STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455478	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands Nursing and Rehabilitation	2501 Maple Ave Waco, TX 76707

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident with limited range of motion and limited mobility receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion and appropriate services, equipment, and assistance to maintain or improve mobility for 1 of 6 residents (Resident #22) reviewed for ROM and mobility, in that:The facility failed on 4/25/2025 to ensure Resident #22 continued to receive OT services that were signed off on by the MD on the resident's initial OT evaluation. This failure placed residents at risk of not maintaining their highest practicable physical, mental, and psychosocial well-being. Review of Resident #22's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included stroke (when blood supply to part of the brain is suddenly reduced, leading to brain cell death and/or permanent damage), high blood pressure, diabetes mellitus (chronic disease where the body does not produce enough insulin), hemiplegia (paralysis) or hemiparesis (weakness on one side of the body). His BIMS score was a 00, indicating severe cognitive impairment. In Section GG - Functional Abilities, for the tasks of sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, he was indicated as being Dependent- Helper does all of the effort, resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. For the task of roll left and right he was indicated as requiring Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.Review of Resident #22's comprehensive care plan last revised 6/29/2025 reflected he had an ADL self-care performance deficit with a goal that he would improve his current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. An intervention of Notify DOR of need for ST/PT/OT evaluation and treatment as per MD orders was listed. He was not care planned for refusing any services. Review of Resident #22's physician's orders, active as of 7/23/2025, reflected the following standing (a written protocol that allows the healthcare team to perform specific clinical tasks without needing a physician's order) orders: PT to eval and treat on admission OT to eval and treat on admission ST to eval and treat on admissionReview of Resident #22's Occupational Therapy Evaluation & Plan of Treatment dated 4/18/2025 reflected diagnoses of cerebral infarction due to thrombosis of left anterior cerebral artery (blockage of blood flow to the front part of the brain) and muscle weakness. The reason for referral listed stated, Patient was referred to OT d/t recent admission to this facility. Patient presents with decreased: bed mobility, activity tolerance, and ROM LUE. Patient will benefit from OT to address these deficits and maximize overall QOL.The treatment approaches included: therapeutic exercises, neuromuscular reeducation, group therapeutic procedure, occupational therapy evaluation: moderate complexity, therapeutic activities, and self-care management training. The Frequency was for 12 time periods, for a duration of 30 days, with an intensity of daily, and the certification period was for 4/18/2025-5/17/2025. The following goals were listed: Patient will perform L UE strengthening exercises x 8-10 minutes, in order to improve strength for bed mobility.Patient will tolerate 5-7 minutes PROM to R UE, in order to improve ROM and prevent contracture.Patient will safely perform bed mobility tasks with Mod (A) with use of siderails for use of compensatory strategies in order todecrease risk for skin breakdown.Patient/caregivers will demonstrate 85% accuracy for safety/compensatory strategies for bed mobility.These were signed off on by the medical director on 4/21/2025 and it stated, I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 4/18/2025 through 5/17/2025.In an observation on 7/21/2025 at 11:18 AM with Resident #22 he was observed to not be responding to the state surveyors' questions with words, rather he was using his left hand to move his thumb in a sideways or upwards movement to indicate a thumbs-up when asked if he felt okay, was being treated well by staff, and if he participated in activities. In a confidential interview the person stated that when Resident #22 first admitted , they thought the facility was going to be giving the resident rehabilitation to regain his functions, but there seemed to be no improvement with the resident's abilities. They stated that staff report that the resident refused therapy. This person stated that every time they visit the resident would be lying in the same position in bed. They confirmed that the resident had right side paralysis, and that his Medicaid had not been approved yet, and the facility would not do anything until that was approved. In an interview on 7/22/2025 at 4:22 PM with the DOR she stated that Resident #22 had been 'Medicaid pending' since his admission on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 of 3 medication carts reviewed (East Cart, 1 [NAME] Back Cart). The facility failed to ensure narcotic logs on the East Cart and 1 [NAME] Back Cart were completely filled out and were not missing nurse signatures from 7/19/25-7/21/25.This failure could place residents at risk of drug outages due to drug diversions and poor inventory control which could result in the diminished health and well-being of residents.Findings included: Observation on 7/22/25 at 4:20 PM of the East Medication Cart Narcotic Log revealed 2 shifts with no narcotic counts recorded and 2 other shifts with partially completed entries. The 7/19/25 6PM line was missing a time and a signature of the off-going nurse for the count. The 7/20/25 6AM and 6PM shifts were both completely blank, indicating that 2 nurses failed to sign or count narcotics for those shifts. The 7/21/25 8AM line had only the signature of the oncoming medication aide and was missing a nurse's signature. Observation on 7/22/25 at 5:00 PM of the 1 [NAME] Back Medication Cart Narcotic Log revealed that the line for 7/20/25 6:05 PM had a blank box where the on-coming nurse should have signed. In an interview on 7/22/25 at 4:37 PM the DON stated that her expectations were that counts be completed prior to passing the narcotic keys every shift. She was not aware the counts had been missed prior to us discussing it and she denied knowing why they were missed. In an interview on 7/22/25 at 4:39 PM MA-B stated 2 agency nurses worked on the East Hall from 6 PM on 7/19/25- 6 AM on 7/21/25. She stated the nurses working on the shifts involved were LVN-A and LVN-B. She denied having any knowledge on why they did not sign out the narcotic count. In an interview on 7/23/25 at 4:30 PM MA-C stated the policy was for 2 nurses to count narcotics and sign the narcotic sheet. He stated it was important to count the narcotics with 2 people to verify and have a witness that the count was correct. He stated the negative outcome if count was missed was that narcotics could be short or missing, and residents could be neglected on their medications. He stated Agency nurses passed medications for the day and night shifts on the East Hall for the 7/19/25. and 7/20/25 shifts. In an interview on 7/23/25 at 4:35 PM RN-A stated, the policy was for 2 nurses to count narcotics and sign the narcotic sheet. She stated it was important to count the narcotics with 2 people to decrease chances of narcotic diversions and safely confirm that narcotics were not missing. She stated not counting narcotics could affect residents if a medication supply was low and a resident could not get their medications. In an interview on 7/23/25 at 4:45 PM the DON stated, the policy was for 2 nurses to count narcotics and sign the narcotic sheet between shift changes. She stated staff could not go home or take the narcotic keys until narcotics were counted and documented. She stated it was important to count the narcotics with 2 people to verify the count was correct. She stated not counting could affect residents if medications were diverted and the medication count was off. She stated, if that happened, then the medication may not be available for the resident, or it could cause a medication dosage error by leading to a missed dose or a duplicated dose. She stated the rule was that if they did not document something, then it was assumed it didn't happen. She stated that this morning she had tried to call the agency nurses that did not sign out but they had not called her back. In an interview on 7/23/25 at 5:02 PM the ADM stated the policy was to count narcotics at shift change and record the count on the log. She stated count should be done by 2 people, so no one could take narcotics. She stated it could affect residents by making them miss medications they needed. In an interview on 7/23/25 at 5:23 PM MA-A stated in a telephone interview with the DON present, that RN-A counted with her on 7/21/25 at 8 AM. In an interview on 7/23/25 at 5:30 PM, RN -A stated she did count with MA-A on 7/21/25 at 8 AM and she must have forgotten to sign the sheet. Interview on 7/23/25 at 6:09 PM attempted with LVN-B but she did not answer, and the phone would not accept a message. No call back was received. In an interview on 7/23/25 at 6:20 PM LVN-A stated she worked the weekend shifts for 7/19/25 at 6 PM-7/21/25 at 6 AM. She stated she did not remember why they didn't sign off the narcotic sheets. She stated they did count each day, and she counted with a facility staff nurse. She stated it was important to count with 2 people to prevent medications from being stolen and to catch if a wrong medication had been given. She stated that she did not think missing counts would affect residents. A record review of the facility policy titled; Controlled Substance Administration & Accountability dated 2025 reflected the following:All controlled substances obtained from a non-automated medication cart are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. For areas without automated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 in 1 of 1 kitchen reviewed for food and nutrition services. The facility failed on 07/22/2025 to ensure dietary CK 2 used proper hand hygienewore gloves while plating food for service on the line. The facility failed on 07/22/2025 to ensure CK 1 wore a beard net while preparing food for the residents. The facility failed on 07/22/2025 to ensure dietary CK 1 washed his hands or changed his gloves while preparing pureed food for the residents and in between tasks. The facility failed on 07/22/2025 to ensure dietary CK 1 cleaned and sanitized the food processer in between pureed food items. These failures could place residents at risk for food contamination and/or foodborne illness. In an observation on 07/22/2025 at 9:35 AM of the facility's only kitchen revealed CK 1 was near the food preparation table preparing food and was not wearing a beard net. CK 1 had a visible beard and mustache no more than one inch in length.In an observation on 07/22/2025 at 10:39 AM of the facility's only kitchen revealed CK 1 was in the kitchen near the food preparation table, and three compartment sink area with his beard net pulled below his bottom lip. CK 1 was wearing gloves while moving about touching other surfaces (food processor, kitchen sink handles, sink, food processor) in the kitchen without changing his gloves after encountering different surfaces and then resumed his food handling with the same gloves. Observation on 07/22/2025 at 11:00 AM, revealed CK 1's beard net was pulled below his bottom lip while preparing pureed chicken with chicken broth. CK 1 washed the food processor in the three-compartment sink, rinsed it with running water, but did not sanitize it. CK 1 proceeded to puree broccoli using the food processor and repeated the same process. CK 1 then proceeded to puree garlic bread with the unsanitized food processor. CK 1 then grabbed a dirty towel with food particles and brown spots off the dirty cart. CK 1 wiped down the food processor base and food preparation area with the same dirty towel. During the entire process of pureeing the chicken, broccoli, and garlic bread, dietary CK 1 did not change his gloves or wash his hands in between tasks.In an observation on 07/22/2025 at 11:20 AM CK 1 was near the stove and food preparation area with his beard net pulled below his bottom lip. In an observation on 07/22/2025 at 11:45 AM, CK 2 did not put on gloves before preparing trays on the serving line. In an interview on 07/22/2025 at 10:39 AM with the DM, she stated the kitchen staff was to always wear gloves and hair/beard nets when preparing food, which included the puree food process. She stated all staff were required to change their gloves and wash hands in between tasks and whenever they touched anything contaminated. This was to avoid cross contamination and sanitation issues. She stated if the kitchen staff were moving about touching other surfaces in the kitchen while preparing food, they must change gloves, wash their hands, and put on new gloves. She stated the food processor should go in the dish washer to be cleaned and sanitized in between uses. She stated the food processor base should be cleaned after each use with soap and water. She stated the staff had sanitizing buckets, one with soap and water and one with water kept under the cooking station. She stated the staff should be pulling the clean towel out of the soapy water and sanitizing the equipment after each use, and when done staff should put the dirty towel in the dirty bin. She stated a potential negative outcome of not using proper washing and sanitizing between pureed food items was there could be cross contamination, the resident could get sick, or it could affect the integrity of the meal.In an interview on 07/22/2025 at 12:15 PM, CK 2 stated she did not put gloves on before preparing trays on the serving line. She stated she was trained on proper hand hygiene. She stated all staff should be washing hands and wearing gloves on the serving line. She stated she was trained to wash and sanitize the blender in between pureed items. She stated the proper technique for cleaning and sanitizing the blender was to use the three-compartment sink to wash with soap and water and air dry in between pureed items. She stated a potential negative outcome of not properly washing and sanitizing the blender in between puree food items was food poisoning and cross contamination. She stated anyone that entered the kitchen was supposed to wear the appropriate hair and beard net to prevent hair from falling into food. She stated she had been trained but did not recall the date.In an interview on 07/22/2025 at 12:30 PM, CK 1 stated he did not change his gloves while preparing food for the residents. He stated he was required to change his gloves and wash hands in between tasks and after touching anything contaminated. He stated the germs on his gloves may spread to the food. He stated he did not wash and sanitize the food processor in between pureed items, and he was running behind on time. He stated the proper technique for cleaning and sanitizing the food processor was to use the three-compartment sink to wash with soap and water and air dry in between

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 transmission of communicable diseases and infections for 4 of 4 residents (Residents #15, #25, #34, and #70) and 1 of 1 laundry carts reviewed for infection control. The facility failed on 07/21/2025 to ensure laundry staff handled and stored linens during transport in a manner to ensure cleanliness, protect from dust, and to prevent cross-contamination and the spread of infections. The facility failed on 07/22/2025 to ensure MA-A sanitized reusable equipment (BP cuff) between Residents #15, #25, #34, and #70. This failure could place residents at risk for development of communicable diseases and infections that could diminish a residents' quality of life. Findings included: Record review of Resident #15's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Hypothyroidism (low thyroid), Ocular Hypertension, Hypertension (High BP in the eye), and Schizophrenia (mental illness). Record review of Resident #15's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated the resident's cognitive ability was not impaired. Record review of Resident #15's Care Plan, reflected a Focus area was initiated for Hypertension on 10/2/15 and revised on 6/20/25 with a goal to have no side effects from BP medications. Resident #15's interventions included to check BP. Record review of Resident #25's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of Congestive Heart Failure, Kidney Transplant, Hypertension, and Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident #25's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated the resident's cognitive ability was not impaired. Record review of Resident #25's Care Plan, reflected a Focus area was initiated for Hypertension on 2/11/25 with a goal to remain free from symptoms of Hypertension. Resident #25's interventions included to give anti-hypertensive medications and monitor for side effects. Record review of Resident #34's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of Hemiplegia (paralysis on 1 side), Bipolar Disorder (mood disorder), Hypertension, and Cerebral Infarct (stroke).Record review of Resident #34's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 08, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident #34's Care Plan, reflected a Focus area was initiated for Hypertension on 2/12/25 with a goal to remain free from symptoms of hypertension. Resident #34's interventions included to give anti-hypertensive medications and monitor for side effects. Record review of Resident #70's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of Multiple Sclerosis (muscle weakening disease), Elevated [NAME] Blood Cell Count, Hypertension, and Elevated Liver Enzyme Levels. Record review of Resident #70's chart reflected that his MDS assessment had not been completed yet related to his recent admission date. Record review of Resident #70's Care Plan, reflected a Focus area was initiated for Hypertension on 7/22/25 with a goal to remain free from complications. Resident #70's interventions included to monitor and document blood pressure readings. Observation on 7/21/25 at 12:42 PM revealed LS-A pushing the laundry cart down the hall on the [NAME] Nursing Unit. The top of the cart was covered with a cloth, but the sides were completely uncovered and open to the air on both sides. Residents and visitors were observed moving down the hall also. Multiple resident's hanging clothes were observed in the exposed area of the cart. Observation on 7/22/25 at 8:56 AM revealed MA-A passing medications. She picked up the blood pressure cuff without cleaning it and entered Resident #34's room and proceeded to take his blood pressure. Upon returning to the medication cart, she placed the uncleaned blood pressure cuff on the top of the cart near the area she was preparing medications. She proceeded to give him his medications then performed hand hygiene but did not clean the cuff. Observation on 7/22/25 at 9:10 AM revealed MA-A passing medications. She picked up the uncleaned blood pressure cuff and entered Resident #70's room and proceeded to take his blood pressure. Upon returning to the medication cart, she placed the uncleaned blood pressure cuff on the top of the cart near the area she was preparing medications. She proceeded to give him his medications then performed hand hygiene but did not clean the cuff. Observation on 7/22/25 at 9:31 AM revealed MA-A passing medications. She picked up the uncleaned blood pressure cuff and entered Resident #25's room and proceeded to take her blood pressure. Upon returning to the medication cart, she placed the uncleaned blood pressure cuff on the top of the cart near the area she was preparing medications. She proceeded to give the resident her

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement their established policy regarding smoking, smoking areas, and smoking safety for 1 (Resident #49) of 8 residents reviewed for smoking. The facility failed to inform Resident #49 of the facility's smoking policy prior to 7/21/2025.The facility failed on 7/21/2025 to maintain a clean smoking area for staff and residents. These failures could result in unwanted fire hazards and pose safety risks to residents and staff. Findings included:Review of Resident #49's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included, amputation, anemia, coronary artery disease (narrowed or blocked arteries caused by plague buildup), diabetes, high cholesterol, hyperlipidemia (high levels of fats in the blood), mild cognitive impairment, and limitation of activities due to disability. Her BIMS score was an 11, indicating she had moderate cognitive impairment. In Section J - Health Conditions, Resident #49 was marked as 'Yes' for J1300 Current Tobacco Use. Review of Resident #49's care plan dated last revised 7/7/2025 reflected that she was care planned for an intervention of Encourage resident to refrain from smoking. due to a diagnosis of coronary artery disease related to hypercholesterolemia (high cholesterol). There was no indication Resident #49 had been informed of the smoking policy.In an observation on 7/21/2025 at 1:49 PM of a smoking break, Resident #49 had a pouch where her smoking materials were kept, and there were no cigars observed. Resident #49 was observed going up to a male resident and asking him for a cigar, when the AD interrupted and stated they could not do that. The smoking area was observed to be littered with cigarette butts and cigar wrappers. Additionally, cigarette butts were observed to be in plant pots by one of the facility's exit doors. In an interview on 07/21/2025 at 1:57 PM with the AD who was providing the smoke break to residents she stated that she provided smoke breaks to residents at 1:45 and 4pm daily when she worked. She stated that she would think it was housekeeping or maintenance's responsibility to clean up the cigarette butts off the ground. She stated that a fire could happen if the butts were put out and/or left in the plant pots and stated that it did look bad out there due to the trash and cigarette butts on the ground. Resident #49 usually smoked [a certain brand] and she came out during every smoke break. When shown a copy of the list of smokers provided to the state survey team, which did not include the name of Resident #49, and asked how she knew if the resident was permitted to smoke, she stated that it was communicated to her from nursing, who conducted the safe smoking assessments. She stated that Resident #49 was newly admitted to the facility, and the DON told the AD that the smoking policy was in the resident's admission packet, when asked if Resident #49 was aware of the smoking rules.In an interview on 07/22/2025 at 12:04 PM with Resident #49 she stated she was never informed of the rules about smoking or that she could not share, until 7/21/25 when the AD stated she could not borrow a cigar from a male resident because the state was present. She stated that her FM would bring her cigars when she ran out or she would ask another resident who smoked the same brand, and they would lend her one. In a follow up interview on 07/23/2025 at 3:24 PM with the AD she stated that Resident #49 would borrow cigars from any resident who smoked the same type as her. She confirmed the name of the resident whom Resident #49 was observed asking from during the 1:45 PM smoke break on 7/21, and that Resident #49 had in the past borrowed from him. She stated that it was the responsibility of the staff providing the smoke break to inform all smokers of the rules. When asked why residents should not share smoking materials, she stated that it was due to incidents years ago where residents would borrow from others after stating they would return the favor, or pay the loaner back, and fail to follow through on those promises, which led to problems, so the policy was put into place. In an interview on 07/23/2025 at 3:40 PM with the DON she stated that she had only been working at the facility for 5 days, however, if a resident was not compliant with the smoking policy, the staff would address it.Review of the facility's undated Smoking policy revealed, Residents are prohibited from sharing or loaning tobacco products to others.Review of the facility's undated Resident Rights policy revealed, 6. Information and communication. The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. 8. Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.