STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676496	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive Burleson, TX 76028

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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #101) of three residents reviewed for Dialysis Care. The facility failed to transport Resident #101 to her dialysis appointment on 09/05/2025 at 6:00am due to not having a driver. On 09/09/2025 at 4:45p.m., an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 9/11/2025, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of not being transported to dialysis, which could cause abnormal vital signs and changes in condition, resulting in a decline in their health, psycho-social well-being, or death. Findings included: Record review of Resident #101's face sheet dated 09/09/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #101's diagnosis included end stage renal disease (kidney failure), anemia in chronic kidney disease (a complication of chronic kidney disease where the kidneys do not function properly over an extended period, abnormalities of gait and mobility, elevated white blood cell count, heart disease, and cognitive communication deficit (problems with communication). Record review of Resident #101's quarterly MDS, dated [DATE], revealed Resident #101 had a BIMS of 15 indicating intact cognition. The MDS also revealed Resident #101 was on dialysis. Record review of Resident #101's care plan, dated 09/04/2025 revealed, Resident #101 received dialysis related to renal failure and was at risk for the potential complications of dialysis. Resident #101 would have no complications from routine dialysis through the next review date. Encourage resident to attend scheduled dialysis appointments. During an interview with Resident #101 on 09/09/2025 at 8:53am revealed she normally sat out front on the porch at 5:00am on days she had dialysis. She said on 09/05/2025 she sat out front from 5:00am until 5:45am waiting for CNA A to pick her up for dialysis. She said at 5:45am she called the DON and did not hear back from her. She said she then went in and found LVN B who said that she forgot to tell her that CNA A was not coming in. Resident #101 stated she missed her dialysis due to the facility not having transportation. She said she started feeling sick on 9/5/25 AM with signs and symptoms of headache, tightening in her hands, tingling feet, and slurred speech. She said the facility sent her to the hospital later that day. She also said the dialysis clinic called and said they had a cancelation and was able to get her in. She said that MA C picked her up from the hospital in her personal vehicle and took her to dialysis. During an interview with LVN B on 09/09/2025 at 9:24am revealed the person who was supposed to take Resident #101 to dialysis called in sick. She said she thought she was supposed to take Resident #101 to dialysis since the other staff member did not show up. She said did not know the person called in sick at the time. She said she did not think about calling the backup van driver. She said if a resident missed dialysis, then the resident could have fluid overload. She said the fluid overload could happen quickly. During an interview with the ADM on 09/09/2025 at 9:32am revealed Resident #101 missed her dialysis appointment due to the staff member who was supposed to take her called in sick. He said the nurse (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 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	should have known that the staff member had called in and should have made other arrangements. He said that different staff are scheduled to take Resident #101 to dialysis. He said that if a staff member who is scheduled to take Resident #101 called out sick the facility should have another staff member take Resident #101. He said that if Resident #101 missed dialysis he did not think she would go into a diabetic coma. He said staff could have walked Resident #101 across the parking lot or taken her in their personal vehicle. During an interview with the Dialysis Nurse on 09/09/2025 at 11:08am revealed that Resident #101 was scheduled for dialysis on 09/05/2025 at 6:00am. She said Resident #101 called and said that she missed her appointment due to transportation. She said Resident #101 asked if the clinic had any other appointments for that day. She said she told Resident #101 that they did not have any openings. She said she also told Resident #101 that if someone canceled, she would let her know. She said that Resident #101 had only missed that one appointment. She said if Resident #101 missed dialysis she could have shortness of breath. She also said Resident #101 puts on fluid quicker than others and depending on how much fluid she put on it could be critical. During an interview with CNA A on 09/09/2025 at 12:35pm revealed that she was sick on 09/05/2025. She said she called LVN D and told her to let LVN B know that she would not be in to take Resident #101 to dialysis. She said normally she transports Resident #101 in her personal car to dialysis. She said the message was not passed to LVN B and Resident #101 was not taken to dialysis on 09/05/2025. During an interview with Resident #101 on 09/09/2025 at 3:23pm revealed that two doctors saw her. She said that the doctor wanted to put an IV in and take blood. She said that the staff member was there to pick her up and said she needed to go. She said she did not do the blood work the hospital had her do an AMA. During an interview with the Ombudsman on 09/09/2025 at 3:26pm revealed that Resident #101 had filed a complaint with her about transportation to dialysis. She said Resident #101 had been late a couple of times due to the facility not having transportation. She said the facility would not allow Resident #101 to walk across the parking lot to dialysis. During an interview with Resident #101's doctor on 09/10/2025 at 11:26a.m. revealed that it was not okay for a resident to miss dialysis. He said he knew Resident #101 very well and Resident #101 never missed dialysis until 09/05/2025. He said that if Resident #101 did not get into dialysis before Monday it could absolutely be life threatening. He said that for the resident to not have transportation was not a good reason to miss dialysis. He also said the staff could have walked Resident #101 over to the clinic. He said he felt the facility did not take it serious of Resident #101 missing dialysis. He said the facility did not seem to realize the importance of Resident #101's dialysis. He said he will never tell a facility it was ok for a resident to miss dialysis. He said he spoke to the doctor at the hospital and the resident had an acute reason to be admitted to the hospital. He went on to say that the clinic had a last-minute cancelation, so the clinic was able get Resident #101 into the dialysis clinic and not have to be admitted to the hospital. He said that he saw her today, 09/10/2025 and said that she looked good. Record review of Nursing Facility Dialysis Agreement, dated 09/21/2021, revealed, Nursing facility will be responsible for the resident during transfer to and from center's location. Record review of Resident #101's discharge paperwork dated 09/05/2025 revealed that she was sent to the hospital due to dialysis. Record Review of the Transportation Policy and Procedures for Facility Based Vehicle dated 03/11/2013 revealed In order for our Residents to maintain the highest practical, physical, mental, and psychological well-being it is the policy of this facility to utilize the Facility vehicle (Van) for residents who because of medical or special needs, require transportation. Facility based vehicles are to be used solely to meet the needs of the residents, including prearranged physician appointments and/or dialysis appointment, if Resident s' legal representative is unable to meet transportation needs. This was determined to be an Immediate Jeopardy (IJ) on 09/09/2025 at 4:46p.m. The Administrator was notified. The Administrator was provided with the IJ template on 9/09/2025 at 4:47p.m. The following Plan of Removal submitted by the facility was accepted on 09/11/2025 at 1:49p.m: Approved POR: Facility Name: Provider Number: 001033774Date of IJ Notification: 09/9/2025 Date/Time IJ Identified by Surveyor: 09/9/2025 at 4:49 (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PMPlan of Removal - F698 (Dialysis Services)Deficient Practice:The facility failed to ensure that Resident #101 was transported to dialysis on 09/05/2025 when the scheduled staff member called out sick. This resulted in the resident missing her appointment, experiencing acute medical symptoms, and requiring hospitalization.Immediate Actions Taken (Date: 09/10/2025):Resident #101:Charge nurse will assess Resident #101 for complications after hospitalization and return from dialysis. Completion date 9/10/2025Charge nurses will obtain vital signs, and weight monitored every shift for 72 hours post-event for Resident #101. Completion date 9/11/2025DON/designee will review and update care plan to include specific backup transportation measures for Resident #101. Completion date 9/9/2025Other Dialysis Residents:DON/designee will immediately review all residents requiring dialysis to ensure no missed or delayed appointments.DON/designee will confirm next scheduled dialysis appointments and transportation arrangements.DON/designee will notify residents and/or representatives of new transportation protocol.Staff Involved:RNC educated the DON/designee immediately on chain of communication and transportation responsibilities.DON/designee will re-educate LVN B and CNA A immediately on chain of communication and transportation responsibilities.DON/designee will council LVN D regarding failure to pass along call-in information.Communication:Administrator and DON contacted the dialysis center to confirm ongoing appointments and reassure clinic of corrective step.Systemic Changes Implemented:Transportation Backup System:A designated backup driver (facility van) is now scheduled and documented for every dialysis transport, this schedule is a written schedule and will be located at each nurse's station.If primary driver calls out, the nursing supervisor must assign the backup driver immediately and document. The nursing supervisor has been educated that there are 2 van drivers. The DON is the nurse managers back up.DON/designee will educate the van drivers on appointment schedules, call-in protocol, back up driver and transportation log along with posttest. Completion date 9/10/25Communication Protocol:All call-ins are reported directly to the charge nurse and DON/designee. If no answer, they call the nurse supervisor on call. A daily Transportation Log will be maintained, reviewed each morning, and signed off by the nursing supervisor.Staff Education:RNC will educate DON/designee on the critical importance of dialysis attendance and risks of missed treatment. Education completed by 09/10/2025.DON/designee will re-educate all staff on the critical importance of dialysis attendance and risks of missed treatment. All nursing staff and DON will be given posttests for understanding compliance. Education completed on 9/10/2025.PRN nursing staff and new hire nursing staff will be educated on dialysis services before working the floor their next shift. On going.Monitoring:DON/designee will review the Transportation Log daily to verify all dialysis residents have transportation coverage. The Transportation Log will be located at each nurse's station.DON/designee will educate all nursing staff on where the Transportation log will be located, at each nurse's station with posttest. Completion date 9/10/2025DON/designee will obtain weekly audits of transportation assignments for 4 weeks, then once a month this will be ongoing. Results reported to QAPI Committee for review and further interventions for 3 months.POR Monitoring Included:Observation of transportation log on 09/11/2025 at 6:06p.m., revealed the DON had reviewed the transportation logs for 09/10/2025 and 09/11/2025.During an interview with MA C on 09/11/2025 at 4:03p.m. revealed she was trained on dialysis and the risk of missing a dialysis appointment. She said the training getting the residents to their appointments on time and that if not going to be into work must call the charge nurse and the DON. She said that if a resident missed dialysis the resident could retain water and possibly pass out. She said if a resident misses dialysis she was to call the nurse and the ADON. She said if the facility did not have transportation for a resident staff were to call the outside transport company. She said it was important for a resident to go to dialysis because if they did not go it could cause heart failure, swelling and the resident could possibly die. During an interview with CNA Q on 09/11/2025 at 4:09p.m. revealed she was trained on dialysis and the risk of missing a dialysis appointment. He said the training covered missing of dialysis, transportation, whom to report if transportation/appt were missed/role of nurses and facility. He said that transportation, (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON, and nursing staff were responsible for ensuring a resident gets to dialysis. He said if a resident missed dialysis staff were to notify the DON so that the facility can arrange transportation. He said it was important for a resident to go to dialysis because dialysis kept the resident alive. During an interview with LVN B on 09/11/2025 at 4:12p.m. revealed she was trained on dialysis and the risk of missing a dialysis appointment. She said that the training covered who the primary person was for transportation and who was secondary and what to do if both are not available. She said if a resident missed dialysis the resident could have fluid overload, blood pressure would get high, and resident might become have dizziness. She said the nurse is responsible for ensuring a resident did not miss dialysis then it would be the van driver. She said if a resident missed dialysis she would find out if the van driver was going to take the resident, or if other transportation was necessary. She said it was important for the resident to go to dialysis because the resident could have some severe complications and end up in the hospital. During an interview with LVN N on 09/11/2025 at 4:13p.m. revealed she was trained on dialysis and the risk of missing a dialysis appointment. She said that the training covered what to do if a resident missed an appointment. She said staff were to go to the second person who drives. She said if a resident missed dialysis the resident could have swelling and shortness of breath. She said the nurse was responsible for ensuring residents get to dialysis. She said if the resident missed dialysis by choice the nurse was to notify the doctor, DON, and family. She said for transportation reasons notify the DON. She said if there was no transportation at the facility the nurse was to call the outside transportation company. She said if a resident did not go to dialysis the resident could die. During an interview with CNA O on 09/11/2025 at 4:18p.m., revealed he was trained on dialysis and the risk of missing a dialysis appointment. He said that the nurse and CNA were responsible for getting the resident ready for dialysis. He said it was all staff responsible for ensuring that the resident got to dialysis. He said if a resident missed dialysis the staff were to inform the charge nurse. He said if a resident missed dialysis the resident could become seriously ill. He said if there was no transportation for a dialysis resident he would talk to the nurse, find a solution, and get someone else to drive the resident. He said it was important for a resident to go to dialysis because if they did not go it could affect their health.During an interview with LVN R on 09/11/2025 at 4:26p.m., revealed she was trained on dialysis and the risk of missing a dialysis appointment. She said the training covered the procedures and what to do if the main transportation driver was not in., she said that staff were to call the DON, ADON, doctor and notify the family if the resident missed dialysis. She said that if the driver and back up driver were not in staff were to call the outside transport company. She said if a resident missed dialysis the resident could have fluid overload, increased heart rate, and shortness of breath. She said the nurse and DON were responsible for ensuring a resident got to dialysis. She said that it was important for a resident to go to dialysis because their kidneys were not functioning. During an interview with CNA A on 09/11/2025 at 4:24p.m., revealed she was trained on dialysis and the risk of missing a dialysis appointment. She said the training covered appointments, who to call, who to report to if a resident had not gone to dialysis and transportation. She said if a resident missed dialysis, they could become ill. She said the charge nurse and the driver were responsible for ensuring the resident got to dialysis. She said if a resident missed dialysis staff were to contact the DON and the nurse. She said some complications of missing dialysis was dizziness, and swelling. She said if there were no transportation for a dialysis resident staff were to call the outside transportation company. She said it was important for a resident to go to dialysis because their kidneys were not functioning. During an interview with LVN P on 09/11/2025 at 4:29p.m., revealed he was trained on dialysis and the risk of missing a dialysis appointment. He said that the training covered transportation, back up transportation and vital signs. He said if a resident missed dialysis the resident could have serious fluid overload. He said everyone was responsible for ensuring a resident got to dialysis. He said if a resident missed dialysis staff were to notify the doctor, DON, ADON and monitor the resident. He said that some complications of dialysis could be chest pain. He said if there were no transportation staff were to call the DON, ADON (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and call the transportation back up. He said it was important for a resident to go to dialysis so the resident would not have fluid overload. During an interview with CNA E on 09/11/2025 at 4:46p.m., revealed she was trained on dialysis and the risk of missing a dialysis appointment. She said that the facility had a book at the nurse's station that tells when a resident goes to dialysis. She said the book will also tell staff who was to pick up the resident, what time the resident went to dialysis, and what time the driver would pick the resident up. She said that if the resident did not get picked up for dialysis, then staff were to notify the DON and nurse supervisor. She said if a resident missed dialysis the resident could get sick, shortness of breath, and it could become critical. She said all staff were responsible for ensuring the resident got to dialysis. She said the CNA gets the resident ready and notify the nurse they are ready. She said if a resident missed dialysis staff were to notify the DON and ADON. She said some complications of missing dialysis was shortness of breath, fluid retention, swelling and the resident could possibly die. She said if there was no transportation available the staff were to call the outside transportation company. She said it was important for the resident to go to dialysis because their kidneys were not functioning, and they are holding all the toxins in their body. Record Review revealed an assessment of Resident #101 for complications was completed on 09/09/2025. There were no findings of complications.Record review revealed weight, and vitals were taken on Resident #101 on all shift on 09/10/2025. Vitals and weight have been taken on 09/11/2025 for the 6-2 and 2-10 shift and scheduled to continue until Saturday. Record review revealed the care plan read, Communicate with resident when appointments are made to ensure she is aware of date, time, and mode of transportation. Dialysis appointment will be followed through by primary transport or secondary back-up. Record review revealed all residents on dialysis was reviewed for missed or delayed appointments no other missed or delayed appointments were found. Resident #110's appointment and transportation were confirmed on 09/09/2025 at 7:35pm for dialysis on 09/10. Resident #101's appointment and transportation were confirmed on 09/09/2025 at 7:31pm for dialysis on 09/10/2025. Resident #3's appointment and transportation were confirmed on 09/10/2025 at 9:36am for dialysis on 09/11/2025.Record review reveals resident and/or representatives were updated on new transportation protocol. Record review revealed the DON and ADON's were in-serviced on 09/09/2025 on transportation responsibilities, who is primary, who is secondary and who to is used when those two are on available. Who to notify for call offs, and nurse supervisor to make immediate arrangements for the resident and the potential harm to residents if dialysis is missed.Record review revealed LVN B and CNA A were in-service on 09/09/2025 on notifying the DON when appointments were missed and to notify on call and charge nurse if unable to come to work.Record review revealed the facility contacted the dialysis center. Contacted both centers to verify DON contacted and person DON talked to was not there. Record review also revealed there was now a backup van driver. Record review revealed staff were in-serviced on 09/09/2025 on calling the charge nurse for call ins, importance of dialysis appointments and dialysis sessions. Staff could walk the resident to dialysis or calling another outside agency to transport the resident.Record review revealed van driver and back up driver were in-serviced on 09/09/2025 on reviewing appointments, call in protocol and who the backups were, the chain of communication, transportation responsibilities, calling on call if there are appointments before 8:30am.Record Review revealed the facility had a QAPI meeting on 09/09/2025.The ADM was informed the Immediate Jeopardy was removed on 09/11/2025 at 6:46p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the facility had sufficient staffing to meet the needs of five Residents (Residents #6, #15, #1, #85 and #97) of 20 residents reviewed for nursing services. The facility failed to ensure that the facility had sufficient staffing to meet the needs of Residents #6, #15, #1, #85 and #97.This failure could affect and diminish the resident's quality of life by potentially placing the residents at risk of not receiving timely care or receiving nursing interventions to meet the resident's needs, risk of injury, risk of safety, and/or it can make the resident feel neglected affecting their mental health and overall psychosocial well-being not being met by facility staff. Findings include:1.Record review of Resident #85's face sheet, dated 06/06/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #85 had diagnoses which included hemiplegia (paralysis of one side of the body - her left side) following cerebral infarction affecting right dominant side of the brain, dysphagia (difficulty swallowing) following cerebral infarction (occurs when blood flow to the brain is interrupted, leading to brain cells death and brain damage), aphasia (a language disorder resulting from brain damage) following cerebral infarction. Record review of Resident #85's admission MDS Assessment, dated 06/13/2025, reflected Resident #85 had a BIMS score of 0, which indicated severe cognitive impairment. According to the Functional Abilities section of MDS this resident required two people max assistance with repositioning and transfers. Record review of Resident#85's Comprehensive Care Plan, revised on 07/10/2025 stated that Resident #85 had potential risk of pressure ulcer and required frequent repositioning.2. Record review of Resident #1's face sheet, dated 09/10/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included unilateral primary osteoarthritis (breakdown of the smooth cartilage within a joint, leading to pain, stiffness, and reduced movement, particularly in weight-bearing joints like the knees, hips, and hands), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body, affecting the arm, leg, and face) following cerebral infarction affecting left non-dominant side (occurs when blood flow to the brain is interrupted, leading to brain cells death and brain damage), dysphagia (difficulty swallowing), reduced mobility, anxiety disorder. Record review of Resident #1's admission MDS Assessment, dated 08/07/2025, reflected Resident #1 had a BIMS score of 15, which indicated her intact cognition. The Functional Abilities section of MDS indicated her total dependent status with toileting hygiene requiring the assistance of 2 or more helpers.Record review of Resident#1's Comprehensive Care Plan, revised on 05/19/2025 stated that Resident #1 had ADL self-care performance deficit and is at risk for not having their needs met in a timely manner with dependent status for transfers: dependent x2 person and incontinent for bowel/bladder. Indicated interventions in Care plan for Resident #1 are to check frequently for wetness and soiling and change as needed.3. Record review of Resident #97's face sheet, dated 09/10/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #85 had diagnoses which included chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing problem), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), recurrent chronic combined systolic and diastolic heart failure (reduced ability of the heart to effectively pump blood throughout the body). Record review of Resident #97's admission MDS Assessment, dated 08/8/2025, reflected Resident #97 had a BIMS score of 11 which indicated her moderate cognitive impairment. The Functional Abilities section of MDS assessment stated her dependent status with transfers requiring the assistance of 2 or more helpers to complete the activity using a mechanical lift. Resident #97 was incontinent of bladder and bowels and required total assistance with toileting and bed mobility requiring 2 or more helpers.Record review of Resident #97's (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Comprehensive Care Plan, revised on 08/5/2025 stated the goal for Resident #97 to maintain a sense of dignity by being clean, dry, odor free, and well-groomed related to functional limitations in range of motion or decreased mobility. 4. Record review of Resident #15's face sheet, dated 09/10/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #15 had diagnoses which included generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about a variety of everyday events and activities), unspecified cirrhosis of liver (condition where the liver is damaged and scarred, but the specific cause of the damage is unknown), type 2 diabetes mellitus (chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels). Record review of Resident #15's admission MDS Assessment, dated 08/8/2025, reflected Resident #15 had a BIMS score of 15 which indicated her intact cognition. Record review of Resident #15's Comprehensive Care Plan, revised on 05/1/2025 stated the goal for Resident #15 to check frequently for wetness and soiling and change as needed with providing colostomy care. 5. Record review of Resident #6's face sheet, dated 09/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses which included anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about a variety of everyday events and activities), depression (serious mood disorder affecting thoughts, feelings, and daily functioning), paraplegia (a form of paralysis characterized by the loss of voluntary movement and sensation in the lower parts of the body, such as the legs, feet, and potentially the abdomen), and obstructive uropathy (a urinary tract blockage that prevents urine from draining, causing it to back up into the kidneys and potentially leading to kidney damage, infection, or acute kidney injury).Record review of Resident #6's admission MDS Assessment, dated 08/5/2025, reflected Resident #6 had a BIMS score of 14 which indicated his intact cognition. GG (functional level) section of MDS specified his substantial/maximal assistance - helper does more than half the effort for bed mobility and incontinence care, and dependent (helper does all the efforts) for chair/bed to chair transfer. Record review of Resident #6's Comprehensive Care Plan, revised on 01/28/25 stated the goal was to assist Resident #6 with activities of daily living. During a confidential interview on 09/09/2025 at 2:30 PM, during Resident council meeting, 4 Residents stated that it took on average 40mins to 2 hours to get help from staff when they called for help. Staff will come to the room, acknowledge the residents, and never came back. Residents stated they reported long time waiting for assistance to the Administrator and DON. Observation of Resident #85 on 09/08/2025 at 1:20 PM thru the day, 09/09/2025 thru the day, 09/10/2025 3:24 at PM for thru the day and 09/11/2025 thru the day revealed Resident #85 stayed in bed on her back without repositioning.Interview on 9/10/2025 at 2:15 PM with Resident #85's family member indicated that she had never seen nursing staff repositioned Resident #85 in bed. She stated that when she called for help it took about 10 mins to get help. Interview on 09/10/2025 3:45 PM of Resident #6, revealed that he sometimes had to wait for staff to come and assist him for two hours, so he transferred himself to the wheelchair or took his own showers. He stated even though he knew it was not safe for him to do it on his own, he gave up on staff answering the call light and assisting him. Resident #6 stated long wait time issue was about the same across the shifts but worse at night and around mealtimes. Interview on 09/09/2025 at 3:25 PM of Resident #1, revealed that she had to wait on staff to answer her call light and provide her with bed pen for long time on multiple occasions due to shortage of staff, so when staff finally came, she already was wet and needed to be changed. Resident #1 stated there was not enough help to assist her with care and nursing staff is always rushing through her care to get to other residents. Interview on 09/10/2025 12:25 PM of Resident #15, revealed that there were not enough staff to assist the residents in this facility and she sometimes helped a resident across the hallway who needed help with care as no staff was available to assist her. She stated she looked for staff to find help, but all staff was busy due to shortage of staff. Interview on 09/08/2025 3:12 PM of Resident # 97 revealed that there was not enough staff to assist (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with her care. She had to wait for 40 mins to have her call light answered on most of shifts and she even does not try to call around mealtime when there is nobody is available to help as nursing staff is busy with passing the trays. Resident #97 stated that she told Administrator and Social Worker regarding long wait time for answering calls, but nothing changed. She stated that nursing staff do not stay here very long. Interview on 09/09/2025 3:25 PM of CNA F, revealed that last Sunday, September 7, 2025, she was the only CNA on two hallways with 20-25 residents. She tried to answer all call lights under 5 mins, but it took much longer to answer some call lights. She stated that she thought a shortage of staff is an issue in this facility especially on weekends and holidays. She also stated that not all nurses assist CNAs in answering calls and just sit at the nursing stations. She stated unreasonable response times could cause the residents to feel frustrated and neglected or mad. She stated she received in-service on residents right and answering call lights. Interview on 09/09/2025 at 10:15 AM of LVN I revealed that facility had an issue with staffing, and sometimes one CNA worked on two hallways. He tried his best answering to call lights as soon as possible. He stated that staff shortage could affect the quality of resident care. He stated that he received an in-service on call lights policy with a reasonable timeframe of 2 mins or less. He stated 40 minutes or more to answer a call light would make the resident feel neglected. He stated that rounding, peri-care, and repositioning should be done every 2 hours. Interview on 9/11/2025 at 5:10PM CNA J stated that she thought there was not enough nursing staff working on each hallway as she had to work on two hallways at the same time and not able to answer all call light in reasonable timeframe under 5 mins wait time. She stated she received an in-service on residents right and answering call lights. Interview on 09/11/2025 5:15 PM of Administrator revealed that the facility is constantly struggling to fill the open positions for nursing staff as they compete with other healthcare facilities in the area for qualified staff and he paid overtime to maintain every shift fully staffed. Currently they have 25 open positions. He stated that everybody is responsibility to answer the call light including himself and everybody else in the facility. All staff had an in-service on answering call lights under 5 mins. He stated 40 minutes or longer to answer a call light would make the resident feel neglected. Interview on 09/11/2025 at 4:45PM the Director of Nursing revealed the nursing staff including herself received an in-service on answering call lights under 5mins. She stated 40 minutes or longer to answer a call light would make the resident feel neglected. She stated that they have an issue with high turnover of nursing staff in this facility, but it is quite common in long term care due to low pay. She stated despite the opened positions they are fully staffed: 7-8 CNAs on day shift, 3 med aides and 4 nurses during the day shift and 4-5 CNAs and 3 nurses during the night every day. She stated that answering call light is everybody's responsibility. Interview on 09/11/2025 at 5:15 PM the Administrator revealed that the facility constantly struggled to fill the open positions for nursing staff as they competed with other healthcare facilities in the area for qualified staff and he paid overtime to maintain every shift fully staffed. Currently they have 25 open positions across different departments. He stated that everybody's responsibility was to answer the call light, including himself and everybody else in the facility. All staff had an in-service on answering call lights under 5 mins. He stated 40 minutes or longer to answer a call light would make the resident feel neglected. Record review of staff scheduled for the month of June, July, August revealed the schedules with 7-8 CNAs on day shift, 3 med aides and 4 licensed nurses during the day shift and 4-5 CNAs and 3 licensed nurses during the night every day including RN for 8hrs x7days/week. Record review of Resident Council Meeting for July 2025 revealed complains of Call lights could be better. Slower at night. Some CNAs on night shift sleep on the job at times and never do their rounds. Record review of the Resident Council Meeting - August 2025 revealed it takes 3 hours for a CAN to answer her call light. She stated it happens often. CNAs are always on the phones. Record review of the facility grievances revealed complaints of long waiting time for staff answering the calls and facility working on resolving this issue. Review of the facility's policy, undated, titled Leadership Policies and Procedures Revised 11/1/2017 revealed The Facility's Leadership will provide a sufficient number of staff to successfully implement patient/resident-focused functions.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 of 10 residents (Resident #9, Resident #53, and Resident #101) reviewed for resident rights. The facility failed to ensure CNA H knocked on Resident #9's and Resident #101's doors before entering the residents' rooms. The facility failed to ensure CNA A closed Resident #53's door during peri-care (cleaning of the private areas). These failures could place residents at risk of feeling like their privacy was invaded or cause psychosocial harm and emotional distress. Findings included: Resident #9 Record review of Resident #9's face sheet, dated 09/10/2025, revealed s a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #9's diagnoses included muscle wasting, cognitive communication deficit (problems with communication), dysarthria and anarthria (severe speech sound disorder), dementia (memory, thinking, difficulty), liver disease, chronic pain, heart failure, history of falling, lack of coordination, hypertension (high blood pressure), obstructive pulmonary disease (chronic progressive lung disease), and Parkinson's disease (a progressive disorder that affects the nervous system). Record review of Resident #9's quarterly MDS assessment dated , 08/03/2025, revealed Resident #9 had a BIMS score of 10 indicating moderate cognitive impairment. Resident #53 Record review of Resident #53's face sheet, dated 09/11/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #53's diagnoses included attention and concentration deficit after a stroke, memory deficit after a stroke, frontal lobe and executive function deficit (a set of cognitive processes that enable individuals to plan, focus attention, remember instructions and juggle multiple tasks successfully), dysarthria (speech sound disorder), anxiety (feeling of uneasiness or worry), and need for assistance with personal care. Record review of Resident #53's quarterly MDS assessment, dated 08/17/2025, revealed Resident #53 had a BIMS score of 07 indicating severe cognitive impairment. Resident #101 Record review of Resident #101's face sheet, dated 09/09/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #101's diagnoses included end stage renal disease (kidney failure), anemia in chronic kidney disease (a complication of chronic kidney disease where the kidneys do not function properly over an extended period, abnormalities of gait and mobility, elevated white blood cell count, heart disease, and cognitive communication deficit (problems with communication). Record review of Resident #101's quarterly MDS dated [DATE] revealed Resident #101 had a BIMS of 15 indicating intact cognitive response. During an observation of 200 hall on 09/08/2025 at 11:30a.m., revealed CNA H did not knock on Resident #9's door before entering. During an observation of 100 hall on 09/08/2025 at 11:45a.m., revealed CNA H did not knock on resident #101's door before entering. During an Observation of peri-care for Resident #53 on 09/10/25 at 2:21p.m., revealed CNA A did not close Resident #53's door for privacy during care. In an attempted interview with Resident #9 on 09/08/2025 at 1:48p.m., revealed Resident #9 did not want to talk to the surveyor. During an interview with Resident #101 on 09/09/2025 at 10:40a.m., revealed Resident #101 revealed that staff do not knock on her door. She said she would like for staff to knock all the time before entering her room. She also said people knock at a hotel so the staff should knock at the facility. She said she gets irritated when staff do not knock. During an interview on 09/10/25 at 2:33p.m., with CNA A revealed she had been trained on resident rights. CNA A stated Resident #53's door should have been closed for privacy when staff were providing care. She said staff should close the door every time care was provided. She said the importance of closing the resident doors when providing care was for privacy and dignity. CNA A further stated not providing privacy during resident care could cause the resident to be uncomfortable and embarrassed. CNA A said she had received training on privacy and closing the resident doors when providing care. She said she forgot to close (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the door when providing care to Resident #53 because she was nervous. During an interview with Resident #53 on 09/11/25 at 11:09a.m., revealed she did not realize staff left her door open while they provided peri-care. She did not answer how it made her feel when staff left her door open when providing personal care. Resident #53 said repeatedly to put her back to bed. She also said, get me some crackers and an A & W root beer from my bottom drawer, and a straw. She would not answer questions regarding the incident. During an interview with CNA H on 09/11/2025 at 1:14p.m., revealed she was trained on resident rights. She said staff were to knock on the door and get permission to enter, introduce themselves and tell the residents what they were there to do. She said staff should knock when they were giving care or when doing rounds to check on the residents. She said all staff were supposed to knock before entering a resident's room. She said the resident may feel like their privacy was violated. She said the only time staff did not have to knock was when there was an emergency. She said the charge nurse was responsible for monitoring to ensure staff were knocking. She said the charge nurse monitored through observations. She said she did not know she walked into the resident's room without knocking. An interview with the DON on 09/11/2025 at 1:43p.m., revealed she and staff were trained on resident rights. She said the policy was that staff were to always knock on the resident's door before entering the resident's room. She said staff did not have to knock if it was an emergency. She also said that if staff did not knock on the door the resident may feel like staff were intruding on their privacy because the facility was the residents' home. She said t she and the ADON were responsible for monitoring to ensure staff were knocking. She said that she and the ADON monitored knocking by making rounds. She said she did not know why staff were not knocking. An interview with the ADM on 09/11/2025 at 2:09 p.m., revealed he and staff had been trained on resident rights. He said the policy was that staff were to always knock on the resident's door before entering their room unless it was a medical emergency. He also said that the residents did not lose their rights when they came to the facility. He also said that if staff did not knock on the door the resident may feel like staff are intruding because the staff does not know what the resident was doing. He said he and the DON was responsible for monitoring to ensure staff were knocking. He said they monitored knocking by walking round. He said he did not know why staff were not knocking. During an interview on 09/11/25 at 5:38PM, the DON revealed she was trained on resident privacy. She said the training included ensuring the curtains, blinds, and door were closed when providing resident care, especially during peri-care, showers, and toileting. The DON stated she conducted training on privacy with staff about three months ago. She said the policy for providing resident privacy included closing the curtains, the blinds, and their door when providing resident care. She further stated privacy should be given when staff were providing peri-care, showers, and toileting, and whenever the resident wanted privacy. The DON stated the staff member who was providing care was responsible for ensuring the resident had privacy when receiving direct care. She stated it was important to give the resident privacy during direct care because it was a dignity issue, and the facility wanted them to feel safe and protect their dignity. She stated the resident could feel embarrassed if they do not have their door closed when they were receiving direct care such as peri-care, toileting, and showers. The DON stated everyone was responsible for monitoring to ensure t staff were closing the residents' doors when providing direct care. During an interview on 09/11/25 at 6:07PM, the ADM revealed he had been working in the facility for 11 months. He stated he was trained on resident privacy. He said the training included residents had a right to have their own space, and staff could not invade their privacy, have their own mail, talk privately, and have visitors. The ADM stated the policy for providing resident privacy included closing the blinds/drapes in their room, knocking on the door before entering, and closing their door when providing personal care. He further stated when someone knocked on the resident's door while staff were providing care, the staff should say, personal care, please come back. The ADM stated he was ultimately responsible for ensuing residents had privacy when receiving any kind of care, and he and all supervisors were responsible for making rounds in the facility. He also stated when they did not have the door closed it could lead (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to embarrassment or degradation, and nobody wanted to expose themselves unnecessarily. Record review of Resident Rights Policy, dated 02/20/2021, revealed, The resident has a right to be treated with respect and dignity, including the right to personal privacy. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Record review of Incontinence Care Policy, dated 04/10/2017, revealed, Assemble equipment, knock on door, and request entrance, introduce self, explain procedure, and provide privacy. Note: it is important to describe, as feasible, each step to the patient prior to care provision in order to reduce fear and promote comfort and dignity.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to promote the residents' right to receive mail, for all facility residents. The facility failed to ensure staff distributed mail received on Saturdays to the residents. This failure could place residents at risk of not receiving mail in a timely manner and a diminished quality of life. The findings were: During a confidential resident group meeting on 09/09/25 at 2:30 p.m., 13 of 13 members of the resident group stated they never received mail on Saturdays and did not know they were allowed to. During an interview on 09/11/25 at 10:34 a.m., the RECP acknowledged she worked as the receptionist on the weekends. She stated, she does not know which employees at the facility are responsible for mail delivery to the residents at this facility. She stated, I was never told that mail delivery on weekends was my responsibility. She stated, she does not know if receiving mail on Saturday is a resident right. She stated, I don't know what the facility policy is regarding mail delivery on Saturdays. The RECP stated, mostly we receive packages for residents on the weekends and sometimes I may find letters in the receptionist draw that were not delivered during the week and I will deliver them to the residents whenever I can. She stated she does not go pick up the mail from the post box on Saturday's. She stated, sometimes a resident will call down to the desk and ask if something has been delivered for them and I will answer their question. She stated, some residents may feel anxious when they are waiting for their mail.? During an interview on 09/11/2025 @ at 6:15 PM, the ADM revealed, the facility did not have a policy regarding mail delivery. He stated, we just have guidelines. He stated, per resident rights they would get their personal mail delivered when it arrived. He stated, on Saturday, the Receptionist was supposed to bring the mail into the building and the Manager on Duty was the designated person in charge of mail delivery. He stated, if the Receptionist doesn't get the mail, the Manager on Duty will get it. He stated, the resident should expect to get mail if it comes but, bills do not get delivered on Saturday because the Management deals with them. The ADM stated the residents may not be happy if they did not get their mail delivered in a timely manner. During an interview on 9/11/0225 @ at 5:50 PM, the DON revealed, On Saturdays, the Receptionist was supposed to gather mail from the post box and deliver it to the residents. She stated, The expectations where residents would get their mail on Saturdays. She stated, one Saturday she saw the Manager on Duty bring the mail into the facility but, she did not witness him delivering it to the residents. She stated, Residents had a right to get their mail when it was delivered to the facility. Record review of the facility policy and procedure titled, Resident Rights, dated 2/23/2016, revealed, in 6. Information and communication, I. The resident has the right to send and receive mail, and to receive letters packages and other materials delivered to the facility for the resident through a means other than a postal service.Record review of Resident Rights under Federal Law revealed, The Resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for three of seven residents (Resident #85, Resident #1, and Resident #97) reviewed for activities. The facility failed to provide Resident #85 and Resident #1 in room activities since their admission on [DATE] for Resident #85, on 08/07/2025 for Resident #1 and Resident #97 post hospitalization during two weeks of August 8th thru August 22nd, 2025.This failure could place residents at risk for boredom, depression, and a diminished quality of life.Findings included:Record review of Resident #85's face sheet, dated 06/06/2025, reflected an [AGE] year-old female, admitted [DATE], readmitted [DATE]. With diagnoses including hemiplegia (paralysis of one side of the body - her left side) following cerebral infarction affecting right dominant side of the brain, dysphagia (difficulty swallowing) following cerebral infarction (occurs when blood flow to the brain is interrupted, leading to brain cells death and brain damage), aphasia (a language disorder resulting from brain damage) following cerebral infarction. Record review of Resident #85's admission MDS Assessment, dated 06/13/2025, reflected Resident #85 had a BIMS score of 0, which indicated severe cognitive impairment. The following activities were important to Resident #85: playing [NAME], listening to music, and going outside for fresh air. Record review of Resident#85's Comprehensive Care Plan, dated 07/10/2025, stated the goal of resident #85 was to be satisfied with activities and be assisted to attend activity functions. Record review of Resident #1's face sheet, dated 09/10/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included unilateral primary osteoarthritis (breakdown of the smooth cartilage within a joint, leading to pain, stiffness, and reduced movement, particularly in weight-bearing joints like the knees, hips, and hands), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body, affecting the arm, leg, and face) following cerebral infarction affecting left non-dominant side (occurs when blood flow to the brain is interrupted, leading to brain cells death and brain damage), dysphagia (difficulty swallowing), reduced mobility, anxiety disorder. Record review of Resident #1's admission MDS Assessment, dated 08/07/2025, reflected Resident #1 had a BIMS score of 15, which indicated her intact cognition. The following activities were important to Resident #1: listening to music and individual/small groups activities. Record review of Resident#1's Comprehensive Care Plan, dated 08/5/2025, stated the goal of resident #1 was to attain satisfaction with activities participation, encourage socialization, and activity attendance, as tolerated.Record review of Resident #97's face sheet, dated 09/10/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #85 had diagnoses which included chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing problem), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), recurrent chronic combined systolic and diastolic heart failure (reduced ability of the heart to effectively pump blood throughout the body). Record review of Resident #97's admission MDS Assessment, dated 08/8/2025, reflected Resident #97 had a BIMS score of 11 which indicated moderate cognitive impairment. The following activities were important to Resident #97: bingo, arts, and crafts, she also enjoys coming to entertainments. Record review of Resident #97's Comprehensive Care Plan, revised on 08/5/2025 states the goal of resident #1 to be satisfaction with activities participation. The in-room activity participation records for Residents #85, #97 and #1 were not available per request.Observation of Resident #85 on 9/8/2025 2:25 PM, 9/9/2025 10:14 AM, 9/10/2025 11:05 AM, and 9/11/2025 4:18 PM (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #85 was in her bed awake but not provided with any activities.Observation of Resident #1 on 9/8/25-9/11/25 revealed Resident #1 in bed not provided with any activities.Interview on 9/10/25 of resident #85's family member revealed Resident #85 spent most of her time in bed and was never seen participating or offered activities in the facility. Per family member, Resident #85 liked to be outside, listened to music, and played dominoes. According to the family member, the Activity Director contacted her after admission regarding the likes and dislikes of Resident 85, but no activities were provided to the resident after that initial interview. Interview on 9/9/25 of Resident #1, revealed she was not offered any in-room activities as she did not go outside of her room for activities due to pain in her back and neck. Resident #1 stated she wanted to have some activities in the room to keep her occupied. Resident #1 stated the Activity Director did not offer in-room activities for her, which made her sad. Interview on 9/8/25 of resident #97 revealed she was in the room for two weeks post hospitalization 08/08/2025 thru 08/22/2025 and spent time in bed without any activities offered to her. Resident #97 stated she liked to attend activities and was not able to do it while being in the room. Resident #97 confirmed she was not able to leave the room and without any in-room activities available made her feel bored. Interview on 09/10/2025 at 1:00 PM, the Activity Director stated Residents #85, #1 and #97 did not receive in room activities. The Activity Director stated she was expected to ensure all residents received activities based on their preferences and their physical abilities. She stated if residents were not coming out of their room, the residents should be provided with in room activities. The Activity Director stated she dropped the activity schedules in the rooms, but she did not have anything planned for in room activities. She stated there was not an excuse why Resident #85 and Resident #1 post admission or Resident #97 (during her post hospitalization two weeks) did not receive in room activities. The Activity Director stated if a resident was not receiving activities on a consistent basis there was a potential a resident may become bored, depressed, or have a decline in their quality of life. She stated she was responsible for ensuring all residents received their personalized activities including in room activities. She stated she was responsible for monitoring to ensure activities including in-room activities were offered to all residents. She stated she was trained on the facility's policy and expectations to provide all residents with personalized activities.Interview on 09/11/2025 at 5:30 PM, the Administrator stated he expected in-room activities to be provided to the residents needing these types of activities. He stated if a resident was not receiving in-room activities there was a possibility a resident may become depressed, bored, and isolated. He stated the Activity Director was responsible for monitoring all resident centered activities in the facility. He stated he was responsible for monitoring the Activity Director and talked to Activity director regarding improving the quality and quantity of activities for residents and heard from residents that activities got more interesting. The Administrator stated it was important for all residents including bed bound residents to receive the activities they needed to enhance their overall quality of life. He stated per facility policy all residents needed to receive personalized activities to accommodate their needs.Interview on 09/11/25 at 5:15 PM, Director of Nurses stated that nursing staff provided help with assisting residents to attend activities if asked by residents or Activity Director. She stated it was important for residents to participate in individualized activities including those residents who stay in their rooms for any reasons. Record review of the facility's Recreation Services Policies and Procedures Manual, dated 1/2025, Rrevised 2/2022, reflected Recreation becomes extremely significant in meeting each resident's needs for quality of life. Well planned programs must be designed to enhance residents' abilities to function at their highest practicable level.

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	676496	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive Burleson, TX 76028

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to have sufficient staff with the appropriate competencies and skill sets to provide quality care for 1 of 12 staff reviewed for nursing services. The facility failed to ensure that MA M renewed her certified nurse aide license. This failure could affect and diminish the resident's quality of life by potentially placing the residents at risk of not receiving competent and skilled care to assure resident safety and maintain the highest practicable physical, mental, and psychosocial well-being of each resident according to their individual comprehensive care plans. Findings include: Record review of Texas Unified Licensure Information Portal (TULIP) for MA M revealed her Nurse Aide certification number expired on [DATE]. Interview on [DATE] at 3:25 PM with MA M revealed that she was not aware that her CNA certification expired and assumed that her med aide license automatically renewed her NA license. She stated that she was working as a CNA on the floor taking care of residents in the facility that day. She confirmed she was not supposed to work with her expired licensure as it was against the law. Interview on [DATE] at 2:15 PM of HR stated that she just started working in that position and it was a mess in the Human resources records. She was currently in process of verifying the licensure of staff to maintain more accurate records and notify staff members that their licensure is about to expire. She stated that she was going to notify MA A of her expired license but got distracted and did not do it. She stated that the staff member with expired license is not supposed to work in the facility. Interview on [DATE] at 2:25 PM of the Director of Nursing revealed that she was responsible for ensuring all nursing staff have their current licenses with current training. She admitted that she overlooked the expired license of MA M. Interview of the Administrator on [DATE] at 5:34 PM revealed that verification and alerting staff of their upcoming license expiration date was Human Resources and the DON's responsibility, and ultimately his as Administrator. He stated that each licensed staff member should have current licenses and completed training requirements for those licenses. He admitted that insufficient training and expired licenses can put residents at risk for inadequate quality of care. Record review of the facility's Training Requirement Policy dated [DATE] revealed that training requirements should be met prior to staff independently providing services to residents annually and as necessary based on the assessment. The Director of Nurses maintains a training schedule and documentation system for completed training by all staff and volunteers.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medications errors for 3 of 15 (Resident #12, Resident #91, and Resident #96) residents reviewed for pharmacy services. The facility failed to ensure MA administered Resident #12's 9:00a.m. scheduled time-sensitive medications until 1.5 - 3 hours after the ordered time on 09/07/2025. The facility failed to ensure MA G administered Resident #91's 9:00a.m. scheduled time-sensitive medications until 1.5 - 3 hours after the ordered time on 09/07/2025. The facility failed to ensure MA L administered Resident #91's 9:00a.m. scheduled time-sensitive medications until 1.5 - 3 hours after the ordered time on 09/11/2025. This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, worsening or exacerbation of chronic medical conditions, and hospitalization. Findings Included: Resident #12 Record review of Resident #12's Face Sheet dated 09/11/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #12's diagnoses included urinary tract infection, heart failure, hyperosmolality and hypernatremia (sodium concentrate caused by water intake being less than water losses), Cardiomegaly (enlarged heart), myelodysplastic syndrome (blood cancers that prevent blood stem cells from maturing into healthy blood cells), difficulty in walking, lack of coordination, delirium, heart failure, memory deficit due to stroke, dysarthria (speech sound disorder), respiratory failure, kidney failure, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), type 2 diabetes mellitus with hyperglycemia (high blood sugar), heart disease, muscle weakness and insomnia (difficulty sleeping). Record review of Resident #12's Quarterly MDS assessment dated [DATE] revealed Resident #91 had a BIMS score of 06 indicating severe cognitive impairment. Resident #12 was partial/moderate assist for upper body dressing, bed mobility, personal hygiene, putting on/taking off footwear, chair/bed-to-chair transfer. Resident #12 was supervision or substantial/maximal assistance with lower body dressing. Resident #12 was dependent on staff for walking. The MDS also reflected diagnoses of anxiety (feeling of uneasiness or worry), type 2 diabetes mellitus with hyperglycemia (high blood sugar), and hypertension (high blood pressure), heart disease, heart failure, sepsis (a life-threatening complication of an infection), and stroke. Record review of Resident #12's Care Plan dated 08/01/2025 revealed diagnoses of hypertension (high blood pressure, heart failure, stroke, liver disease, diabetes, fluid overload, depression, and anxiety. The relevant interventions reflected to give medications as ordered. Monitor/document side effects and effectiveness. Record review of Resident #12's Order Summary Report, dated 09/10/2025, reflected the following medication orders: Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth one time a day for supplement. Torsemide Oral Tablet 20 MG (Torsemide) Give 1.5 tablet by mouth two times a day for fluid retention. Vitamin B Complex Oral Tablet (B-Complex Vitamins) Give 1 tablet by mouth one time a day for supplement. Protonix Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD. Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for anemia. Sitagliptin Phosphate Tablet 50 MG Give 1 tablet by mouth one time a day for DM. Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression. Multivitamin Oral Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day for supplement. Cyanocobalamin Tablet 500 MCG Give 1 tablet by mouth one time a day for supplement. Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 1 scoop by mouth one time a day for constipation. Ondansetron HCl Oral Tablet 4 MG (Ondansetron HCl) Give 1 tablet by mouth two times a day for nausea. Record review of Resident #12's medication administration record dated 09/06/2025 revealed that Resident #12 did not get her 9:00a.m. medication until 10:33a.m. Resident #12 also did not get her 9:00a.m medications on 09/06/2025 until 10:35a.m. Resident #91 Record review of Resident #91's Face Sheet dated 09/10/2025 revealed she was a [AGE] year-old female who was admitted to the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Resident #91's diagnoses included anxiety (feeling of uneasiness or worry), tinea Unguium (fungal nail infection), repeated falls, type 2 diabetes mellitus without complications (high blood sugar), Parkinson's disease (a progressive disorder that affects the nervous system), hypertension (high blood pressure), insomnia (difficulty sleeping), Parkinson's disease (a progressive disorder that affects the nervous system), heart disease, cognitive communication deficit (problems with communication), and difficulty walking. Record review of Resident #91's Quarterly MDS assessment dated [DATE] revealed Resident #91 had a BIMS score of 15 indicating intact cognitive response. Resident #91 was independent for eating, upper body dressing, bed mobility, and personal hygiene, putting on/taking off footwear, chair/bed-to-chair transfer. Resident #91 was supervision or touching assistance with lower body dressing, and walking. The MDS also reflected diagnoses of anxiety (feeling of uneasiness or worry), tinea Unguium (fungal nail infection), type 2 diabetes mellitus without complications (high blood sugar), and hypertension (high blood pressure). Record review of Resident #91's Care Plan dated 07/24/2025 revealed diagnoses of cognitive communication deficit (problems with communication), heart disease, hypertension (high blood pressure), type 2 diabetes mellitus without complications (high blood sugar), Parkinson's disease (a progressive disorder that affects the nervous system). Resident #91 was also on pain management. The relevant interventions reflected to give medications as ordered. Monitor/document side effects and effectiveness. Record review of Resident #91's Order Summary Report, dated 09/10/2025, reflected the following medication orders: Magnesium Oxide Tablet 400 MG Give 1 tablet by mouth one time a day for supplement. Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth four times a day for pain. Ferrous Sulfate Oral Tablet Delayed Release 324 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth one time a day for supplement. Colace Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for constipation. Metformin HCl ER Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCl) Give 2 tablet by mouth one time a day for diabetes DO NOT CRUSH. Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 2 capsule by mouth one time a day for depression. Multi-Vitamin/Minerals Oral Tablet (Multiple Vitamins w/Minerals) Give 1 tablet by mouth one time a day for supplement. Gabapentin Capsule 100 MG Give 2 capsule by mouth three times a day for neuropathy. Torsemide Oral Tablet 20 MG (Torsemide) Give 1 tablet by mouth one time a day for edema. Potassium Chloride ER Oral Tablet Extended Release 10 MEQ (Potassium Chloride) Give 1 tablet by mouth one time a day for supplement DO NOT CRUSH Allopurinol Oral Tablet 300 MG (Allopurinol) Give 1 tablet by mouth one time a day for Gout. Cetirizine HCl Oral Tablet 10 MG (Cetirizine HCl) Give 1 tablet by mouth one time a day for allergies. Methocarbamol Oral Tablet 500 MG (Methocarbamol) Give 2 tablet by mouth three times a day for muscle spasms Give 2 tablets =1000mg. Bisoprolol Fumarate Oral Tablet 5 MG (Bisoprolol Fumarate) Give 2 tablet by mouth one time a day for blood pressure hold for sbp 110, dbp 60, pulse 60. Record review of Resident #91's medication administration record dated 09/07/2025 revealed that Resident #91 did not get her 9:00a.m. medication until 10:16a.m. Resident #91 also did not get her 9:00a.m medications on 09/07/2025 until 10:22a.m. Resident #96 Record review of Resident #96's undated face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), chronic atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat.), congestive heart failure (a serious condition where the heart cannot pump enough blood to meet the body's needs, leading to symptoms like shortness of breath, fatigue, and fluid buildup), functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord), epilepsy (A neurological disorder that causes seizures or unusual sensations and behaviors.), diabetes mellitus type 2 (A condition results from insufficient production of insulin, causing high blood sugar.), depression (A mental condition characterized by a persistently depressed mood and long-term (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.), chronic respiratory failure, muscle wasting and atrophy (shrinkage), legal blindness, neuromuscular dysfunction of bladder (A condition where your bladder doesn't empty all the way or at all when you urinate.), and cognitive communication deficit. Record review of Resident #96's Quarterly MDS assessment dated [DATE] reflected a BIMS Score of 03, indicating severe cognitive impairment. Resident #96 required substantial/maximal assistance for eating, upper body dressing, bed mobility, and personal hygiene, and was dependent for oral hygiene, toileting hygiene, shower/bathing, lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfer. The MDS also reflected diagnoses of dementia, chronic atrial fibrillation, epilepsy, constipation, dysphagia, chronic respiratory failure, and muscle wasting and atrophy. Record review of Resident #96's Care Plan, last revised on 09/09/25, reflected diagnoses of GERD, congestive heart failure, neuromuscular dysfunction of the bladder, epilepsy, depression, and chronic respiratory failure. The relevant interventions reflected to give medications as ordered. Monitor/document side effects and effectiveness. Record review of Resident #96's Order Summary Report, dated 09/11/25, reflected the following medication orders: Bumetanide 2mg give 1 tablet by mouth in the morning for congestive heart failure. Citalopram Hydrobromide 10mg give 1 tablet by mouth one time a day for depression. Docusate Sodium capsule 100mg give 1 tablet by mouth one time a day for constipation. Fish oil capsules 1000mg (Omega-3 Fatty Acids) 1 tablet by mouth every day for labs. Lactobacillus capsule 1 tablet by mouth every day for supplement. Levetiracetam oral solution 100mg/mL, give 7.5mg by mouth twice a day for seizures. Losartan Potassium 25mg give 1 tablet by mouth one time a day for proteinuria, hold for blood pressure under 100/60. Magnesium Oxide 400mg give 1 tablet by mouth one time a day for hypomagnesemia. MiraLAX oral powder (Polyethylene glycol) 17 grams/scoop mixed in 8 ounces of water by mouth one time a day to promote bowel movement. Multi-vitamin/minerals give 1 tablet by mouth every morning for labs. Vitamin D3 25mcg give 1 capsule by mouth one time a day for low Vitamin D level. Lidocaine Pain Relief External Patch 4 % (Lidocaine) Apply to lower back topically two times a day for pain apply and remove after 12 hours. Lidocaine Pain Relief External Patch 4 % (Lidocaine) Apply to right knee topically two times a day for pain apply at 0900 and remove after 12 hours. Observation on 09/11/25 at 11:32 AM revealed MA L was passing 9:00 am medications to Resident #96, including: Docusate Sodium capsule 100mg give 1 tablet by mouth one time a day. Magnesium Oxide 400mg 1 tablet by mouth every day. Multivitamin with minerals 1 tablet by mouth every day. Omega-3 Fish oil capsules 1000mg 1 tablet by mouth every day. Lactobacillus acidophilus 1 tablet by mouth every day. Vitamin D3 25mcg 1 tablet by mouth every day. Losartan Potassium 25mg 1 tablet by mouth every day, hold for blood pressure under 100/60. Citalopram 10mg 1 tablet by mouth every day. Bactrim DS 800-160mg give 1 tablet by mouth twice a day for UTI (first dose 9/04/25 in the evening and last dose given on 09/11/25 at 11:32 AM. Bumetanide 2mg 1 tablet by mouth every day. Levetiracetam oral solution 100mg/mL, give 7.5mg by mouth twice a day. Polyethylene glycol 17 grams mixed in water by mouth every day. An interview with Resident on 09/09/2025 at 6:00 pm revealed that she did not get her morning medication on time. She said that she would not get her medication until after 10 am. She said she must ask staff for her medications. She said she does not get her medication on time every morning. She said that she cannot move until she gets the medication. An interview with Resident #12 on 09/11/2025 at 10:27 am revealed she did not know if she was getting her medications late. She said she had to ask staff often about getting her medication. She said she had not had any effects of not getting her meds on time. She said it has affected her daily living because she will get a little depressed when she does not get her medications on time. During an interview on 09/11/2025 11:49 AM, MA L stated there were normally three medication aides on the schedule for day shift, and today there were only two medication aides scheduled. MA L stated she had been working in the facility since the beginning of July 2025 and was new to the facility. MA L stated she would continue to pass the residents' medications even though they were late, and Resident #96 was her last resident until the noon (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication pass started. An interview with MA C on 09/11/2025 at 10:59 a.m., revealed that she had been trained on medication administration. She said the policy for passing medications was staff had one hour before and one hour after the scheduled time to give the resident the medication. She said the nurses and MAs were responsible for giving residents medication on time. She said that if the resident did not get their medication on time, the resident might get irritated, upset or be in pain. She said that by law she had to report to the nurse if the medication was out of the time frame, it was supposed to be given. She said if she were running behind, she would tell the nurse to see if someone could help her. She said the person who was giving the medication was the one who monitored to ensure they were given timely. She said the nurse or medication aide monitored it by checking the resident's chart. An interview with MA G on 09/11/2025 at11:27 a.m., revealed she had been trained on medication administration. She said the policy was staff had one hour before and one hour after the scheduled time to give the resident the medication. She said the MAs were responsible for giving the residents their medication on time. She said the resident may become frustrated or irritated if they were not given their medication on time. She said if she were running behind, she would try to explain to the resident why she was running behind and apologize to the resident for being late. She said the ADON and DON were responsible for monitoring to ensure the residents were getting their medications on time. She said she thought the DON and ADON monitored by checking the residents' charts. She said she is not supposed to give medication outside of the one-hour window. She said she is supposed to notify the ADON that she was running late. She said the reason she passed medication late was because the facility was short on MAs, and she had a heavier medication load. An interview with the ADON on 09/11/2025 at 11:50 a.m., revealed she had been trained on medication administration. She said the policy was staff had one hour before and one hour after the scheduled time to give the resident the medication. She said the MAs were responsible for giving the residents their medication on time. She also said that the nurses were available if the MA is running late. She said the negative outcome depended on the medication and the resident. She said the nurse was to call the doctor and assess the resident to make sure there was no complications due to the medication being administered late. She said if the MA was running late, they should get one of the ADONs and ask for help. She said the DON monitors to ensure residents are getting their medications on time. She said the DON will monitor medication by looking at the report for missed medication or not signed for medications. She said she did not know why the MAs were giving medication late because they never came and told her. An interview with the DON on 09/11/2025 at 11:53 a.m., revealed she had been trained on medication administration. She said the policy was staff had sixty minutes before and sixty minutes after the scheduled time to give the resident the medication. She said the MAs or nurse who was on the cart was responsible for giving the residents their medication on time. She also said that the nurses were available if the MA is running late. She said the negative outcome was if the resident got their medication too close together it could prevent the resident from going to activities. She said the MA were supposed to let the charge nurse, ADON and DON know they were running behind so the Nurse, ADON or DON could get the MA help. She said she monitors to ensure residents get their medications on time. She said she pull a report every day, but it did not have the times. She said now that she knew how to pull the times, she was going to start checking to ensure residents were getting medication on time. She said the MA was probably giving medication late because they had too many to give. During an interview with the ADM on 09/11/2025 at 2:25 pm revealed he was only trained on the general overview of medication administration. He said the policy was staff had one hour before and one hour after the scheduled time to give the resident the medication. He said the MA or nurse were responsible for giving the resident their medication on time. He said if the resident did not get their medications within the one-hour time frame, it would be a medication error, and the MA or nurse should call the doctor. He said if the nurse or MA were running behind on medication, the MA should alert the ADON and DON. He said the nursing managers were responsible for monitoring to ensure that the residents were getting their medication on time. He said (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the nursing managers should be reviewing the medication administration records. He said he did not know why the MAs were passing medication late. He said the MA might have gotten too busy. Record review of Medication Administration: Medication Pass Policy revised on 02/10/2020 revealed to safely and accurately prepare and administer medication according to physician orders and patient needs. Administer medication in accordance with frequency prescribed by physician - within 60 minutes before or after prescribed dosing time. Record review of Medication-Treatment Administration and Documentation Guidelines Policy revised on 02/10/2020 revealed provide a process for accurate, timely administration and documentation of medication and treatments. Administer the medication according to the physician order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions for 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure food items were labeled and dated with the received or expiration date. 2. The facility failed to properly store food in the pantry and freezer. 3. The [NAME] failed to wash her hands and change gloves between puree tasks. These failures could place residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings included: An observation on 09/09/2025 5:59 PM of the freezer in the main kitchen preparation area revealed the following:1. An opened box of hamburger patties with 1 bag in the box. The box and bag were opened. 2. A box of biscuits was open to the air. An observation on 09/09/2025 5:59 PM of the storage pantry revealed the following: 1. A 3-bin grain storage unit were partially full and were unlabeled and undated. 2. One bag of spaghetti was unlabeled and opened to air. In an observation and interview on 09/08/2025 at 11:05 am, [NAME] was observed in the kitchen preparation area, preparing puree foods without continuously wearing gloves and without washing her hands. [NAME] stated, she has been trained on food safety. She stated, Cross contamination could occur if food was not handled safely. An interview on 09/08/2025 @ 1:48 PM, KM revealed she has received food safety training, and that training included what the safe internal temperature of cooked chicken was. She stated, she has a Texas Food Manager Certification Program certificate. KM revealed she does not recall the safe internal temperature of cooked chicken. She stated, all the cook staff have all been trained in food safety. KM stated, the dry grains, including 3 bins in the facilities pantry, do not need to be labeled or dated when opened. She stated, she oversees posting information regarding food expiration dates. She stated the expiration dates of the grains are posted on the refrigerator. She stated every morning the food is checked for expired dates. She stated Residents could get sick if they consume expired foods. She stated, she does not know why someone would not use gloves while cooking or preparing food in the kitchen. She stated, everyone should wear gloves when they are preparing or cooking food, and we must wash our hands and change gloves between tasks. In an interview on 09/08/2025 @ 2:15 PM, the RD stated, I do a query (WITH) the food service staff one time per week to confirm the staff know the acceptable parameters for food labeling. She stated, expired foods could CAUSE illness, and expired food is not within acceptable parameters. She stated all staff members who cooks food should be trained regarding food safety. An Interview on 09/11/2025 at 6:15 PM with ADM revealed, ADM has not had any training on safe food handling. Record review of the facility's Food & Nutrition Services Policy and Procedure Manual: Dry Food and Supplies Storage policy revised on 11/15/2017 Fundamental Information reflected All bulk food items that are removed from original containers into food grade containers must have tight fitting lids and must be properly labeled with the common name of the product. Use by, Best by and Sell by dates should routinely be checked to ensure that items which have expired are discarded appropriately. Record review of the facility's Food & Nutrition Services Policy & Procedure Manual: Frozen and Refrigerated Food Storage Policy revised on 11/16/2017reflected (Potentially hazardous/ Time temperature control for safety) Foods will be properly refrigerated or frozen to reduce the potential for food borne illness and maintain product integrity. These procedures are applicable to pantry refrigerators and freezers on nursing units. 10. Packaged frozen items that are opened and not used in their entirety must be properly sealed, labeled, and dated for continued storage. Record review of the facility's Food & Nutrition Services Policy & Procedure Manual updated November 2017 Reflected Employees should never use bare hand contact with any foods. Since skin carries microorganisms, it is critical that all involved in food preparation and services consistently utilize good hygienic practices and techniques. Gloved hands are considered a food contact surface that can get contaminated or soiled. Disposable gloves are a single use items and should be discarded between and after each use. The use of disposable gloves is not a (continued on next page)

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	676496	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Burleson	275 SE John Jones Drive Burleson, TX 76028

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substitute for proper hand washing. Hand must be washed before putting on gloves and after removing gloves. Failure to change gloves and wash hands between tasks, such as medical treatments or contact with resident. Between handling raw meat and ready to eat foods or between handling soiled and clean dishes, can contribute to cross- contamination.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a new resident was not admitted with mental illness unless the state mental health authority determined eligibility, based on independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission for 1 of 12 residents (Resident #66) reviewed for PASRR services. The facility failed to ensure a positive PASRR screening was sent to the mental health authority for Resident #66. This deficient practice could place residents at risk for not obtaining the services needed to treat their mental health diagnoses. The findings include: Record review of Resident #66's face sheet, dated 09/08/2025, revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #66's diagnoses included cerebral palsy (a group of conditions that affect movement and posture), dry eye, hypertension (high blood pressure), history of falling, muscle weakness, anxiety (feeling of uneasiness or worry), major depressive disorder (mental health disorder characterized by persistent depressed mood), chronic pain, and schizoaffective disorder (mental disorder that affects a person's ability to think, feel and act). Record review of Resident #66's quarterly MDS assessment, dated 08/03/2025, revealed Resident #66 had a BIMS score of 15 indicating intact cognitive response. The MDS also revealed Resident #66 had schizoaffective disorder (mental disorder that affects a person's ability to think, feel and act), anxiety (feeling of uneasiness or worry), and depression. Record review of Resident #66's care plan, dated 6/26/2025, revealed, Resident #66 used psychotropic medication related to schizoaffective disorder (mental disorder that affects a person's ability to think, feel and act). Resident #66 uses psychotropic medications (antidepressants, antipsychotics, anxiolytics, or hypnotics) related to depression, generalized anxiety.disorder, bipolar disorder. Record review of Resident #66's PASRR dated 05/19/2021 revealed Resident #66 had mood disorder (major depression), schizoaffective disorder and anxiety. Record review of the list of residents PASRR positive received from the ADM on 09/08/2025 at 12:32p.m., revealed Resident #66 was not on the list. During an interview with Resident #66 on 09/11/2025 at 10:40a.m., revealed he did not know he had a mental illness diagnosis. He said he knew he was on medications but did not know he was diagnosed. He said he did not know if he had the diagnosis of mental illness before he admitted to the facility. He said he was not sure if he was getting specialized services. He said he was on medication and saw a psychiatric doctor but did not receive any other services. He said he would want to know if he could get other services. During an interview with the SW on 09/11/2025 at 12:50p.m., revealed she was trained on PASRR. She said she had PASRR training in 2021. She said the PASRR policy was that all residents had to have a PASRR before admission. She said the facility reviewed the medical records and diagnosis to identify a resident with a possible MI. She said for residents with newly identifying residents with possible MI, the facility found the diagnosis and then the facility did an audit on people with depression and may be PASRR positive. She said then she would complete the for mental illness/dementia resident review. She said she was responsible for sending or making the referral to the appropriate state-designated authority. She said the process for submitting the referral to the appropriate state-authority was she submitted the PASRR in the portal and if the PASRR was positive then she would call and set up a meeting with the PASRR representative. She said then the PASRR representative would do their screening to see if the resident was positive and do an IDT meeting. She said depending on the outcome of the meeting the resident would get services. She said she did not submit the referral to the mental health authority for Resident #66 because she thought the behavior/developmental referral she sent in covered both MI and ID. During an interview with the ADM on 09/11/2025 at 2:14pm revealed that he was trained on PASRR. He said he had the PASRR training in 2020. He said that the policy was that all residents needed a completed PASRR before being admitted to the facility. He said the social worker was responsible for ensuring that the PASRR was (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed and submitted to the appropriate state-authority. He said the only reason a resident who was PASRR positive would not get [NAME] services was if the resident did not want the services. He said the SW was responsible for monitoring to ensure all residents had a PASRR. He said he did not have any issues with PASRR before, so he had not had to do any training or corrective actions. He said he thought that Resident #1's PASRR was sent to the MI state- authority. Record review of Preadmission and Screening Resident Review Rules and Guidelines Policy, dated 07/2023, revealed, The Social Worker or designee enters the positive PL1 into the Simple LTC Portal for Expedited admission and Exempted Hospital Discharges. The Social Worker/designee monitors the Simple LTC portal for the PE. The Social Worker/designee prints out the PE form, reviews the PE Recommendations with the IDT. Social Worker/Designee Certify on the Simple LTC Portal that the facility can or cannot provide or support the Specialized Services recommended on the PE. Social Worker/Designee files the PE on the chart. Social Worker/Designee schedules IDT Meeting and it is held within 14 days of admit with the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 1 of 5 residents (Resident #97) reviewed for infection control. The facility failed to ensure CNA E was following infection control protocol during urinary catheter care and peri-care for Resident #97 by not changing her gloves when cleansing the catheter tubing and doing peri-care on 09/10/25. This failure could place residents at risk of transmission of disease and infection. Findings included: Record review of Resident #97's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included psoriasis vulgaris (Also known as chronic plaque psoriasis, is a common autoimmune skin disorder characterized by well-defined, red, scaly patches on the skin.), erythema intertrigo (a local infection of the skin and subcutaneous tissue), atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat.), acute and chronic respiratory failure (an acute and chronic condition where the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide.), congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply.), encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion.), cognitive communication deficit, and a non-pressure chronic ulcer of buttock. Record review of Resident #97's PPS MDS assessment following hospital stay, dated 08/11/25, reflected a BIMS score of 15, which indicated no cognitive impairment. The assessment further reflected Resident #97 had an indwelling urinary catheter, and required partial to moderate assistance with most of her activities of daily living and she had a manual wheelchair for mobility. Record review of Resident #97's Order Summary Report dated 09/10/25 reflected, Foley catheter care every shift for urinary catheter use. and Enhanced Barrier Precautions due to foley catheter and wound every shift. Record review of Resident #97's Treatment Administration Record dated 09/10/25 reflected, Foley catheter care every shift for urinary catheter use. and Enhanced Barrier Precautions due to foley catheter and wound every shift. Observation on 09/10/25 at 1:57 PM revealed peri-care and indwelling catheter care was conducted for Resident #97 by CNA E and CNA F. During Foley catheter care, CNA E pulled one wipe at a time from the package without changing her gloves when cleansing the catheter tubing and doing peri-care, which contaminated the resident's package of wipes, and had the potential to cross-contaminate the resident. Interview on 09/10/25 at 2:12 PM with CNA E revealed she had forgotten to pull the wipes from the package for Resident #97 before doing her foley catheter care and peri-care. CNA E stated this could lead to cross-contamination and an infection to the resident. CNA E further stated she had received training on infection control, conducting peri-care and Foley catheter care. Interview on 09/11/25 at 5:38 PM with the DON revealed she had been working here almost 4 months. She stated she had been trained on infection control, and she had done infection control modules, EBP, handwashing, PPE, peri-care, and handwashing. The DON stated she had just reinstated her Infection Preventionist certification. The DON stated the adult wipes should have been pulled from the package prior to providing care. She stated the policy for hand washing when providing care was to use gloves when providing peri-care. The DON stated sometimes the gloves become torn or soiled, and all staff were to remove soiled gloves, conduct hand hygiene, put on a clean pair of gloves, and pull all the wipes out of the package needed to provide care. The DON stated if staff did not conduct proper hand hygiene and pull enough wipes from the package to provide care, it could lead to cross contamination, and if there were not enough wipes the peri-care might not get done properly and the resident could get an infection. She further stated the ADON and herself monitored to ensure staff are washing hands and using wipes in a hygienic manner by having training competencies that they have been doing with all staff, and as staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member evaluations come up, the facility was evaluating their performance and progress. Interview on 09/11/25 at 6:07PM with the ADM revealed he had been working in the facility for 11 months. The ADM stated he had been trained on infection control and hand hygiene. He stated staff members should have pulled the wipes needed before providing care. The ADM stated the DON, and all department heads should be monitoring their staff for proper hand hygiene during all levels of care in the facility. The ADM further stated the consequence was resident could pick up a bug during peri-care, a urinary tract infection, or a wound could become infected. Record review of facility's policy and procedure, dated 10/24/2022, titled, Infection Prevention and Control Program reflected: This facility has established and maintains 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 as per accepted national standards and guidelines.