, Infection control. So they're not picking up bugs. Residents could be at risk of respiratory infections. She also stated the nurse on shift documented amount of oxygen liters in residents' TAR. She stated her, the ADON and DON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR by conducting daily audits. She stated she knew it was important to document amount of oxygen liters and said, To make sure staff were going by orders and make sure staff were giving not more or less than what residents need.During an interview with LPN J on 01/30/26 at 3:51 p.m., she stated the nurses were responsible for bagging oxygen tubing when not in use. She stated she checked throughout her shift and ensured oxygen equipment was stored away when not in use. She stated the ADM, ADON, and DON oversaw and ensured oxygen equipment was properly stored away when not in use during night shifts and angel rounds. She stated she knew it was important to store away oxygen equipment when not in use and said, For Infection control. Residents could be susceptible to respiratory infections or infections. She also stated the nurses documented amount of oxygen liters in residents' TAR. She also stated the ADON and DON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, So we know as far as how much oxygen resident received. Residents could be at risk of receive respiratory failure due to not receiving enough oxygen and fall into hypoxia.During an interview with LPN L on 01/30/26 at 4:03 p.m., she stated the nurses were responsible for bagging oxygen tubing when not in use. She stated she checked throughout her shift. She stated the charge nurses, ADON, and DON oversaw and ensured oxygen equipment was properly stored away when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, For Infection control. Residents could be at risk of infection because it could fall on the floor, get dirty, and residents could become septic. She also stated the charge nurses documented amount of oxygen liters in residents' TAR. She stated the ADON and DON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, Depending on what they are at with respiratory status and need to find out if need more or less and need to know if it needs to be tapered down. Residents could be at risk of staff not knowing how much oxygen the resident needed and if therapy was effective. During an interview with RN M on 01/30/26 at 4:12 p.m., she stated the nurses were responsible for bagging oxygen tubing when not in use. She stated she checked anytime she went into residents' rooms and ensured oxygen equipment was stored away when not in use. She stated the ADM and DON oversaw and ensured oxygen equipment was properly stored away when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, Uh, germs, if it falls on the floor, you must replace the tubing, and if it's in the plastic bag, it'll be okay. Residents could be at risk of falls and infection. She also stated the nurses documented amount of oxygen liters in residents' TAR. She stated the DON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR. She stated she knew it was important to document amount of oxygen liters and said, Go by the order and must follow the orders. Residents could become hypoxic and shortness of breath. Residents could not be getting oxygen enough or too much.During an interview with the DON on 01/30/26 at 4:43 p.m., she stated the CNAs, therapy and nurses were responsible for bagging oxygen tubing when not in use. She stated she expected all staff to check throughout their shift and ensure oxygen equipment (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was stored away when not in use. She stated she knew it was important to store away oxygen equipment when not in use and said, Because we can find where it is at. So it is readily available. So that it does not get dirty and if it does it needs to be thrown away. She stated she did not believe there would be an adverse outcome to residents if oxygen equipment was not bagged when not in use. She also stated the nurses documented amount of oxygen liters in residents' TAR. She also stated she and the ADON oversaw and ensured nurses documented amount of oxygen liters in residents' TAR by conducting daily chart checks. She stated she knew it was important to document amount of oxygen liters and said, To get a baseline. She stated she did not believe there was an adverse outcome that likely could result if staff did not document amount of oxygen liters. During an interview with the ADM on 01/30/26 at 5:17 p.m., he stated he would expect staff to bag oxygen equipment and tubing when not in use. He stated angel rounds are conducted every morning by management staff to ensure oxygen equipment was stored away when not in use. He stated he knew the importance of storing away oxygen equipment when not in use and said, Because you don't want the resident to get tangled with it or have it fall on the resident. He also stated he expected staff to follow physician's orders. He stated he knew it was important to follow physician's orders and said, It's what we do. We got to follow it. If it's too much or too little, call the doctor, DON or NP and get a new order. Review of the facility's oxygen tubing policy and procedure, revised 02/09/23, reflected, Purpose:Oxygen therapy may be provided through various types of supply and delivery systems. Equipment may include the provision of oxygen through nasal cannulas, trans-tracheal oxygen catheters, oxygen canisters, cylinders, or concentrators.Procedure:For a patient receiving oxygen therapy: The Oxygen tubing may be changed monthly. Oxygen tubing may be changed when it becomes soiled. Change PRN Change Oxygen tubing if dropped on the floor.For a patient receiving oxygen therapy, the patient's record must reflect ongoing evaluation of the patient's respiratory status, response to oxygen therapy and include, at a minimum, the attending practitioner's orders, and indication for use. In addition, the record should include: The type of oxygen delivery system When to administer, such as continuous or intermittent and/or when to discontinue Equipment settings for the prescribed flow rates Monitoring of SpO2 levels and/or vital signs, as ordered; and Based upon the individual patient's risks, if applicable, monitoring for complications, such as skin integrity issues related to the use of a nasal cannula. Concentrators, Wall oxygen and portable tanks should be checked. If any defect noted, it should be replaced. The defected item needs to be tagged. If any issues noted with the wall oxygen maintenance/management should be notified as soon as the problem is noted.

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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 each resident receives adequate supervision and assistive devices to prevent accidents for 1 of 8 sampled residents (R#63). CNA A failed to lower R#63's bed per physician's orders after performing resident care and exiting his room on 01/28/26 at 11:47 a.m. This failure could place residents at risk of falls, injuries and hospitalization. Review of R#63's admission record, dated 01/29/26, showed he was admitted to the facility on [DATE] with medical diagnoses including wedge compression fracture, low back pain and altered mental status. Review of R#63's 5-Day MDS assessment, dated 01/15/26, showed he had a BIMS score of 7/15, which indicated he had severe cognitive impairment. Section J reflected he had no falls since admission/reentry. Review of R#63's progress notes showed:- RN K created a note on 01/13/26 at 8:00 a.m. that reflected she notified the PCP of his change in condition evaluation for fall on 01/13/26. The PCP recommended increasing frequent monitoring, place fall mats, educate him on importance of using call light to prevent falls and keeping his bed low to the ground after fall.-Physician A signed an encounter note on 01/15/26 at 10:08 p.m. that reflected, Chief Complaint / Nature of Presenting Problem: Staff reports patient had a fall. History Of Present Illness: .Patient seen and examined at bedside. According to the staff patient was found on the floor at bedside this morning. Patient says he was trying to get out of bed independently and landed on his back. Denies any pain, and no signs of injury noted. Neurologically at his baseline. Denies nausea, HA, vision changes. Will continue to monitor. Stable vitals. Labs reviewed with family.Review of R#63's care plan, initiated 01/09/26, showed he was a high risk faller and had a fall on 01/13/26. Interventions include call don't fall signs in his room to remind him to call for assistance, safety rounds by all staff, fall mats at bedside, have adequate lighting, and transfer and change positions slowly. Interventions did not include the PCP's recommendation of lowering bed to the ground. Review of R#63's Change in Condition Evaluation, dated 01/13/26 at 8:00 a.m. showed he had a fall on 01/13/26 in the morning time, had previous falls at home and surgical interventions, notified his PCP and FAM on 01/13/26 at 8:00 a.m. and the PCP recommended increase frequent monitoring, place fall mats, educate patient on importance of using call light to prevent falls and keep the bed low to the ground. During an observation and interview of R#63 on 01/28/26 at 11:47 a.m., he was lying in bed with FAM sitting next to him. Fall mats were on each side of his bed. Call don't fall sign was in his room. There was adequate lighting. A female CNA left his room after finishing resident care on him. The female CNA did not lower his bed to the ground before leaving his room. The surveyor attempted to interview R#63, but he did not answer any of the surveyor's questions. R#63's FAM stated he fell on the ground at the facility. They also stated staff did not lower his bed to the ground before leaving his room and they often had to remind staff. During an interview with CNA E on 01/30/26 at 1:34 p.m., she stated all staff were responsible for ensuring residents' fall interventions were implemented. She stated nurses oversaw and ensured all staff ensured residents' fall interventions were put in place and implemented. She stated she knew the importance of ensuring fall interventions were implemented and said, Because we don't want another injury or for them to get hurt again. Residents could be at risk of accident, fall and develop an injury. During an interview with CNA F on 01/30/26 at 1:58 p.m., she stated the CNAs, nurses and DON were responsible for ensuring residents' fall interventions were implemented. She also stated nurses oversaw and ensured fall interventions were implemented. She stated she knew the importance of implementing fall interventions and said, Because to prevent resident injuries. Residents could be at risk of accident and could fall while trying to reach the call light to bring it closer to the resident.During an interview with CNA G on 01/30/26 at 2:23 p.m., she stated the CNAs and nurses were responsible for ensuring residents' fall interventions were implemented. She stated she did not know who oversaw and ensured fall interventions were (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented. She stated she knew the importance of implementing fall interventions and said, So residents don't break another hip, leg or arm.During an interview with the DON on 01/30/26 at 2:38 p.m., she stated the facility did not have an accidents and supervision policy and procedure. During an interview with LVN H on 01/30/26 at 2:51 p.m., she stated the nurses oversaw and ensured residents' fall interventions were implemented and checked at least every 30 minutes or one hour to ensure the interventions were in place. She stated she knew the importance of implementing fall interventions and said, To prevent further injuries. During an interview with CNA O on 01/30/26 at 3:09 p.m., she stated the CNAs and nurses were responsible for ensuring residents' fall interventions were implemented. She stated nursing staff oversaw and ensured fall interventions were implemented. She stated she knew the importance of implementing fall interventions and said, Because residents could fall, bump their head, or break a bone. Residents could get injured really bad or worse if the bed were higher than lower.During an interview with the Weekend Supervisor on 01/30/26 at 3:24 p.m., she stated the CNAs and nurses were responsible for ensuring residents' fall interventions were implemented. She explained residents' 24 hour reports, plan of care and staff communication were used to oversee and ensure fall interventions were implemented. She stated she knew the importance of implementing fall interventions and said, Safety for the resident. Resident could be at risk of harm if proper measures were not in place. During an interview with LPN J on 01/30/26 at 3:51 p.m., she stated the nurses were responsible for ensuring residents' fall interventions were implemented. She stated the IDT team, ADON, MDS Coordinators, and DON oversaw and ensured fall interventions were implemented. She also stated she knew the importance of implementing fall interventions and said, Safety. To make sure residents don't get injured and to make sure resident safety is on the same page for everyone. During an interview with LPN L on 01/30/26 at 4:03 p.m., she stated the IDT team were responsible for ensuring residents' fall interventions were implemented. She stated she knew the importance of implementing fall interventions and said, To prevent injuries. During an interview with RN M on 01/30/26 at 4:12 p.m., she stated the nurses implemented residents' fall interventions. She stated the ADON and DON oversaw and ensured fall interventions were implemented. She stated she knew the importance of implementing fall interventions and said, Safety measurements. During an interview with the DON on 01/30/26 at 4:43 p.m., she stated the nurses oversaw and ensured fall preventative devices were put in place and implemented. She stated she knew the importance of implementing fall interventions and said, So residents do not have another fall . During an interview with the ADM on 01/30/26 at 5:17 p.m., he stated the IDT team ensured that fall preventative devices were put in place. He stated he knew it was important to implement fall interventions and said, For safety and to prevent injury. Review of the facility's fall prevention policy, revised 07/24/23, reflected, PROCEDURE:Any patient deemed to be high risk by nursing and/or therapy staff will have the following interventions at least considered: .Low bed (or lower our standard bed to its lowest position).Post fall Procedure:.Determine what interventions need to be implemented to prevent further falls. Complete orders and/or tasks for fall prevention and for skin injuries if indicated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to comprehensively assess within 14 days after the facility determined, or should have determined, that there has been a significant change in resident's physical or mental condition for 1 of 8 sampled residents (R#7). 1.The facility failed to complete a significant change assessment within 14 days of determining R#7 had 5% or more significant weight loss. 2. The facility failed to document R#7's weekly weights per her physician's order. This failure could place residents at risk of inadequate care planning or not receiving appropriate care.Review of R#7's admission record, reviewed on 02/28/26, showed she was admitted to the facility on [DATE] with medical diagnoses that included Parkinson's disease (a chronic, progressive neurological disorder where brain neurons slowly break down), cognitive communication deficit, protein-calorie malnutrition and dementia. Review of R#7's admission MDS, dated [DATE], showed she had a BIMS score of 7/15, which indicated she had severe cognitive impairment. Section I reflected she had malnutrition as an active diagnosis in the last 7 days. Review of R#7's assessments reviewed on 01/28/26 showed there was no significant change in condition MDS assessment completed.Review of R#7's care plan, completed 01/17/26, showed she was at risk for inability to maintain nutrition. Staff created a note on 12/05/25 that she had a diagnoses on 12/01/25 of severe malnutrition. Interventions included monitor and record weight per facility guidelines. Review of R#7's order summary report, dated 01/28/26, showed she had a verbal order on 12/21/25 for daily weights every day shift every Sunday that started on 12/28/25.Review of R#7's MAR/TAR for January 2026 showed staff weighed her on 01/18/26 at 121.1lbs. Review of R#7's progress notes showed Physician A created a note on 12/31/25 that reflected her weight was 130lbs on 12/28/25. Physician B created a note on 01/05/25 that reflected her weight was 121lbs on 01/04/26. Review of R#7's weight summary showed staff documented she weighed 130lbs on 12/28/25. Staff documented she weighed 121lbs on 01/04/26, which triggered a warning notification of 5% or more weight change. There were no subsequent documented weights. During an interview with CNA E on 01/30/26 at 1:34 p.m., she stated CNAs weighed residents every Sunday, notify the nurse of residents' weights and sometimes documented weights in residents' TAR. She also stated nurses mostly documented weights in residents' TAR and oversaw and ensured residents' weekly weights were documented. She stated she knew it was important to weigh residents and said, It's very important because we need to make sure the resident is getting healthier and declining. Staff would not know how resident is doing if weights were not documented. During an interview with CNA F on 01/30/26 at 1:58 p.m., she stated CNAs weighed residents every Sunday. She stated the CNAs have not been able to document residents' weights in the last 2 months because the system was down. She stated she would notify the nurse whenever she could not document residents' weights. She also stated nurses documented weights in residents' TAR and oversaw and ensured weekly weights were documented. She stated the ADON, DON and ADM were aware of the system being down. She stated she knew it was important to weigh residents and said, It's very important because there were residents who did not eat and to prevent residents from getting sick or developing wounds. During an interview with CNA G on 01/30/26 at 2:23 p.m., she stated CNAs weighed residents. She also stated nurses documented weights in residents' TAR. She stated the DON oversaw and ensured nurses documented weights in TAR. She stated she knew it was important to weigh residents and said, To make sure residents were not retaining fluids and gaining or losing too much weight. During an interview with LVN H on 01/30/26 at 2:51 p.m., she stated CNAs weighed residents. She also stated nurses documented weights in residents' TAR. She stated the ADON and DON oversaw and ensured nurses documented weights in residents' TAR. She stated she knew it was important to weigh residents and said, To see if residents were getting adequate nutrition and diets. Residents could be at risk of malnutrition. During an interview with CNA I on 01/30/26 at 3:09 p.m., she stated CNAs weighed residents and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented weights in residents' TAR weekly. She also stated nurses documented residents weights monthly. She stated the DON oversaw and ensured nurses documented weights in residents' TAR. She stated she knew it was important to weigh residents and said, Because you want to make sure residents were not losing too much weight. During an interview with the Weekend Supervisor on 01/30/26 at 3:24 p.m., she stated CNAs weighed residents. She also stated the nurses documented weights in residents' TAR and notified the DON and NP of any weight changes. She stated the Dietician, ADON and DON oversaw and ensured nurses documented weights in residents' TAR. She stated she knew it was important to weigh residents and said, Because residents could have CHF, they could stop eating and you want to make sure you're reporting any loss in weight. During an interview with LPN J on 01/30/26 at 3:51 p.m., she stated CNAs weighed residents. She also stated nurses documented weights in residents' TAR and notified the dietician and NP of weight changes. She stated the Dietician, Wound Care, ADON, and DON oversaw and ensured nurses documented weights in residents' TAR. She stated she knew it was important to weigh residents and said, Malnutrition. Obesity. To make sure residents does not have a change in condition worsen. The surveyor attempted to call RN K on 01/30/26 at 4:01 p.m The surveyor left a voicemail and call back number. RN K did not return the surveyor's call before exit. During an interview with LPN L on 01/30/26 at 4:03 p.m., she stated CNAs weighed residents. She also stated nurses documented weights in residents' TAR. She stated the Dietician, ADON, and DON oversaw and ensured nurses documented weights in residents' TAR. She stated she knew it was important to weigh residents and said, To keep track and make sure there was no significant weight loss. During an interview with RN M on 01/30/26 at 4:14 p.m., she stated nurses documented weights in residents' TAR. She also stated the ADON and DON oversaw and ensured nurses documented weights in residents' TAR. She stated she knew it was important to weigh residents and said, We need to report and make sure residents weight is stable, lost or gained or to add more nutrition. During an interview with the DON on 01/30/26 at 4:43 p.m., she stated MDS Coordinator C and D reviewed and revised residents' MDS assessments. She also stated she or the ADON oversaw and ensured residents' MDS assessments were reviewed and revised by reviewing orders and 24 hour reports daily. She also stated the nurses weighed residents and documented weights in residents' TAR once a week and on admission. She also stated her and the ADON oversaw and ensured nurses weighed and documented weights in residents' TAR by conducting morning meetings on the weights. She stated she knew it was important to weigh residents and said, To make sure residents do not lose any more weight.The surveyor attempted to call MDS Coordinator C on 01/30/26 at 5:05 p.m The surveyor left a voicemail and call back number. MDS Coordinator C did not return the surveyor's call before exit. During an interview with MDS Coordinator D on 01/30/26 at 5:07 p.m., she stated the IDT team reviewed and revised MDS assessments. She explained the ADON and DON identify changes in residents' condition and determine if a significant change in status assessment must be completed. She stated she knew it was important to review and revise MDS assessments and said, Because the plan of care could change. Resident could be at risk of death, risk of falls, injuries, metabolic, cardiac, endo, kidney, etc. During an interview with the ADM on 01/30/26 at 5:17 p.m., he stated the IDT team reviewed and revised residents' MDS assessments. He knew it was important to review and revise residents' MDS assessments and said, It keeps residents health status up to date and what their status is. He also stated the ADON or DON oversaw and ensured nurses documented weights by conducting morning meetings on the weights. He also stated he knew it was important to weigh residents and said, To see where the resident was at in condition and or to document if refused or allowed weight to be scaled. Review of the facility's MDS policy and procedure, revised 02/08/21, reflected, All staff members will be responsible for completion of the MDS and transmission processes in accordance with the MDS RAI instruction manual.The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. The policy did not reflect the regulatory timeframes for completing the significant change in condition assessment.