

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Five Points Nursing & Rehabilitation of College St		STREET ADDRESS, CITY, STATE, ZIP CODE 3105 Corsair Drive College Station, TX 77845	
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 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 observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing 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 one of five residents (Resident # 9) reviewed for activities. The facility failed to provide Resident #9 in room activities three times per week from April 2026 through June 18, 2026. This failure could place residents at risk for boredom, depression, and a diminished quality of life. Findings include: Record review of Resident #9's face sheet, dated 06/17/2026, reflected an [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, mild, with mood disturbance (early-stage of minor memory decline that affects daily functioning, but the exact cause has not been specifically identified), cognitive communication deficit (an impaired ability to communicate caused by disruptions in brain function such as: attention, memory, or problem-solving rather than physical speech or primary language issues), and anxiety disorder (a group of mental health conditions that cause intense, persistent, and excessive fear or worry in non-threatening situations). Record review of Resident #9's Significant Change MDS Assessment, dated 03/31/2026 reflected Resident #9 had a BIMS score of 9 indicating her cognition was moderately impaired. She was assessed by the staff in Section F Preferences for Customary Routine and Activities of not wanting the following: Choosing clothes to wear Caring for personal belongings Receiving a shower Receiving bed bath Receiving sponge bath Snacks between meals Staying up past 8:00 p.m. Family or significant other involvement in care discussions. Use of phone in private Place to lock personal belongings Reading books, newspapers, or magazines Listening to music. Keeping up with the news. Doing things with groups of people Participating in favorite activities Spending time away from the nursing home. Participating in religious activities or practices. Record review of Resident #9's Activity Assessment, dated 04/07/2026 reflected Resident #9 preferred not to participate in group activities. Resident #9 received one on one (in room activities) three times per week. She enjoyed reading, watching television, the news, and coloring. Signed by the Activity Director. Record review of Resident #9's Care Plan, revised on 05/06/2026, reflected Resident was dependent on staff for activities, cognitive stimulation, and social interaction related to physical limitations. Interventions: Introduce Resident #9 to other residents with similar interests and encourage interaction. Invite Resident #9 to scheduled activities. Observation and Interview on 06/16/2026 at 9:15 a.m. Resident #9 was lying in bed. She did not respond to a lot of conversation about her activities. She stated no when asked if she attended group activities or if anyone came to her room and visited with her or did activities with her in the room. Resident #9 (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, Yes I would when asked if she would enjoy for someone to come to her room and do an activity in her room. She did not respond to any further questions. There was not any sensory stimulation in Resident #9's room. In an interview on 06/18/2026 at 7:50 a.m., CNA D stated if a resident was not receiving any type of activities there was a possibility a resident may become bored or lonely. She stated she knew who Resident #9 was and she did not recall observing anyone in Resident #9's room assisting with activities. She stated she had been working at the facility a few weeks. Interview on 06/18/2026 at 8:05 a.m., the Activity Director stated Resident #9 was on the in-room activity program. She stated Resident #9 did not receive in-room activities during the months of April 2026, May 2026, or from June 1st through June 18th, 2026. She stated , I forgot to add Resident #9's name to the in-room activity list. The Activity Director stated if a resident was not receiving in-room activities there was a possibility a resident may become bored, feel isolated, and may have a decline in their mental status. She stated she was responsible to ensure all residents received the activities they needed. The Activity Director stated she had been an employee as Activity Director since December 11, 2025. In an interview on 06/18/2026 at 10:40 a.m., LVN A stated she was not aware of Resident #9 socializing outside of her room. She stated she had a change of condition over the past few months and stayed in her room. LVN A stated she had not observed anyone in Resident #9's room doing any type of activity. She stated she was assigned to Resident #9 frequently, however, she did not recall how many days a week or month. Interview on 06/18/2026 at 9:52 a.m., the Administrator stated it was very important for the residents unable to come out of their room or unable to participate in group activities to receive activities in their room. She stated the Activity Director was over the activity department and she was her supervisor. She stated there was a possibility that a resident may become lonely if they were not receiving activities in their room. The Administrator stated she expected all activities to be documented on every resident on a daily basis to capture who was attending group activities and what the residents were doing during in-room activities. The Administrator stated anytime a resident was assessed by the Activity Director to receive in-room activities her expectations were the Activity Director to begin the in-room activities immediately and follow the resident's activity preferences. Record review of the Facility's Policy on Activity Programming , dated 2011, reflected The Activity Director and staff will provide for ongoing Activity programs. PRACTICE GUIDELINES: Recreation programs are based on the interests and needs of the residents expressed through the Activity assessment. Resident's or family's expressed needs and interests are included in the development of programs. Input from residents may be done individually or discussed at Resident Advisory Council meeting. Activity programs are based on resident's leisure interests and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents. Programs will be geared to maintain functional ADL's, provide social interaction and, at the same time, protect residents from environmental over stimulation. Those who cannot participate in group settings are provided individual programming. Inability to participate could include those who refuse to participate in activities, those who are in isolation, or physician ordered bed rest.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide food that was palatable, and at a safe and appetizing temperature for residents # 12, # 18 and Confidential Resident # 1 who consumed foods orally from the only kitchen in the facility in that: The facility failed to provide palatable food that was appetizing to residents who complained the food did not taste good, it was too salty and that it was frequently cold. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. The findings included: Observation on 06/17/2026 at 1:50 p.m., revealed the 3 lunch test trays for a regular diet, a pureed diet, and a mechanically soft altered diet were tasted. The meal consisted of Chicken Fajitas, Charro Beans, Guacamole & Lettuce Salad, Warm Tortilla, Tapioca Pudding w/ Topping and Iced Tea. Observation revealed the chicken and charro beans were very salty. During an observation/interview conducted on 06/16/2026 at 11:16 AM, Resident #12 was sitting in her bed. Resident #12 reported a concern regarding meal service. She stated the food had changed a lot. She stated the food is too spicy, and it is cold when served in the room. A record review of Resident #12's, undated, face sheet revealed a [AGE] year-old female who was admitted to the facility originally 01/03/2025 and readmitted on [DATE]. Resident #12 had diagnoses which included chronic obstructive pulmonary disease (incurable lung disease), Type II diabetes mellitus (body resists the effects of insulin and sugar builds up in blood), anxiety (excessive worry and irritability) and morbid obesity due to excess calories. A record review of Resident #12's quarterly MDS, dated [DATE], revealed a BIMS of 15, which indicated the resident was cognitively intact. Additional interview conducted 06/18/2026 at 2:06 PM, Resident #12 stated her mash potatoes were salty at lunch meal. She stated the food is too spicy for more days than salty. She stated, the chicken and dumplings are always too salty. During an interview on 06/16/2026 at 1:05 p.m., it was revealed that Resident #18's only complaint was that her soup was too salty. During a confidential interview on an undisclosed date and time, Confidential Resident # 1 stated the food was not all that great'. Confidential Resident # 1 stated he ate in his room and lunch and dinner were served cool. He stated it was so salty I can't eat it most of the time. Confidential Resident # 1 denied complaining to anyone about the food. During an interview on 06/16/2026 at 10:15 a.m., DC K said the Dietary Manager was out for the day and DC K oversaw the kitchen for the day. DC K stated she has worked at this facility for 1 year and she stated the menus are planned by the DM and the RD, and she simply follows the recipes she is given for the daily menus. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/17 /2026 at 9:34 a.m., RD said she is responsible for meal plans and for establishing the dietary requirements for all residents. RD was not aware of the complaint that the food was too salty. Record Review of Policy Preparation for Food Production and Meal Service Table of Contents Preparation of Foods dated 6/2020, reflected: We will establish safe and nutritional preparation of food. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Procedure: 2. All food will be prepared by methods that preserve nutritive value, flavor, and appearance with a variety of color, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident . 6. The Dietary Service Manager and cooks will taste and test meals daily. The administrator and DON may taste test meals if requested.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure that SNA J sanitized hands between food tray distribution on hallway 200.2. The facility failed to ensure DC M used proper hand hygiene prior to putting on gloves. 3. The facility failed to ensure the [NAME] used proper sanitation when touching kitchen chicken broth jar lid. These deficient practices could place residents at risk for food borne illness. Findings Included: During an observation on initial tour of the kitchen on 06/16/2026 at 11:00 a.m., SNA J failed to sanitize hands between distributing lunch trays to room [ROOM NUMBER] and room # 213. During an interview on 06/16/2026 at 12:55 a.m., SNA J stated, I did use sanitizer when I delivered meals on the 200 hallways. She stated she did not remember that she did not use hand sanitizer when entering rooms [ROOM NUMBERS]. SNA J stated, she was trained on hand sanitation and hand sanitation is important to prevent germs. During an observation and interview on 06/17/2026 at 8:19 a.m., DC M picked up a can of pudding from the pantry, and she moved across the kitchen to a preparation counter where she served individual portions of pudding in small cups. Observation revealed DC M failed to wash her hands before serving the pudding into the small cups. DC M stated she was trained in proper hand hygiene; she is supposed to use gloves when working with food and she is to wash her hands between tasks. DC M said if proper hand hygiene is not practiced there could be cross contamination and someone could get sick. During a phone interview on 06/17/2026 at 9:34 a.m., RD stated it is her expectation that all staff will use proper hand sanitation to prevent food borne illness. RD said that staff are expected to always use gloves when working with food. During an observation and on 06/17/2026 at 11:08 a.m., during the puree process, DC L dropped the chicken broth jar lid onto the kitchen floor. Observation revealed DC L picked the lid up from the floor and she rinsed the lid in the kitchen sink before she replaced the soiled lid on top of the chicken broth jar. During an interview on 06/17/2026 at 11:08 a.m., DC L stated she had cleaned the lid to the chicken broth jar, and it was ok for her to put the lid back on the jar. During an observation on 06/17/2026 at 11:27 a.m., DC M walked in the kitchen, from the dry goods pantry where she had been moving the inventory boxes around and she proceeded to walk to the dishwasher where she obtained the clip board and pen used for logging the dishwasher temperatures. DC M failed to wash hands before putting on gloves and approaching salad prep station where she performed preparation of individual portions of salad Findings Included: (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on initial tour of the kitchen on 06/16/2026 at 11:00 a.m., SNA J failed to sanitize hands between distributing lunch trays to room [ROOM NUMBER] and room # 213. During an interview on 06/16/2026 at 12:55 a.m., SNA J stated, I did use sanitizer when I delivered meals on the 200 hallways. She stated she did not remember that she did not use hand sanitizer when entering rooms [ROOM NUMBERS]. SNA J stated that she was trained on hand sanitation, and hand sanitation is important to prevent germs. During an observation and interview on 06/17/2026 at 8:19 a.m., DC M picked up a can of pudding from the pantry, and she moved across the kitchen to a preparation counter where she served individual portions of pudding in small cups. Observation revealed DC M failed to wash her hands before serving the pudding into the small cups. DC M stated she was trained in proper hand hygiene; she is supposed to use gloves when working with food and she is to wash her hands between tasks. DC M said if proper hand hygiene is not practiced there could be cross contamination and someone could get sick. During a phone interview on 06/17/2026 at 9:34 a.m., RD stated it is her expectation that all staff will use proper hand sanitation to prevent food borne illness. RD said that staff are expected to always use gloves when working with food. During an observation on 06/17/2026 at 11:08 a.m., during the puree process, DC L dropped the chicken broth jar lid onto the kitchen floor. Observation revealed DC L picked the lid up from the floor and she rinsed the lid in the kitchen sink before she replaced the soiled lid on top of the chicken broth jar. During an observation on 06/17/2026 at 11:27 a.m., DC M walked in the kitchen, from the dry goods pantry to the dishwasher where she logged the dishwasher temperature. DC M failed to wash hands before putting on gloves and approaching salad prep station where she performed preparation of individual portions of salad. Record review of Food Handler Certificates reflected all kitchen staff had valid food handler's cards. Record Review of Dietary Services Policy & Procedures Manual 2012, revised 4/9/25 reflected: Infection Control We will ensure that all employees practice infection control in the Food and Nutrition Services Department and maintain sanitary food Preparation. Procedure: Personal cleanliness is required in sanitary food preparation. Employees should follow general sanitation guidelines from the Center of Disease Control and the state food code when working in the Food and Nutrition Department. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Careful hand-washing by personnel with be done in the following situations: b. Between handling dirty dishes, boxes, or equipment and handling clean food or utensils. 5. All kitchenware and food contact used in the preparation and/or serving of food are cleaned and sanitized before use and cleaned after each meal preparation. 6. Plastic disposable gloves are used when handling raw foods or in salad and sandwich preparation. There shall be no bare hand to foods or in salad and sandwich preparation. There shall be no bare hand to food contact. However, gloves are not a substitute for through and frequents handwashing. When using gloves, always wash hands before touching or putting on new gloves, and use single use gloves for on task. 10. Ware washing a. In order to ensure that all dishware is appropriately cleaned and sanitized the dish machine and three compartment sink must be operated at the appropriate chemical and temperature level. Fundamentals of Infection Control Precautions Hand hygiene is a general term that applies to washing hands with water and either plain soap or soap/detergent containing an antiseptic agent; or thoroughly applying an alcohol-based hand rub (ABHR). Hand washing refers to washing hands with plain (i.e., nonantimicrobial) soap and water. Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene Gloving Gloves are worn for three important reasons 1 To provide protective barriers and prevent. Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves.		

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interviews and record reviews, the facility failed to ensure that it employed a qualified social worker on a full-time basis for one of one facility reviewed for social work services in that: The facility, which was licensed for 130 beds, failed to employ a qualified social worker on a full-time basis since 2/21/2026. This failure could place residents at risk for unmet social services and psychosocial needs. Findings included: Review of the Facility Summary Report from the Texas Unified Licensure Information Portal (TULIP) dated 06/24/2024 reflected the facility had a total licensed capacity of 130 beds. Review of facility's Resident Council meeting minutes dated 03/04/2026, Social Services section noted in minutes read We need one, we don't have one. Review of facility's Resident Council meeting minutes dated 06/01/2026, Social Services section noted in minutes read We don't have one. Review of facility's Resident Council meeting minutes dated 07/01/2026, Social Services section noted in minutes read Residents say, we don't have one. Review of the undated job description for the facility's 'Social Worker' revealed: Knowledge Base: Develops social histories of residents and develops a social assessment and care plan for each resident which identifies medically related social and emotional problems and needs. Participates in interdisciplinary care plan conferences and contributes to the development of care plans for residents. Establishes specific social action plans and realistic goals for each resident consistent with medically related social and emotional needs. Provides individual and group help for residents and families at times of adjustment, crisis or particular need. Orients residents and families to the facility environment and assists the adjustment of both through individual and group programs. Coordinates discharge planning with staff, residents, and families. Coordinates social services in-service and educational programs for staff. This was signed by the unlicensed SW on 04/17/2026. In an interview conducted on 06/18/2026 at 11:45 AM with SW, she stated that she had been working at the facility since 04/17/2026. SW stated she was a PRN Social Worker for the facility, and she worked after hours and on Saturdays. She stated she does not work full-time. SW stated she completed assessments and set up careplan meetings. SW stated she was told the facility hired another Social Worker, but she did not have any information on a start date. In an interview conducted on 06/18/2026 at 11:51 AM with the HRC, she stated she has been employed with the facility since 03/02/2026. The HRC stated the facility's last fulltime SW's last day of employment was on 02/20/2026. She further stated the current SW is not a full-time employee, and she worked on evenings and weekends. The HRC stated the residents report concerns to the Administrator if needed. In an interview conducted on 06/18/2026 at 2:49 PM, the Administrator stated the facility has a licensed capacity of 130 residents. She stated that the current social worker was hired April 16, 2026 and worked on a part-time basis rather than full-time. The Administrator was asked how the facility ensures resident's social service needs are met in the social worker's absence, she stated the residents brought their concerns to her or the DON, and they addressed the residents' issues as needed. The facility's Social Worker Policy was requested 06/17/2026 at 9:18 AM and again on 6/18/2026 at 12:05 PM from the Administrator. The Interim DON stated the facility did not have a Social Work policy and that the facility followed the National Association of Social Workers Long-term Standards. Review of National Association of Social Workers Long-term Standards assessed on 6/18/2026 reflected: Standard 5. Staffing A sufficient number of appropriately trained licensed or credentialed and experienced social work and supportive personnel shall be available to plan, provide, evaluate, and modify all social work services. Interpretation The number and qualifications of the social work staff and the level of consultation needed shall be based on criteria related to the type, scope, and complexity of the social work (continued on next page)		

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	program, the size of the facility, and the biopsychosocial needs and characteristics of the population served. All social work services shall be provided by social workers with experience in long-term care and a master's degree in social work or a baccalaureate degree in social work from an accredited school of social work. All social work staff and consultants shall be licensed, certified, or registered as mandated by specific state licensing agency requirements in the state in which the social worker practices. The social work program shall have a sufficient number of appropriately trained or experienced support personnel to enable the provision of social work services that ensure each resident maintains or attains the highest practicable level of well-being.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 of 10 residents (Resident #20 and Resident #34) reviewed for resident rights. The facility failed to ensure SNA J knocked on Resident #20 and Resident #34's door when going into the residents' rooms to deliver lunch meal. The deficient practice could place residents at risk of feeling like their privacy was being invaded or the facility was not their home. Findings included: Review of Resident #20's Face Sheet dated 06/18/2026 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20's diagnoses included Chronic Obstructive Pulmonary Disease (Is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough.), Chronic Respiratory Failure (is a long-term condition where the lungs cannot maintain adequate oxygen levels or remove carbon dioxide from the blood), and unspecified Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) Record review of Resident #20's Quarterly MDS assessment dated [DATE] revealed that Resident #20's BIMS score was 12 which means the resident had moderate problems with thinking and memory. Review of Resident #34's Face Sheet dated 05/18/2026 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #34's diagnoses included Inclusion Body Myositis (IBM, a progressive muscle disease that causes gradual weakness, particularly in the wrists, fingers, and front thigh muscles), Unspecified Dementia (loss of cognitive functioning that interferes with daily life and activities), and Essential Hypertension (High Blood Pressure). Record review of Resident #34's Quarterly MDS assessment dated [DATE] revealed that Resident #34's BIMS score was 09 which means the resident had moderate problems with thinking and memory. Observation done on 200 hallway on 06/16/2026 at 12:55 a.m., revealed SNA J did not knock on Resident # 20 or Resident # 34's door before entering the residents' rooms. During an interview with Resident # 34 on 06/18/2026 at 8:40 a.m. he said they never knock on his door. Resident #34 said he does not like it when staff come into his room without knocking. He said that he likes to know who is coming in his room. During an interview with Resident # 20 on 06/18/2026 at 8:35 a.m. she said that staff do not knock all the time. She said, I like to be able to relax and sometimes it bothers me when they do that because I'm not expecting anyone. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Five Points Nursing & Rehabilitation of College St		STREET ADDRESS, CITY, STATE, ZIP CODE 3105 Corsair Drive College Station, TX 77845	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/16/2026 at 12:55 a.m., SNA J said she was a student nurse. SNA J said she has been trained in Residents Rights and residents have a right to dignity. She stated she was taught that staff should knock before entering a resident's room. During an interview on 06/16/2026 at 12:25 p.m., CNA H said residents have rights and they have choices. CNA H said a resident has a right to privacy and staff should knock before entering a resident's room. Record review of SNA J's Employee file reflected SNA J's training included resident rights. SNA J was employable, background check was acceptable Record Review of the undated facility Policy of Resident Rights reflected: Resident Rights The resident has a right to a dignified existence, self-determination, and communication with and access to people and services inside and outside the facility, including those specified in this policy. A facility must 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, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for one of seven residents (Resident #9) reviewed for care plans. The facility failed to update the comprehensive care plan to reflect Resident #9 received in room activity programs and resident preferences of not wanting showers, baths, snacks, and not having family involved with care discussions. These failures could place residents at risk of not receiving appropriate interventions to meet their psychosocial needs. Findings include: Record review of Resident #9's face sheet, dated 06/17/2026, reflected an [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, mild, with mood disturbance (early-stage of minor memory decline that affects daily functioning, but the exact cause has not been specifically identified), cognitive communication deficit (an impaired ability to communicate caused by disruptions in brain function such as: attention, memory, or problem-solving rather than physical speech or primary language issues), and anxiety disorder (a group of mental health conditions that cause intense, persistent, and excessive fear or worry in non-threatening situations).Record review of Resident #9's Significant Change MDS Assessment, dated 03/31/2026 reflected Resident #9 had a BIMS score of 9 indicating her cognition was moderately impaired. She was assessed by the staff in Section F Preferences for Customary Routine and Activities of not wanting the following:Caring for personal belongingsReceiving a showerReceiving bed bathReceiving sponge bathSnacks between mealsStaying up past 8:00 p.m.Family or significant other involvement in care discussions.Use of phone in privatePlace to lock personal belongingsReading books, newspapers, or magazinesListening to music.Keeping up with the news.Doing things with groups of peopleParticipating in favorite activitiesSpending time away from the nursing home.Participating in religious activities or practices.Record review of Resident #9's Care Plan, revised on 05/06/2026, reflected there was not a focus area on the care plan for in-room visits, resident's preferences of not having baths or showers, not receiving snacks and not having family involved with care discussions.Record review of Resident #9's Activity Assessment, dated 04/07/2026 reflected Resident #9 received one on one (in room activities) three times per week. Signed by the Activity Director.Observation and Interview on 06/16/2026 at 9:15 a.m. Resident #9 was lying in bed. She did not respond to a lot of conversation about her activities. She stated no when asked if she attended group activities or if anyone came to her room and visited with her or did activities with her in the room. Resident #9 stated, Yes I would when asked if she would enjoy for someone to come to her room and do an activity in her room. She did not respond to any further questions. Interview on 06/18/2026 at 8:05 a.m., the Activity Director stated Resident #9 was on the in-room activity program. She stated all residents were expected to have their care plan revised to meet their activity preferences. The Activity Director stated she did not revise Resident # 9's care plan to meet their current activity preferences of receiving in-room activities. She stated she did not realize she did not revise Resident #9's care plan. She stated, if a resident was feeling lonely or had behavior issues the staff would not have the information of the activities to use to help the resident.In an interview on 06/18/2026 at 8:25 a.m., the MDS Coordinator RN stated the information the CNAs followed on the Kardex (electronic system for CNAs use to know what type of care to give the residents) came from the care plan. She stated if a resident needed a certain type of care or had (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors and it was not care planned, the CNAs or nurses would not have that information to know what type of care to give the residents. The MDS Coordinator stated it was the Activity Director's responsibility to ensure the activity care plans of the residents' activity preferences were documented on the care plan. She stated the residents' preferences of care, food, activities, etc. were expected to be care planned and she was not responsible to ensure the residents' preferences were on the care plan. The MDS Coordinator did not respond when asked if a resident had a preference of bathing/ showers or any type of ADL care who was responsible to document these preferences on the care plan. She stated it was the facility's protocol and policy the DON is responsible for the Comprehensive Care Plan and revising the care plans. The MDS Coordinator RN stated it was not her responsibility to ensure the care plans were completed and accurate. She stated the IDT met once a week and discussed residents' care plans due that week. She stated the Activity Director attended weekly care plan meetings. The MDS Coordinator RN stated the interdisciplinary care plan team consists of the following: Social Worker Activity Director MDS Coordinator RN Nursing administration either ADON or DON Sometimes Director of Therapy Dietary Manager In an interview on 06/18/2026 at 9:20 a.m., the Nurse Consultant (interim DON) stated there was not a facility policy reflecting the DON is responsible for the Comprehensive Care Plan and revising the care plans. She stated it was the MDS Coordinator's responsibility to ensure the Comprehensive Care Plan was completed. She stated the IDT met weekly to discuss care plans. She stated anytime there was an acute concern with a resident the DON or ADON would revise the care plan. The Nurse Consultant stated all disciplines were responsible for their own care plans and each resident's plans were expected to be discussed as a group during the weekly care plan meetings. She stated all residents were expected to have their activity preferences documented on the comprehensive care plan. The Nurse Consultant stated if a resident was sad or had behaviors, the staff would refer to the care plan to know what their activity preferences were to re-direct the resident. In an interview on 06/18/2026 at 9:52 a.m., the Administrator stated her expectations of care plans were the IDT discussed care of each resident and if there was a change with anything which included resident preferences the care plan was expected to be revised. She stated the IDT was expected to ensure the resident's information to give appropriate care to each resident was documented on the care plan whether it was physical, emotional, resident preference, activities, etc. She stated there was not a facility policy or protocol reflecting the DON was responsible for the comprehensive care plan. The Administrator stated the MDS Coordinator RN was responsible for the comprehensive care plan and ensuring the care plans were completed on time. She stated the Interdisciplinary Team consists of the following: MDS Coordinator RN Social Worker Dietary Manager Activity Director Someone from nurse administration (DON, ADON), if needed Director of Therapy - if applicable Record review of the facility's Comprehensive Care Planning, not dated, reflected Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. The care plan will be prepared by an interdisciplinary team. Interdisciplinary means that the professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident # 60 and Resident # 78) reviewed for ADL care. The facility failed to ensure Resident #60's nails were cleaned on 06/16/2026. The facility failed to ensure Resident # 78's facial hair on chin, under chin, and above upper lip was removed on 06/16/2026. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings include: 1. Record review of Resident #60's face sheet, dated 06/16/2026, reflected a [AGE] year-old-female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #60 had diagnoses which included muscle weakness (the affected muscle cannot move normally or contract with the required power, even when you try as hard as you can), type 2 diabetes mellitus with diabetic chronic kidney disease (prolonged high blood sugar has caused a person's body to struggle to process insulin, resulting to damage to a person's kidneys), and unspecified lack of coordination (impaired ability to perform smooth, controlled, and voluntary muscle movement). Record review of Resident #60's Quarterly MDS Assessment, dated 05/18/2026, reflected Resident #60 had a BIMS score of 14, which indicated her cognition was intact. Resident #60 was dependent on staff for showers and toileting hygiene. Record review of Resident #60's Comprehensive Care Plan, revised on 06/12/2026 reflected Resident #60 had an ADL self-care performance deficit. Intervention: Bathing: check nail length, trim, and clean on bath day and as needed. Report any changes to the nurse. If diabetic, the nurse will provide toenail care. Observation and interview on 06/16/2026 at 9:44 a.m. revealed Resident #60 was sitting near her bed in her wheelchair. She was talking to her roommate. Resident #60's fingernails on her right hand underneath her forefinger, middle and ring fingernails had a blackish/ brownish substance. She stated I don't know when asked about if staff cleaned her fingernails. Resident #60 did not respond to any further questions about her ADL care of fingernails. 2. Record review of Resident #78's face sheet, dated 06/16/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #78 had diagnoses which included muscle weakness (the affected muscle cannot move normally or contract with the required power, even when you try as hard as you can), lack of coordination (impaired ability to perform smooth, controlled, and voluntary muscle movement), and cognitive communication deficit (an impaired ability to communicate caused by disruptions in brain function such as attention, memory, or problem-solving rather than physical speech, or primary language issues). Record review of Resident #78's Quarterly MDS Assessment, completed on 05/06/2026, reflected Resident #78 had a BIMS score of 3, which indicated her cognition was severely impaired. Resident #78 required partial/moderate assistance (helper does less than half the effort) with personal hygiene. She was dependent on staff for showers, lower body dressing and toileting hygiene. Resident #78 required substantial / maximal assistance (helper does more than half the effort) with upper body dressing. Record review of Resident #78's Comprehensive Care Plan, dated 06/12/2026, reflected Resident #78 had impaired visual function. Intervention: Arrange consultation with eye care practitioner as required. Encourage Resident to wear her glasses. Resident #78 had an ADL self-care performance deficit. Intervention: Bathing required one person with assistance. Encourage Resident #78 to discuss feelings about self-care deficit. Observation and interview on 06/16/2026 at 9:50 a.m. Resident #78 was sitting in her wheelchair near her bed in her room. She was talking to her roommate. Resident #78 had approximately 6 long hairs (approximately 1/2 inch in length) under her chin. She (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had approximately 5 long hairs (approximately 1/2 inch in length) on her chin and above her lip. Resident #78 stated she did not know she had hair on her face. She stated she never let hair grow on her face and she could not get it off of her face. She did not respond to any further questions about her facial hair grooming. In an interview on 06/18/2026 at 7:35 a.m., CNA C stated if a CNA observed any problems with a resident's nails the CNAs was to report it to the nurse supervisor with any resident. CNA C stated the CNAs completed all nail care for residents without a diabetes diagnosis. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as nausea and diarrhea. CNA C stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated if a female resident had facial hair there was a possibility the female resident may become embarrassed and not want to be around other residents. She stated the nursing staff was expected to check for facial hair on female residents during showers and when giving ADL care. CNA C stated anytime a resident refused any type of care she reported it to the charge nurse and the charge nurse would document it in the resident's medical record. CNA C stated she had given some care to Resident #78 and Resident #60, however, she did not recall if they refused nail care. She stated she was not aware of Resident #78 or Resident #60 shower schedules. CNA C stated she was not assigned to Resident #78 or Resident #60 on 06/16/2026. In an interview on 06/18/2026 at 9:20 a.m., the Nurse Consultant (interim DON) stated the CNAs were responsible to clean and trim all residents' nails except for the residents with diabetes. She stated the residents' nails were usually cleaned during shower days and as needed. She stated if a resident ingested blackish/brownish substance there was a potential the resident may experience vomiting or diarrhea. The Nurse Consultant stated it depended on the type of bacteria. She stated she expected nail care to be completed as needed and on shower days. The Nurse Consultant stated anytime there was an issue with nails the staff was to report it to the nurse supervisor. She stated any refusal of care would be documented on the resident's care plan. The Nurse Consultant stated if a female resident had facial hair and it was the resident's preference for it to be removed she expected the nursing staff to remove the facial hair during showers or as needed. She stated a female resident may become humiliated if she was seen by other people with facial hair on her chin, above her lip or under her chin. Record review of the facility's policy on Activities of Daily Living (ADLs), dated 2001, reflected Residents will be provided with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal, and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). Record review of the facility's Policy on Nail Care, not dated, reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle and is usually done during the bath. Record review of the facility's Policy on Dressing and Personal Grooming, not dated, reflected The purposes of this procedure are to assist the resident as necessary with dressing and undressing and to promote cleanliness. Should be performed according to the resident centered plan of care. Report abnormalities to charge nurse.		