STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 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 observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (Resident #5) reviewed for dignity. 1.The facility failed to ensure CNA AA treated Resident #5 with respect and dignity when CNA AA provided incontinent care to Resident #5 and did not cover her buttocks when she left the room to gather more supplies on 02/14/26. 2. The facility failed to ensure CNA Q closed the window blinds prior to providing incontinent care for Resident #5 on 02/17/26. These failures placed residents at risk of diminished quality of life, loss of dignity and self-worth.Findings included: 1.Record review of Resident #5's face sheet dated 02/18/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (cognitive decline that affects daily life caused by brain cell damage), generalized anxiety disorder (excessive, persistent worry), depression (persistent sadness, loss of interest, fatigue, and change in sleep/appetite), diabetes mellitus (condition that causes the blood sugar to be elevated), and atrial fibrillation (heart arrhythmia characterized by rapid irregular heart beat). Record review of Resident #5's annual MDS assessment dated [DATE] indicated she was able to make herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. Record review of Resident #5's comprehensive care plan revised on 02/04/26 indicated she had an ADL self-care deficit and impaired cognitive function related to dementia with interventions that included she required 1 staff assistance for bathing, 2 staff assistance with a mechanical lift for transfers, and staff to supervise as needed for toileting, bed mobility, dressing, and eating. The care plan also indicated Resident #5 had bladder incontinence, impaired mobility, and physical limitations with interventions to apply barrier cream after incontinent episodes. During observation on 02/18/26 at 8:13 AM of a video, date stamped from 02/14/26 at 7:58 PM until 02/14/26 at 8:01 PM in Resident #5's room. Resident #5 was lying in her bed on her left side with privacy curtain open when CNA AA left the room to go get supplies and left her buttocks uncovered and exposed to anyone who was to step in her room. During an interview on 02/23/26 at 12:09 PM CNA AA said she took care of Resident #5 on 02/14/26. CNA AA said she changed Resident #5 about 8 but did not recall leaving the room and not covering her or pulling the privacy curtain. CNA AA said not using the privacy curtain and leaving a resident uncovered placed a risk for loss of dignity. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/23/26 at 5:45 PM the DON said she expected the CNAs to provide privacy during incontinent care. The DON said it placed the residents at risk for decreased dignity. During an interview on 02/23/26 at 7:55 PM the Administrator said she expected the CNAs to ensure curtains and blinds were closed and ensure residents were covered and not at risk for exposure. The Administrator said the failure could make the residents feel embarrassed or unhappy. 2. During an observation and interview on 02/17/26 at 11:29 AM, surveyor entered Resident #5's room. Resident #5 was laying in her bed. Resident #5's gown was lifted up to her chest. Resident was exposed completely from the chest down and the blinds were open. CNA Q went to close the blinds upon surveyor's' entrance into the room. CNA Q said the blinds should have been closed prior to starting Resident #5's care. CNA Q said if someone had seen Resident #5 through the window undressed and half naked that would have been embarrassing for Resident #5. During an interview on 02/17/26 at 12:15 PM, Resident #5 said she wanted the staff to close the window blinds but sometimes she forgets to ask the staff to close the window blind before they provide her care. During an interview on 02/19/26 at 3:24 PM, the ADON said she expected the staff to treat all the residents with dignity and respect. The ADON said the blinds should be closed prior to any type of personal care such as dressing or incontinent care to prevent embarrassment. The ADON said it was a dignity issue for the residents if window blinds were left open when personal care was provided. During an interview on 02/23/26 at 6:04 PM, the DON said she expected all the staff to treat the residents with dignity and respect their rights. The DON said it could be embarrassing for the residents to be exposed when the window blinds were left open during incontinent care. The DON said she expected nursing staff to be aware of those situations during personal care to ensure those situations do not occur. The DON said she and the ADON worked on the floor all the time to observe, monitor and instruct the staff. During an interview on 02/23/26 at 07:11 PM, the Administrator said all staff were responsible for ensuring the residents were treated with dignity and respect. The Administrator said it was her expectation that the nursing staff provided privacy during personal care to increase all residents' quality of life. Record review of the undated facility policy Resident Rights indicated, the resident has a right to a dignified existence, self-determination, and communication with and access to persons 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 resident.Respect and dignity - The resident has a right to be treated with respect and dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for 1 of 4 halls (Hall C), reviewed for a homelike environment. The facility failed to ensure that Hall C was free of offensive odors. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life.Findings: During an observation on 02/17/2026 at 10:25 AM, there was an odor of musty urine on Hall C. During an observation and interview on 02/17/2026 at 01:32 PM, there was an odor of musty urine on Hall C. The Housekeeper Supervisor stated she thought it was because one of the residents had incontinent episode in the hallway or maybe it was somebody that had walked by. During an observation on 02/17/2026 at 04:32 PM, there was an odor of musty urine on Hall C. During an observation and interview on 02/18/2026 at 10:32 PM, there was an odor of musty urine on Hall C. While walking down Hall C, CNA T said she could smell a strong odor but was unable to identify the odor. During an interview on 02/19/2026 at 3:24 PM, the ADON said she had not noticed a urine odor or any foul odors on C Hall. The ADON said the residents had not complained to her about any odors. The ADON said all the staff were responsible for making sure the facility did not have offensive odors. The ADON said the offensive odors could make the residents not want to leave their room, and it could affect their mental health. During an observation on 02/19/2026 at 10:23 AM, there was an odor of musty urine on Hall C. During an observation 02/20/2026 at 08:15 AM, there was an odor of musty urine on Hall C. During observation and interview on 02/20/2026 at 10:30 AM, there was an odor of musty urine on Hall C. The Social Worker stated she smelled an offensive odor but was unable to identify the smell or location. During an observation and interview on 02/20/2026 at 10:45 AM, there was an odor of musty urine on Hall C. NA Z said she smelled an offensive odor and thought it was from the end room on Hall C because a resident's soiled brief was changed recently. During an observation and interview on 02/20/2026 at 11:20 AM, there was an odor of musty urine on Hall C. The Corporate Compliance Nurse said a resident that resided on Hall C had told the staff that the family was going to be washing their laundry. The Corporate Compliance Nurse said the family was contacted and stated they were not washing the residents' laundry therefore housekeeping had started to clean up the resident's room where the dirty laundry had been stored. Staff were observed transferring soiled laundry with a pungent musty urine odor into a bag. During an observation on 02/23/2026 at 08:00 AM, there was an odor of musty urine on Hall C. During an interview on 02/23/2026 at 6:04 PM, the DON said she had not noticed any offensive odors in the facility. The DON said she expected the CNAs to change the residents' sheets on shower days and clean the mattress when necessary and keep the residents clean and dry frequently to prevent odors. The DON said all the staff should be making sure the facility did not have offensive odors. The DON said it was important to keep the facility free of offensive odors because I don't like to smell bad odors. Record review of the facility's undated policy titled, Resident Rights , indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean bed and bath linens that are in good condition.The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: . institutional odors.

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NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interviews, and record reviews, the facility failed to ensure residents were free from abuse for 2 of 8 residents (Resident #5 and Resident #2) reviewed for resident abuse. 1. The facility failed to ensure CNA AA and NA Z provided incontinent care and turning and repositioning for Resident #5 every 2 hours on 02/14/26 and 02/20/2026. 2. The facility failed to protect Resident #5 from verbal abuse when CNA BB spoke to Resident #5 in a degrading manner while providing incontinent care to her on 12/15/2025. 3. The facility failed to protect Resident #2 from physical abuse when the ADON hit Resident #2's hand about three months ago. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included:

1. Record review of Resident #5's face sheet dated 02/18/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (cognitive decline that affects daily life caused by brain cell damage), generalized anxiety disorder (excessive, persistent worry), depression (persistent sadness, loss of interest, fatigue, and change in sleep/appetite), diabetes mellitus (condition that causes the blood sugar to be elevated), and atrial fibrillation.

Record review of Resident #5's annual MDS assessment dated [DATE] indicated she was able to make herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact.

Record review of Resident #5's comprehensive care plan revised on 02/04/26 indicated she had an ADL self-care deficit and impaired cognitive function related to dementia with interventions that included she required 1 staff assistance for bathing, 2 staff assistance with a mechanical lift for transfers, and staff to supervise as needed for toileting, bed mobility, dressing, and eating. The care plan also indicated Resident #5 had bladder incontinence, impaired mobility, and physical limitations with interventions to apply barrier cream after incontinent episodes.

Record review of Resident #5's comprehensive care plan dated 02/23/26 after surveyor intervention indicated she had a potential psychosocial well-being problem related to an allegation of verbal abuse with interventions to allow resident time to answer questions and to verbalize feelings, perceptions, and fears.

During an observation on 02/18/26 at 8:13 AM of a video, date stamped from 02/14/26 at 1:56 PM in Resident #5's room. Resident #5 was lying in her bed, and she was not turned, repositioned, nor provided incontinent care until 02/14/26 at 7:55 PM.

During an interview on 02/20/26 at 12:15 PM, Resident #5's family member said she called the facility on 02/20/26 at 11:15 AM, and requested the staff provide incontinent care for Resident #5. Resident #5's family member expressed concerns because no staff had checked on Resident #5 since before 6 AM when the night shift staff checked on her prior to the end of their shift. Resident #5's family member said this type of neglect could cause Resident #5 to have skin breakdown.

During an observation of a video on 02/20/26 at 1:30 PM, date stamped 02/20/26, with audio and visual revealed Resident #5 was laid down in the middle of the bed on her back with the bed in a flat position. The video had a time lapse from 5:45 AM to 11:45 AM, which indicated no care was provided

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Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

between these times. There were no staff observed to check, change or reposition Resident #5 for 6 hours.

During an interview on 02/20/26 at 1:38 PM, NA Z said she had not been in the room on 2/20/26 to provide care to Resident #5 because she had not had time to check on her. NA Z said she was new, and it was difficult for her to provide care to all the residents assigned to her. NA Z said she tries to check on everybody every 2 hours. NA Z said not providing care at least every 2 hours could be considered neglect, and it could cause her skin to be irritated, red and lead to bed sores.

During an interview on 02/23/26 at 12:09 PM CNA AA said she took care of Resident #5 on 02/14/26 but she believed she arrived to work about 2:30 PM. CNA AA said she thought she had gone in Resident #5's room to provide her with fresh ice and at that time CNA AA asked her about being changed but she had told CNA AA she was clean. CNA AA said she changed Resident #5 about 8 PM because she believed Resident #5's family had called the facility but did not recall changing her at all since she came to work. CNA AA said she should have made rounds on every resident every 2 hours to check and clean them, and the failure placed Resident #5 at risk for neglect.

During an interview on 02/23/26 at 6:06 PM the DON said she expected the CNAs to check on all residents every 2 hours, and some residents may need to be checked more often than others. The DON said she expected the charge nurses to make rounds on the hallways and check behind the CNAs, and she checked documentation and made rounds as well. The DON said the failure of residents not being checked an extended amount of time placed a risk for neglect. The DON said neglect can affect the residents by causing skin breakdown and falls.

During an interview on 02/23/26 at 7:55 PM the Administrator said she expected the CNAs to make rounds and check residents and change them. The Administrator said the failure could place residents at risk for neglect and skin issues.

2. During an observation of a video on 02/19/26 at 3:23 PM, date stamped 12/15/25, with audio and visual revealed Resident #5 was laid down in the middle of the bed on her back with the bed in a flat position. CNA BB entered Resident #5's room and snatched gloves from the wall box. Resident #5 said, I need to be changed. CNA BB condescendingly replied, of course, I know! I am in the middle of doing everybody else too – there is a line – there ain't no first privileges here and there! Resident #5 said, you don't like your job – do you? CNA BB hatefully said, no, I like my job – I just don't like it when people can't wait in line. Resident #5 responded with, you must be having a bad day . CNA BB said, what – actually - it is awesome until people think they are privileged – you already know the nurse told you that I was in the middle of doing everyone else, but you just kept hitting your light umhhh!. Resident #5 said someone must have peed in your cheerios. CNA BB said, Nah, nobody did anything in my cheerios, but I been doing this too long to deal for people like this – I ain't gonna hold my tongue for nobody. CNA BB continued to provide incontinent care to Resident #5 while interjecting instructions between comments to roll that way and pointed in a rude manner. Resident #5 said I have never seen a nurse like you before. CNA BB said, I bet you haven't - I am the new aide on the block!.

During an interview on 02/19/26 at 3:30 PM, Resident #5's family member said they brought the video to the ADON and asked her to watch the video. Resident #5's family member said they requested CNA BB not be allowed back in Resident #5's room because of the way she talked and treated Resident #5. Resident #5's family member said the ADON declined to watch the video of the verbal abuse allegations. Resident #5's family member said the ADON said no I do not need to watch the video – if you

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said it happened – then, it happened – I will retrain the aide. Resident #5's family member said the ADON walked off and started moving tables in the dining hall and left them standing there. During an interview on 02/19/26 at 3:45 PM, Resident #5 said there was one staff member that was talking mean to her one time when she asked to be changed. Resident #5 said the staff member must have had a bad day. Resident #5 said the staff member did not hurt her, but she did not want her back in her room. Resident #5 said she could not recall the staff member's name. Resident #5 could not recall if that same staff member had returned to her room after the incident or not. Resident #5 said, I don't think she works here anymore. During an interview on 02/19/26 at 4:00 PM, the ADON said she declined the offer to watch the video related to CNA BB on 12/16/25 when Resident #5's family member offered to show it to her. The ADON said Resident #5's family member did not say that CNA BB had talked rudely to Resident #5. The ADON said Resident #5's family member told her CNA BB had provided all the care perfectly for Resident #5 but if she was going to get along with Resident #5, CNA BB needed to talk to her when care was provided. The ADON said she did not retrain CNA BB but the next time she saw her in the facility she told CNA BB to do the required care and get out of Resident #5's room. The ADON said she did not expect CNA BB to carry on conversation with Resident #5 just get in and out. The ADON said there was no reporting or investigation because Resident #5's family said everything was done right so what would she be reporting or investigating. The ADON said it was not important to talk to the residents when providing care to the residents. The ADON said Resident #5's family member did not request CNA BB not be allowed back into Resident #5's room. The ADON said she did not watch the video because Resident #5's family always had a video to show them. The ADON said she told Resident #5 to take the video to the Administrator to watch it. The ADON said if allegations of abuse were not reported and investigated properly, it placed residents at risk of abuse. During an interview on 02/23/26 at 07:11 PM, the Administrator said she started on January 19, 2026, at the facility, and she expected the staff to follow the abuse and neglect policy and report abuse and neglect immediately. The Administrator said she was not aware of any abuse allegations involving Resident #5 until she viewed the video after asking Resident #5's family to bring it to the facility on [DATE]. The Administrator said CNA BB should have been nicer and helpful to Resident #5. The Administrator said the way CNA BB treated Resident #5 could be considered verbal and mental abuse. The Administrator said when allegations are made but not reported and investigated, it puts other residents at risk of further abuse and/or neglect. 3. Record review of a face sheet dated 02/23/2026 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included senile degeneration of the brain (deterioration of the brain which leads to cognitive decline, memory impairment, and changes in behavior and personality), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), and atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow with chest pain). Record review of Resident #2's Quarterly MDS assessment indicated Resident #2 was understood by others and usually understood others. The MDS assessment indicated Resident #2 had a BIMS score of 5, which indicated her cognition was severely impaired. Resident #2's MDS assessment indicated she had disorganized thinking. The MDS assessment indicated Resident #2 required supervision or touching assistance with eating and was dependent on staff for toileting and transfers. The MDS assessment (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident #2 was incontinent of bowel and bladder. Record review of Resident #2's care plan reviewed 12/09/2025 indicated she had an ADL self-care performance deficit related to impaired mobility and cognition, weakness, and reliance on staff for ADL assistance. During an interview on 02/22/2026 at 5:55 PM, Anonymous Person #1 said about three months ago Resident #2 was in the dining room hollering Help! Help!, the ADON walked by Resident #2, Resident #2 reached out to grab her to stop her, and the ADON hit Resident #2 on the hand and said, Leave me alone don't touch me. Anonymous Person #1 said she went to assist Resident #2. Anonymous Person #1 said [NAME] D also witnessed the incident. Anonymous Person #1 started crying, and they said they were tired of so many injustices the residents were put through. Anonymous Person #1 said the ADON often refused to assist the residents, and they reported it to the DON, and the DON did nothing about it. Anonymous Person #1 said this was why they had not reported the incident. Anonymous Person #1 said many other employees witnessed the ADON's mistreatment towards the residents and reported it to the DON but would not report it further due to fear of being fired. During an interview on 02/22/2026 at 7:40 PM, [NAME] D said he had not seen the ADON abuse or mistreat any of the residents. [NAME] D said he did not see the ADON hit Resident #2 about 3 months ago in the dining room. During an interview on 02/23/2026 at 8:24 AM, the Administrator said the ADON was currently suspended related to the allegation of hitting Resident #2 yesterday (02/22/2026). During an observation and interview on 02/23/2026 at 9:26 AM, Resident #2 said she did not remember any staff hitting her or mistreating her. Resident #2 said everybody treated her well. Resident #2 displayed confusion during the interview. Resident #2's cell phone started ringing, and she picked up her drink and started saying hello. During an attempted phone interview on 02/23/2026 at 2:28 PM, the ADON did not answer the phone. During an interview on 02/23/2026 at 5:58 PM, the DON said abuse should be reported immediately to the abuse coordinator. The DON said if the staff would not report to her, they should have gone to the Administrator that they knew who else they could go to. The DON said the staff not reporting abuse and neglect immediately to the abuse coordinator placed the residents at risk for not being protected from abuse. The DON said she was not aware of the ADON abusing any of the residents. The DON said she had not received any complaints about the ADON. During an interview on 02/23/2026 at 7:11 PM, the Administrator said she started on January 19, 2026, at the facility, and she expected the staff to follow the abuse and neglect policy and report abuse and neglect immediately. The Administrator said she was not aware of any abuse allegations involving Resident #2. The Administrator said Resident #2 was confused, but she denied any abuse. The Administrator said she had not received any complaints from the residents or family regarding the ADON. The Administrator said abuse not being reported placed the residents at risk of further abuse. Record review of the facility's undated policy, Abuse and Neglect, from the Nursing Policy and Procedure Manual, indicated, The resident has the right to be free from abuse. neglect, misappropriation of resident property, and exploitation as defined in this subpart.Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility .3. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. 5. Physical Abuse: Includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. 6. Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will provide the residents, families, and staff an environment free from abuse and neglect. 3. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. 1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation. mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 8/29/24. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026
NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents, for 2 of 8 residents (Resident #2 and Resident #5) reviewed for abuse. 1. The facility failed to implement their abuse policy when the ADON did not report an allegation of verbal abuse to the abuse coordinator after Resident #5's family member reported to her CNA BB spoke to Resident #5 in a demeaning manner on 12/15/25. 2. The facility failed to implement their policy on reporting abuse when Anonymous Staff Member #1 witnessed the ADON hit Resident #2's hand about three months ago and failed to report it to the abuse coordinator. This failure could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life.Findings included: 1. Record review of Resident #5's face sheet dated 02/18/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (cognitive decline that affects daily life caused by brain cell damage), generalized anxiety disorder (excessive, persistent worry), depression (persistent sadness, loss of interest, fatigue, and change in sleep/appetite), diabetes mellitus (condition that causes the blood sugar to be elevated), and atrial fibrillation (fast heart rate). Record review of Resident #5's annual MDS assessment dated [DATE] indicated she was able to make herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. Record review of Resident #5's comprehensive care plan revised on 02/04/26 indicated she had an ADL self-care deficit and impaired cognitive function related to dementia with interventions that included she required 1 staff assistance for bathing, 2 staff assistance with a mechanical lift for transfers, and staff to supervise as needed for toileting, bed mobility, dressing, and eating. The care also indicated Resident #5 had bladder incontinence, impaired mobility, and physical limitations with interventions to apply barrier cream after incontinent episodes. Record review of Resident #5's comprehensive care plan dated 02/23/26 after surveyor intervention indicated she had a potential psychosocial well-being problem related to an allegation of verbal abuse with interventions to allow resident time to answer questions and to verbalize feelings, perceptions, and fears. During an observation of a video on 02/19/26 at 3:23 PM, date stamped 12/15/25, with audio and visual revealed Resident #5 was laid down in the middle of the bed on her back with the bed in a flat position. CNA BB entered Resident #5's room and snatched gloves from the wall box. Resident #5 said I need to be changed. CNA BB condescendingly replied, of course, I know! I am in the middle of doing everybody else too – there is a line – there ain't no first privileges here and there! Resident #5 said, you don't like your job – do you? CNA BB hatefully said, no, I like my job – I just don't like it when people can't wait in line. Resident #5 responded with you must be having a bad day. CNA BB said, what – actually - it is awesome until people think they are privileged – you already know the nurse told you that I was in the middle of doing everyone else, but you just kept hitting your light umhhh!. Resident #5 said someone must have peed in your cheerios. CNA BB said, Nah, nobody did anything in my cheerios, but I been doing this too long to deal for people like this – I ain't gonna hold my tongue for nobody. CNA BB continued to provide incontinent care to Resident #5 while interjecting instructions between comments to roll that way and (continued on next page)

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

Printed: 05/05/2026
Form Approved OMB
No. 0938-0391

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

pointed in a rude manner. Resident #5 said I have never seen a nurse like you before. CNA BB said, I bet you haven't - I am the new aide on the block!.

During an interview on 02/19/26 at 3:30 PM, Resident #5's family member said they brought the video to the ADON and asked her to watch the video. Resident #5's family member said they requested CNA BB not be allowed back in Resident #5's room because of the way she talked and treated Resident #5. Resident #5's family member said the ADON declined to watch the video of the verbal abuse allegations. Resident #5's family member said the ADON said no I do not need to watch the video – if you said it happened – then, it happened – I will retrain the aide. Resident #5's family member said the ADON walked off and started moving tables in the dining hall and left them standing there.

During an attempted telephone call to CNA BB on 2/19/26 at 3:42 PM, CNA BB did not answer the phone a message was left requesting for her to call back.

During an interview on 02/19/26 at 3:45 PM, Resident #5 said there was one staff member that was talking mean to her one time when she asked to be changed. Resident #5 said the staff member must have had a bad day. Resident #5 said the staff member did not hurt her, but she did not want her back in her room. Resident #5 said she could not recall the staff member's name. Resident #5 could not recall if that same staff member had returned to her room after the incident or not. Resident #5 said I don't think she works here anymore.

During an interview on 02/19/26 at 4:00 PM, the ADON said she declined the offer to watch the video related to CNA BB on 12/16/25 when Resident #5's family member offered to show it to her. The ADON said Resident #5's family member did not say that CNA BB had talked rudely to Resident #5. The ADON said Resident #5's family member told her CNA BB had provided all the care perfectly for Resident #5 but if she was going to get along with Resident #5, CNA BB needed to talk to her when care was provided. The ADON said she did not retrain CNA BB but the next time she saw her in the facility she told CNA BB to do the required care and get out of Resident #5's room. The ADON said she did not expect CNA BB to carry on conversation with Resident #5 just get in and out. The ADON said there was no reporting or investigation because Resident #5's family said everything was done right so what would she be reporting or investigating. The ADON said it was not important to talk to the residents when providing care to the residents. The ADON said Resident #5's family member did not request CNA BB not be allowed back into Resident #5's room. The ADON said she did not watch the video because Resident #5's family always had a video to show them. The ADON said she told Resident #5 to take the video to the Administrator to watch it. The ADON said if allegations of abuse were not reported and investigated properly, it placed residents at risk of abuse.

During an interview on 02/20/26 at 11:15 AM, CNA BB said she provided care for Resident #5 on the second night of being hired at the facility. CNA BB said she was educated many times on verbal abuse but could not recall the exact date. CNA BB said she provided the necessary care to Resident #5. CNA BB said the DON, ADON and the other CNAs told her the next night (12/16/25) to be careful in Resident #55's room because there was a camera. CNA BB said she was told to do the care and get out because Resident #5's family had been up to the facility to complain about her. CNA BB said she did not go back into the room after 12/15/25 that she recalled. CNA BB said Resident #5 felt privileged. CNA BB said Resident #5 would not stay off the call light instead of waiting her turn to be changed. CNA BB said she provided the necessary care for Resident #5 where the family had dropped her off at (referring to Resident #5 residing at the facility as opposed to her family taking care of her at home). CNA BB said Resident #5's family watched the camera but dropped her off for others to take care of

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because they did not want to take care of her because they were privileged. CNA BB said, I give truths and walk in my truth, and I don't care what corporate, or the surveyor has to say about any of that. CNA BB said, do you have any more questions?. CNA BB hung up the phone prior to surveyor response. During an interview on 02/23/26 at 6:04 PM, the DON said after watching the video, the way CNA BB acted towards Resident #5 was very unacceptable. The DON said she had not seen the video when Resident #5's family reported CNA BB to the ADON. The DON said the ADON told her Resident #5's family reported to her that they were okay with everything CNA BB did they just did not like that CNA BB did not talk to Resident #5 while providing the care. The DON said there was no need to watch the video before 02/19/26, because the family had not made an actual complaint. The DON said the family had only reported CNA BB not talking to Resident #5 when she provided care to her. The DON said the ADON did everything right. The DON said it did not matter what the staff were doing Resident #5's family were constantly bringing videos to them to watch. The DON said she called CNA BB after watching the video on 02/19/2026, and CNA BB said the nurse had told her twice that Resident #5 needed to be changed. CNA BB said she went to Resident #5's room and Resident #5 was trying to talk to her, and CNA BB was trying to talk to Resident #5 about being patient. CNA BB said maybe Resident #5 did not like her tone. The DON said the allegations of abuse and neglect should be reported and investigated to prevent abuse from happening. During an interview on 02/23/26 at 07:11 PM, the Administrator said she started on January 19, 2026, at the facility, and she expected the staff to follow the abuse and neglect policy and report abuse and neglect immediately. The Administrator said she was not aware of any abuse allegations involving Resident #5 until she viewed the video after asking Resident #5's family to bring it to the facility on [DATE]. The Administrator said when allegations were made but not reported and investigated, it puts other residents at risk of further abuse and/or neglect. 2. Record review of a face sheet dated 02/23/2026 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included senile degeneration of the brain (deterioration of the brain which leads to cognitive decline, memory impairment, and changes in behavior and personality), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), and atherosclerotic heart disease of native coronary artery with unspecified angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow with chest pain). Record review of Resident #2's Quarterly MDS assessment indicated Resident #2 was understood by others and usually understood others. The MDS assessment indicated Resident #2 had a BIMS score of 5, which indicated her cognition was severely impaired. Resident #2's MDS assessment indicated she had disorganized thinking. The MDS assessment indicated Resident #2 required supervision or touching assistance with eating and was dependent on staff for toileting and transfers. The MDS assessment indicated Resident #2 was incontinent of bowel and bladder. Record review of Resident #2's care plan reviewed 12/09/2025 indicated she had an ADL self-care performance deficit related to impaired mobility and cognition, weakness, and reliance on staff for ADL assistance. During an interview on 02/22/2026 at 5:55 PM, Anonymous Staff Member #1 said about three months ago Resident #2 was in the dining room hollering Help! Help!, the ADON walked by Resident #2, Resident #2 reached out to grab her to stop her, and the ADON hit Resident #2 on the hand and said, Leave me alone don't touch me. Anonymous Staff Member #1 said she went to assist Resident #2. Anonymous Staff Member #1 said [NAME] D also witnessed the incident. Anonymous Staff Member #1 started crying, and (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

they said they were tired of so many injustices the residents were put through. Anonymous Staff Member #1 said the ADON often refused to assist the residents, and they reported it to the DON, and the DON did nothing about it. Anonymous Staff Member #1 said this was why they had not reported the incident. Anonymous Staff Member #1 said many other employees witnessed the ADON's mistreatment towards the residents and reported it to the DON but would not report it further due to fear of being fired.

During an interview on 02/23/2026 at 8:24 AM, the Administrator said the ADON was currently suspended related to the allegation of hitting Resident #2 made on 02/22/2026.

During an observation and interview on 02/23/2026 at 9:26 AM, Resident #2 said she did not remember any staff hitting her or mistreating her. Resident #2 said everybody treated her well. Resident #2 displayed confusion during the interview. Resident #2's cell phone started ringing, and she picked up her drink and started saying hello.

During an attempted phone interview on 02/23/2026 at 2:28 PM, the ADON did not answer the phone.

During an interview on 02/23/2026 at 5:58 PM, the DON said abuse should be reported immediately to the abuse coordinator. The DON said if the staff would not report to her, they should have gone to the Administrator that they knew who else they could go to. The DON said the staff not reporting abuse and neglect immediately to the abuse coordinator placed the residents at risk for not being protected from abuse. The DON said the staff were expected to follow the abuse and neglect policy, and in-services were provided to the staff at least monthly on abuse and neglect.

During an interview on 02/23/2026 at 7:11 PM, the Administrator said she started on January 19, 2026, at the facility, and she expected the staff to follow the abuse and neglect policy and report abuse and neglect immediately. The Administrator said she was not aware of any abuse allegations involving Resident #2. The Administrator said Resident #2 was confused, but she denied any abuse. The Administrator said abuse not being reported placed the residents at risk for more abuse.

Record review of the facility's undated policy, Abuse and Neglect, from the Nursing Policy and Procedure Manual, indicated, The resident has the right to be free from abuse. neglect, misappropriation of resident property, and exploitation as defined in this subpart.Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility .3. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. 5. Physical Abuse: Includes, hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. 6. Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will provide the residents, families, and staff an environment free from abuse and neglect. 3. All reports of abuse or suspicion of

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. 1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. 3. Facility employees must report all allegations of: abuse, neglect, exploitation. mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14, 8/29/24. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand for 1 of 5 residents (Resident #6) reviewed for discharge. 1.The facility failed to notify Resident #6's responsible party of his discharge prior to him being discharged from the facility. This failure placed residents at risk of not having an advocate who can inform them of their options, rights, and the added protection from being inappropriately transferred or discharged . Findings included: Record review of Resident #6's face sheet dated 02/23/26 indicated he was a [AGE] year-old-male who re-admitted to the facility on [DATE] with the diagnoses which included paranoid schizophrenia (a chronic health disorder marked by intense, irrational delusions and hallucinations), diabetes mellitus (condition that causes the blood sugar to be elevated), anxiety (excessive, persistent worry), high blood pressure, and cognitive communication deficit (impairment in communication verbal or non-verbal resulting from underlying cognitive issues). Record review of Resident #6's discharge MDS dated [DATE] indicated his discharge was unplanned to the hospital, and his return was not anticipated. The MDS also indicated he had a memory problem, but he was cognitively independent in his daily decision making. Record review of Resident #6's nursing progress notes dated 08/19/25 at 2:47 PM completed by the DON, indicated Resident #6 was transferred to a hospital as an emergency related to abnormal behavior and threats of suicide with no check beside who the notice was provided to. During an interview on 02/20/26 at 9:59 AM Resident #6's responsible party said she was upset with the facility because no one notified her of Resident #6's discharge to another facility. She said she found out he was at another nursing facility 3 days after he admitted (08/23/25). She said he was over at the other facility those 3 days without clothing, his personal belongings, or family involved. Resident #6's responsible party said she spoke with the DON on 08/18/25 and there was no mention that he was being transferred to another nursing facility. During an interview on 02/23/26 at 03:40 PM the Social Worker said she knew that Resident #6 was sent to the emergency room visit, and she thought he was sent to the hospital on [DATE], and while he was out another nursing facility accepted him. The Social Worker said she did not talk to Resident #6's responsible party during the time of him being discharged . The Social Worker said if the nursing facility had not accepted Resident #6, they were planning on him returning back to the facility. The Social Worker said she notified the ombudsman and made her aware of the situation with Resident #6. During an interview on 02/23/26 at 6:40 PM The DON said Resident #6 had a behavior incident that caused him to be sent to the hospital and the DON said called Resident #6's responsible party. The DON said she did not have a conversation with Resident #6's responsible party about discharging to the hospital nor the other facility. The DON said someone else should have called her, but she did not. The DON said the failure placed a risk for the family not knowing where Resident #6 was and it was a violation of resident rights. During an interview on 02/23/26 at 8:05 PM the Administrator said she was not working at the facility when Resident #6 was discharged but the responsible party should have been notified prior to discharge. The Administrator said the failure was a violation of Resident #6 and his responsible party's rights.Record review of the facility policy Discharge or Transfer to another Facility revised 04/10/2024 indicated: Facility Initiated Discharge The facility will permit each resident to remain in the facility, and not transfer or discharge the resident from the facility.Emergency Transfers When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer will be (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to the resident and resident representative as soon as practicable. Copies of notices for emergency transfers will also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative and will also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provided supervision to prevent avoidable accidents for 1 of 3 residents (Resident #1) and 1 of 1 shower rooms (Hall C communal shower) reviewed for quality of care. The facility failed to ensure Resident #1 was adequately supervised after she had been wandering and exit seeking, which resulted in Resident #1 exiting the facility and being found outside the facility in the facility's driveway headed toward a busy public street on 05/17/2025. An IJ was identified on 02/19/2026. The IJ began on 05/17/2025 and removed on 06/13/2025. While the IJ was removed on 06/13/2025, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The facility failed to ensure Resident #1 was provided with adequate supervision to prevent her from spilling coffee on herself on 05/02/2025. The facility failed to ensure a safe environment when the door to the communal shower on Hall C was left open and there were puddles of water on the floor, and an open cabinet inside the shower room had cleaning chemicals in it on 02/18/2026. These failures could place residents at risk of potential accidents, injuries, harm or death. Findings included: 1. Record review of a face sheet dated 02/19/2026 indicated Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] and was discharged on 05/19/2025 with diagnoses which included dementia severe with other behavioral disturbances (deterioration of memory, language, and other thinking abilities with behaviors), longstanding persistent atrial fibrillation (irregular heartbeat lasting more than 12 months which can lead to health complications), and chronic kidney disease stage 3A (mild to moderate loss of kidney function). Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated she was usually understood by others and usually understood others. The MDS assessment indicated Resident #1 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #1 was dependent on staff for toileting, personal hygiene, and showering/bathing self, and required setup or clean-up assistance with eating. The MDS assessment indicated Resident #1 was dependent on staff for transfers. The MDS assessment indicated Resident #1 required supervision or touching assistance with wheeling in her manual wheelchair. The MDS assessment indicated Resident #1 wandered 1 to 3 days in the 7-day look-back period. Record review of Resident #1's care plan indicated the following: Focus with date initiated 01/12/2025 and revised 05/17/2025, indicated she was at risk for wandering, was an elopement risk, and attempted to elope. Interventions with date initiated 01/12/2025 included if the resident was exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member or via call system. Interventions with date initiated 05/17/2025 indicated placed on 1 on 1 supervision, assess/record/report to doctor risk factors for potential elopement such as wandering, repeated requests to leave facility, statements such as I am leaving, I am going home, attempts to leave the facility, elopement attempts from previous facility, home, or hospital, supervise closely and make regular compliance rounds whenever resident is in room, determine the resident is attempting to elope, is the resident looking for something or someone, does it indicate the need for more exercise, intervene as appropriate, provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, and books. Record review of Resident #1's electronic medical record indicated she was an elopement risk on Elopement Risk Assessments with assessment dates of 01/06/2025, 04/06/2025, 05/02/2025, and 05/17/2025. Record review of Resident #1's progress notes indicated: Resident was seen pushing on the door going out to the courtyard. Resident was unable to get out because the door is locked. Signed by LVN A 05/02/2025 4:02 PM. Event-Elopement/Attempted, Door exited B Hall, how long missing 5 minutes, the resident was outside the courtyard by C Hall exit. Cognition / Behavior at Time of Event: Restless, Cognitive Impairment, refuses to call for assistance, Wanders, Exit seeking, The resident was wandering around the facility and was last seen on B hall. The med aid [sic] for C/D was looking for the resident to administrate medication. Staff then begin looking for the resident. LVN C was taking her trash to the dumpster when she said, I saw her out of the corner of my eye, she was by gated area of C hall courtyard on the outside of the gate. Initial Treatment/New Orders: one on one monitoring, Resident Statement: I'm looking for my dog. You can have one too. Signed by LVN A, 05/17/2025 5:58 PM. During an observation and interview on 02/17/2026 at 2:45 PM, LVN C said on 05/17/2026, she was the one who saw Resident #1 outside of the facility in the driveway outside of the gate by the C Hall exit. LVN C said it was towards the end of her shift, and she was taking out her trash to the bins outside of the B Hall exit door. LVN C said she happened to look to her right and saw Resident #1 in her wheelchair in the driveway outside of the gate by the C Hall exit. LVN C said Resident #1 was headed towards the road in her wheelchair. LVN C said she was not Resident #1's nurse that LVN A was her nurse that day, and CNA CC was providing care to Resident #1. LVN C said she called LVN A, and they took Resident #1 back inside the facility for LVN A to assess her, and Resident #1 did not have any injuries. LVN C demonstrated where she found Resident #1. Observation of where Resident #1 was found revealed a narrow driveway approximately 75 feet from the B Hall exit door and approximately 20 feet from the busy public street. During an interview on 02/18/2026 at 4:04 PM, LVN A said on 05/17/2025 when Resident #1 was found outside of the facility in the driveway, the alarm on the door for the exit to the laundry on B hall did not go off. LVN A said before Resident #1 was found outside she had been exit seeking and trying to get out the doors. LVN A said Resident #1 had been exit seeking since she returned to the facility, and she had reported it to the DON. LVN A said she told the DON Resident #1 needed a memory care unit. LVN A said Resident #1 has been roaming around the facility, caught the door behind somebody else leaving, and went outside. LVN A said they were trying to watch Resident #1, when she was roaming the facility. LVN A said she did not remember when the last time she saw Resident #1 was prior to her being found outside. LVN A said Resident #1 could have gotten injured. LVN A said after Resident #1 was brought back inside the facility, she was assessed and had no injuries. LVN A said Resident #1 was placed on one-on-one monitoring until she was discharged to a memory unit. During an interview on 02/19/2026 at 10:51 AM, CNA CC said she was no longer working at the facility. CNA CC said she was the CNA when Resident #1 was found outside in the driveway on 05/17/2025. CNA CC said Resident #1 had been trying to escape the day she was found outside, and it was not the first time she tried to leave the facility. CNA CC said when Resident #1 was found outside she was doing her rounds or passing ice. CNA CC said a nurse was taking out her trash and saw her outside by the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	gate near the road. CNA CC said Resident #1 was being monitored by rounds every 2 hours, and they were trying to keep her in the day area. CNA CC said the last time she saw Resident #1 before she was found outside, she was rolling around the nurses' station. CNA CC said she did not remember how long it was from the last time she saw Resident #1 to when she was found outside. CNA CC said somebody left the door going to the laundry open. CNA CC said she thought it was a housekeeper who left the door open, but she did not remember who it was. CNA CC said Resident #1 could have gotten hurt, hit by a car, or fallen out of her wheelchair. During an interview on 02/23/2026 at 5:45 PM, the DON said when Resident #1 was found outside on 05/17/2025, she received a phone call from the nurse reporting Resident #1 was found outside, taken back inside the facility, and was not hurt. The DON said Resident #1 was placed on one-on-one monitoring until she was transferred to a secured unit at another facility. The DON said after Resident #1 eloped they completed elopement risk assessments on all the other residents to see who was at risk. The DON said she could not remember everything that was completed after Resident #1 eloped, but they had followed their policy. The DON said when she interviewed the staff working the day Resident #1 eloped, the staff told her Resident #1 had been wandering on the wrong hall asking for her room and had to be redirected. The DON said to her knowledge Resident #1 had not been exit seeking. The DON said Resident #1's baseline was confusion, and she could have rolled out into traffic or fallen. During an interview on 02/23/2026 at 7:11 PM, the Administrator said she started working at the facility on 01/19/2026. The Administrator said her expectations were if a resident was wandering, they should have an elopement assessment completed, and if they were exit-seeking, they should be placed on one-on-one supervision. The Administrator said if a resident was exit-seeking and got out of the facility without the staff's supervision/knowledge, it placed them at risk for injuries. Record review of the facility's undated policy titled, Elopement Prevention, indicated, Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1.The Elopement Risk Assessment will be completed upon admission. The assessment should be completed by reviewing the resident's medical history and social history. Information may be obtained by reviewing current medical records, if available, interview with resident/family, or conference with the interdisciplinary team member. The assessment tool should be completed, and interventions implemented as indicated. The Elopement Risk Assessment is to be completed at least quarterly and upon change of condition. 2. All residents who are at risk for harm because of wandering (elopement) will be assessed by the interdisciplinary care planning team. 3. The resident's current chart and assessments will be reviewed to determine what changes have occurred that would trigger elopement episodes. 4. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. 5. Interventions into elopement episodes will be entered onto the resident's care plan and medical record.Follow the resident to see where he/she goes. If the destination is safe, consider use of volunteer companion or family member as a suitable escort. Allow the resident to wander in a safe and secure setting, use door locks that are out of reach/sight to prevent wanderers from opening doors, use door alarms or monitoring devices to notify staff when residents try to leave the facility. Physical Plant All facility exits that residents have access to will have a device in place to alert staff of possible elopement attempts. Examples of these devices: Wanderguard system (locking or alarming), Keypad exit magnetic locks, Keyed Alarms, Secured Unit or a combination. The facility had corrected the noncompliance on 05/17/2025 by the following: One on one monitoring of Resident #1 until discharged from the facility on 05/19/2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's care plan was updated Trauma Assessment for Resident #1 Physician notification Elopement risk assessments completed for all other residents Care plans updated for those determined to be at risk for elopement In-service 05/17/2025 on Elopement and Abuse and Neglect Notified families to be mindful of residents attempting to exit the facility and not to share a door code with the residents. Signage placed at visitor exits to be mindful of residents attempting to exit the facility Doors were checked for alarms functioning properly for four weeks Elopement drills were conducted three times per week once every shift Record review completed of the one-on-one monitoring tool for Resident #1 dated from 05/17/2025-05/19/2025. Record review completed of Resident #1's Trauma Informed assessment dated [DATE], did not indicate any negative findings. Record review completed of the Elopement Risk Assessments dated 05/17/2025. The Elopement Risk Assessments indicated Resident #1, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #15, Resident#16, Resident #17, Resident #18, Resident #19, Resident #20, and Resident #21 were at risk for elopement. Record review completed of Resident #1, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #15, Resident#16, Resident #17, Resident #18, Resident #19, Resident #20, and Resident #21, care plans and they were all updated on 05/17/2025. Record review of the Resident Transfer Form dated 05/19/2025 indicated Resident #1 was transferred to a facility with a lockdown unit. Record review completed of the elopement drills conducted indicated they were completed as follows: Week 1 05/19/2025 6-2 shift Week 1 05/19/2025 2-10 shift Week 1 05/20/2025 10-6 shift Week 2 05/30/2025 6-2 shift (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Week 2 05/30/2025 2-10 shift Week 2 05/31/2025 10-6 shift Week 3 06/06/2025 6-2 shift Week 3 06/06/2025 2-10 shift Week 4 06/07/2025 6-2 shift Week 4 06/07/2025 2-10 shift Week 4 06/07/2025 10-6 shift. Record review of the elopement monitoring indicated the doors were checked for proper functioning daily from 05/17/2025-05/21/2025, 05/26/2025-05/30/2025, 06/02/2025-06/06/2025, and 06/09/2025-06/13/2025. Record review of the elopement monitoring indicated visitors were observed through daily rounds for allowing residents to exit the facility unsupervised from 05/17/2025-05/21/2025, 05/26/2025-05/30/2025, 06/02/2025-06/06/2025, and 06/09/2025-06/13/2025. Record review of the Ad Hoc QAPI tool indicated the Medical Director was notified on 05/17/2025. On 02/18/2026 starting at 10:14 AM, observations were made of the signs posted at visitor exits to be mindful of residents attempting to exit the facility. During interviews between 02/17/2026 2:45 PM-02/20/2026 1:54 PM, LVN A, LVN B, LVN C, [NAME] D, NA E, Housekeeper F, PTA G, SLT H, CNA K, LVN L, CNA M, CNA N, CNA O, CNA P, CNA Q, OT R, CNA S, CNA T, LVN U, RN V, OTA W, Housekeeper X, CNA Y, and NA Z were able to verbalize proper procedures for handling a wandering resident, an elopement, and they verbalized understanding of the facility's abuse and neglect policy. All staff interviewed indicated they had been in-serviced on elopement procedures, interventions to implement with a wandering resident, making sure the door locked behind them when they exited and there were no residents behind them. 2. Record review of Resident #1's Order Summary Report dated 02/17/2026 indicated monitor redness to abdomen and left upper thigh for worsening notify the doctor if blistering occurs for 3 days with a start date of 05/02/2025 and end date of 05/05/2025. Record review of Resident #1's care plan indicated the following: Focus with date initiated 01/07/2025, Resident #1 had an ADL self-care performance deficit and was able to feed herself. Focus with date initiated 05/02/2025, indicated she was at risk of burns due to hot liquids and required physical assistance when she had hot liquids, a cup with a lid, clothing/lap protector when drinking hot liquids, and should be seated in an upright position with table or overbed table when hot liquids were being consumed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Event Nurses' Note-Burn dated 05/02/2025 indicated Burn/Blister, the location was the dining room. The burn was caused by coffee, tea, or other hot liquid. The part of body burned was indicated as, scattered, left side of abdomen small area, and left upper thigh (no measurements indicated). The type of injury, dimensions, appearance indicated blanchable redness to affected areas (no measurements indicated). The cognition/behavior at time of event was cognitive impairment, refused to call for assistance, wandered, required cueing, resists redirection. The nurse description of the event indicated resident spilled coffee on self while in the dining room, resident statement related to event I spilled it all over me, responsible party and physician notified. Other information indicated resident has blanchable redness without complaint of pain. The interventions initiated by nurse indicated lid on cup/mug/glass, supervision when drinking or eating hot fluids, signed by the MDS Coordinator on 05/02/2025. Record review of Resident #1's Weekly Skin assessment dated [DATE] indicated other skin findings spilled hot liquid on 5/5/25 left thigh with redness 5 cm x 1.5 cm and 8 cm x 1.5 cm completed by the ADON. During an interview on 02/18/2026 at 3:38 PM, the MDS Coordinator said she could not exactly remember what happened when Resident #1 spilled coffee on herself on 05/02/2025. The MDS Coordinator said she thought maybe she was the one that found Resident #1 when she spilled coffee on herself. The MDS Coordinator said she was not able to remember if there were any new orders or what the burn looked like. The MDS Coordinator said she documented the burn did not have any blisters and there was blanchable redness. The MDS Coordinator said she believed after the burn they talked about putting lids on Resident #1's drinks. During an observation and interview on 02/18/2026 at 3:45 PM, [NAME] D said he had worked at the facility for four months, and to his knowledge there had been no coffee burns. [NAME] D said when he made the coffee he checked the temperature, wrote it down, and put it on top of the Dietary Manager's desk. [NAME] D said the Dietary Manager was gone for the day. [NAME] D said the coffee was supposed to be 155 F and was not supposed to be higher than 165 F. [NAME] D said if the coffee was higher than 165 F, he could put ice in it or let it sit for a few minutes and re-check the temperature. [NAME] D said if a resident required a lid on their coffee the meal ticket would indicate it. [NAME] D said he was making the coffee for dinner. An observation of the coffee temp was made with [NAME] D. The coffee temperature was 162 F. [NAME] D took the coffee into the dining room and set it out for the residents. During an interview on 02/18/2026 at 4:04 PM, LVN A said she was the nurse when Resident #1 spilled coffee on herself. LVN A said she did not document the incident because she did not witness it. LVN A said she was just told about it by somebody else, but was unable to remember who it was. LVN A said Resident #1 was monitored after the incident, and she did not think it ever blistered. She just had redness. LVN A said after Resident #1 spilled coffee on herself they started putting lids on her coffee. LVN A said she did not do the hot liquid assessments. LVN A said if a resident was observed to be shaky, she would put a lid on their coffee to prevent injuries. During an interview on 02/20/2026 at 1:30 PM, NA Z said she had been working at the facility for about 2 months. NA Z said she had not been instructed that there were certain residents who required a lid on their coffee. NA Z said she noticed sometime lids were placed on coffee cups and sometimes they were not. NA Z said that she was aware there had not been any burns. NA Z said there were some residents who were shaky and could possibly spill coffee on themselves and get burned. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/20/2026 at 1:40 PM, NA E said she had been working at the facility for about 2 months. NA E said lids were placed on the coffee cups here and there. NA E said in the dining room she had just been handing the coffee to the residents without a lid. NA E said she had not been instructed that there were residents who required a lid on their coffee. NA E said she was not aware of any residents getting burned. NA E said if the resident needed assistance, she would put a lid on the coffee because it could burn their tongue. During an interview on 02/23/2026 at 8:12 AM, the Dietary Manager said the coffee temperature should be taken prior to putting the coffee out for the residents, and the temperature should not be more than 140 F. The Dietary Manager said it was important for the coffee temperature not to be too high because it could burn the residents. The Dietary Manager said the residents meal ticket would indicate if they needed a lid on their coffee. During an interview on 02/23/2026 at 4:39 PM, the MDS Coordinator said she did not remember why she did not document any measurements for Resident #1's burn. The MDS Coordinator said measurements should be documented so they could monitor for any changes accurately, and not documenting properly could lead to missing something or worsening of the skin condition. During an interview on 02/23/2026 at 5:45 PM, the DON said she remembered Resident #1 spilled coffee on herself, and they monitored the red spot she has after the coffee spill, but it did not blister. The DON said the doctor was notified and they were instructed to monitor the area for a few days. The DON said they implemented the measure to place a lid on Resident #1's cup. The DON said Resident #1 was not able to get coffee for herself, therefore, the staff had to have given Resident #1 the coffee when she spilled it on herself. The DON said it would have been helpful to have measurements to Resident #1's reddened area after the coffee spill, and a better description of the injury should have been documented. The DON said it was important for an accurate description of the injury and measurements to be documented to be able to see if the injury had improved or worsened. The DON said the staff should be monitoring who is safe to have hot liquids by observations and conducting the hot liquid assessments quarterly. The DON said residents having hot liquids placed them at risk for getting burned and they needed to lessen the risk as much as possible. During an interview on 02/23/2026 at 7:11 PM, the Administrator said the kitchen staff were responsible for ensuring coffee was served between 135-140 F. The Administrator said she did not know how the facility was monitoring to see which residents were safe to get hot liquids. The Administrator said residents with hot liquids were at risk for burns. The Administrator said if a resident received a burn the doctor should be called, and their instructions followed. The Administrator said she expected for a thorough assessment to be completed and for measurements to be taken and properly documented. The Administrator said proper documentation of the injury and measurements was necessary because burns could get worse and it allowed for proper monitoring. Record review of the coffee temperature logs for February 2026 indicated from 02/01/2026-02/17/2026 the coffee temperatures were between 134 F-149 F. The coffee logs for the month of May 2025 were requested from the Administrator and not provided upon exit of the facility. Record review of the breakfast menu for 2/18/2026 indicated the coffee for breakfast was 162 F. Record review of the facility's undated policy, Guidelines on Serving Coffee in the Nursing Facility, 2. the standard for coffee service will be 135 degrees, unless the facility's residents have stated an overwhelming preference for coffee to be served at a higher temperature and additional safety (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	measures have been implemented, or the safety of residents warrants a lower temperature. If coffee is served at 135 degrees, it will cool to 133 degrees when dispensed into a roomtemperature coffeecup or mug, and per Time and Temperature Relationship to Serious Burns from the American Burn Association website, this temperature will allow approximately 15 seconds before a serious burn will occur, based on the physical condition of the individual person. 3. Any residents who have risk factors for coffee burns, such as significant cognitive impairment or extreme shaking may be evaluated for additional safety precautions using a hot beverage risk assessment. Safety precautions may include but are not limited to additional supervision when consuming coffee, insulated or non-insulated coffee mugs with sippy lids, coffee service at lower temperatures, or restricted coffee availability.Process for cooling coffee in the kitchen 1. Brew coffee in kitchen until brewing process is complete. 2. Add xxx (change the xxx to the amount of ice needed to cool the coffee at your facility)- 8 oz cups of ice stir well until ice is dissolved. 3. Take temperature of coffee in TF server, if it is 135-140, then screw on lid tightly and take to dining room to be served. 4. If it is still over 140 degrees, stir until it reaches 140 degrees or less, or add ice, a few cubes at a time, until it reaches 140 degrees or less. Then screw on lid and take to dining room to be served. 3. During an observation on 02/18/2026 at 10:32 PM, the communal shower room located on Hall C door was open and unoccupied. The floor was wet with scattered puddles of water. There was an open cabinet door adjacent to the shower stall with an opened K-Quat spray cleaner bottle and a Tub and Tile Cleaner spray bottle sitting on the second shelf. There was a resident sitting in the hall across from the shower room unsupervised. During an interview on 02/18/2026 at 10:40 PM, LVN U said she was not aware of any resident that had received a bath/shower since she arrived for her shift at 6:00 PM. LVN U said the baths/showers were not scheduled on the 6PM-6AM shift. LVN U said the cleaning supplies should have been behind a closed cabinet and the shower room door should remain closed and locked to prevent accidents such as falls or accidental ingestion of the cleaning supplies by a resident. LVN U said all staff are responsible for the safety of the residents but normally the aide that completed the resident's shower would ensure the shower room door is shut and locked. During an interview on 02/18/2026 at 10:45 PM, CNA T said she worked Hall C. CNA T said she had not assisted any residents with any baths/showers on her shift. CNA T said she had no knowledge of the shower room being used. CNA T said a resident could wander in the shower room and slip or spray the cleaner on their skin or eyes. CNA T said she was busy at the opposite end of the hall and had not noticed the shower room door opened. CNA T said anyone could close the shower room door and lock it at any time. CNA T said it was the responsibility of the last staff member who provided a shower to clean the area, close and lock the shower room door to prevent an accident. During an interview on 02/23/2026 at 6:04 PM, the DON said she noticed upon her arrival that evening that the shower door was open. The DON said she closed the door immediately. The DON expected the nursing staff to pick up, close and lock the shower room door after each use. The DON said that all staff were responsible for ensuring the facility was safe and accident free to protect the residents. The DON said a resident could have entered the open shower room and slipped. The DON said a resident could have entered the open shower room and drank the cleaning supplies. The DON said both instances could have resulted in harm to a resident. During an interview on 02/23/2026 at 07:11 PM, the Administrator said all staff were responsible for preventing and ensuring the safety of each resident. The Administrator said all cleaning supplies should be kept in a cabinet out of access to the residents. The Administrator said the shower door (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	should be closed and locked if there was water on the floor. During an interview on 02/23/2026 at 11:18 AM, the Administrator said they did not have a policy regarding accidents/supervision or to address the shower room and storage of cleaning supplies.

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F 0725 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 1 of 1 facility reviewed for care and services. The facility failed to provide sufficient CNAs according to the facility assessment on 02/09/2026, 02/13/2026, 02/20/2026. This failure placed residents at risk of inadequate supervision, an unsafe environment, falls, serious harm and injury, exacerbations of disease processes, abuse, and death.Findings included: During a confidential interview, Anonymous Person #2 said they were often short staffed, and it was difficult for them to accomplish all their tasks. Anonymous Person #2 said sometimes showers were missed due to not having enough staff. Anonymous Person #2 said the hall they worked on had residents who required two-person assistance, and this made it difficult to provide the care because they were the only one on the hall. Anonymous Person #2 said nurse management was not assisting them to provide care when they were short. Anonymous Person #2 said she reported to the DON not being able to accomplish all her tasks, and they were told they were trying to hire more staff. During a confidential interview, Anonymous Person #4 said most of the time they had two CNAs at night and on a good day three. Anonymous Person #4 said it was a struggle to provide care to the residents, but they tried to figure it out. Anonymous Person #4 said when they arrived for their shift many of the residents were dirty and had to be changed because there were only two CNAs on the previous shift. During a confidential interview, Anonymous Person #5 said they were not able to provide the care the residents required in a timely manner because they needed more help. Anonymous Person #5 said because some residents required assistance of two Persons, she had to call another CNA from another hall to come help her. The other CNAs were usually busy too and this resulted in the residents having to wait a long time for care to be provided. During a confidential interview, Anonymous Person #7 said sometimes they were not able to give showers and baths when they should because there was not enough staff. Anonymous Person #7 said there were usually three CNAs. Anonymous Person #7 said when she asked for assistance from the MAs or management, they tell them they are busy. Anonymous Person #7 said they had reported to the DON they were not able to accomplish all their tasks, and the DON told them they were a strong CNA, and they could handle it. During a confidential interview, Anonymous Person #9 said many times there were just two CNAs on their shift. Anonymous Person #9 said this was not enough to provide care to all the residents. Anonymous Person #9 said it made it difficult to accomplish all their tasks, and many times they were not able to get residents out of bed for mealtimes. Anonymous Person #9 said they did their best to try to keep the residents clean and changed at least every 2 hours. During an interview on 02/23/2026 at 5:45 PM, the DON said during their staff meetings the staff had reported needing more CNAs. The DON said it was not reported to her that they were not able to accomplish their tasks. The DON said when they were short staffed, she helped the staff. The DON said the goal was to have one CNA per hall (the facility had 4 halls). The DON said staffing was challenging and they were doing job fairs, posting online, offering employee referral incentives, and training hospitality aides to be CNAs. The DON said not having enough staff could lead to the residents missing out on ADLs, having to wait longer for assistance, falls, behavior, and not getting changed/turned. During an interview on 02/23/2026 at 7:11 PM, the Administrator said it had not been reported to her that the staff were not able to complete their tasks. The Administrator said it had been reported to her that more staff were needed, and she started to hire a lot of people, and they were preparing hospitality aides to become CNAs. The Administrator said the DON was responsible for ensuring they had enough staff. The Administrator said they were meeting (continued on next page)

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	455532	A. Building B. Wing	02/23/2026

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F 0725 Level of Harm - Potential for minimal harm Residents Affected - Some	their staffing needs. The Administrator said staffing was subjective, and if the staff sat around, they were not going to have enough time to complete their tasks. The Administrator said the facility was adequately staffed because she had seen nurses provide care to 30 residents and be the CNA too. The Administrator said they did not have a policy for staffing. Record review of the Facility Assessment reviewed 07/24/2025 indicated the PPD for nursing direct care was 3.0. During an interview on 02/23/2026 at 7:08 PM, the Area Director of Operations said he did not know how to generate the facility hours worked for the full month of January 2026 and February 2026. Record review of the Facility Hours dated 02/09/2026, 02/13/2026, 02/14/2026, 02/19/2026 and 02/20/2026 indicated the total PPD worked was not 3.0 on 02/09/2026, 02/13/2026, 02/20/2026. The Facility Hours for the whole months of January 2026 and February 2026 were requested but not provided upon exit of the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 3 of 4 medication carts (A/B Medication Aide Medication Cart, A/B Nurse Medication Cart, and the C/D Medication Aide Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure the A/B Medication Aide Medication Cart and the A/B Nurse Medication Cart were properly secured, when LVN B went to break, left the facility, and left them unlocked and unattended on 02/18/2026. The facility failed to ensure antifungal powder was stored properly, when it was left on top of the A/B Nurse Medication Cart unattended on 02/18/2026. The facility failed to ensure a red pill was disposed of properly, when it was left on top of the C/D Medication Aide Medication Cart This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.Findings included: During an observation and interview on 02/18/2026 at 10:38 PM, there were 2 unlocked, unattended medication carts at the nurse's station. Surveyor was able to open both medication carts. One top of one of the medication carts there was a medicine cup with a white powder in it. Staff members were observed walking by and there was a resident by the medication carts. LVN U said the medication carts were not hers that they were LVN B's medication carts. LVN U said LVN B was not in the facility because she had gone on break about 20 minutes ago. LVN U said medication carts should be locked when not in use and if they stepped away from the medication carts or the medication carts were out of sight. LVN U said she did not realize LVN B left her medication carts unlocked and did not notice the medication cup with the white powder on top of the medication cart. LVN U said medication carts should be locked to ensure nothing went missing and for the residents' safety. LVN U waited approximately 10 minutes before going to lock the medication carts. During an observation and interview on 02/18/2026 at 11:25 PM, LVN B returned from her break and identified the medication carts as the A/B Medication Aide Cart and the A/B Nurse Medication Cart. The white powder in a cup was still on top of the A/B Nurse Medication Cart. LVN B said the white powder was antifungal powder, and it should not be left on top of the medication cart because the residents could take it. LVN B said she thought she had locked the medication carts when she left for break, and medication carts should be locked at all times when unattended. LVN B said leaving the medication carts unlocked could result in the residents getting into the medication cart, and this could cause patient harm. During an observation and interview on 02/20/2026 at 8:30 AM, there was a red pill in a medication cup on top of an unattended/unsupervised medication cart. Multiple residents and staff were observed around the medication cart. MA DD came to the medication cart from the hall and said it was her medication cart. MA DD said it was the C/D Medication Aide Medication Cart. MA DD said earlier she had dropped the pill and placed it on top of the medication cart to dispose of it. MA DD said she could not remember what medication the pill was. MA DD said when she needed to dispose of a medication, it should not be left on top of the medication cart because the residents could get it and take it. MA DD said medications should be disposed of in the biohazard box on her medication cart immediately. During an interview on 02/23/2026 at 5:51 PM, the DON said medication carts should be locked when not within eyesight, and medications should not be left on top of the medication cart. The DON said if a medication needed to be disposed it should have been destroyed immediately and not left sitting on top of the medication cart. The DON said she monitored for proper storage of medications and locked medication carts by walking down the hallways daily, and providing education if errors were observed. The DON said unlocked (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication carts and medications left on top of the medication cart could result in somebody getting into the medication cart, medications getting stolen, and a resident who did not know could take medications they should not be taking. During an interview on 02/23/2026 at 7:21 PM, the Administrator said she expected the staff to follow the rules, lock the medication carts, and not leave medications on top of the medication cart. The Administrator said unlocked medication carts and medications on top of the medication cart placed the residents at risk of taking the medications and the staff could take the medications too. Record review of the facility's policy, Medication Storage in the Facility, dated 03/2025, indicated, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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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, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure:A dented can was stored separately from the undented cans2 opened loaves of bread were stored properly in the dry storage areaAn opened, unsealed carboard box with mushrooms was not stored in the refrigerator directly on top of onions inside a Ziploc bag. These failures could place residents at risk for food contamination and foodborne illness.Findings included: During an observation starting on 02/23/2026 at 7:14 AM, there was an opened, unsealed cardboard box with mushrooms in the refrigerator. The cardboard box was laid directly on top of onions in Ziploc bags. There was a 4 pound 2 ounces dented can of caramel sauce dessert topping stored with the undented cans. There were two open loaves of bread not sealed properly in the dry storage area. One loaf of bread was twisted around and tucked underneath, but it was not knotted. The other loaf of bread was just folded halfway and tucked underneath. During an interview on 02/23/2026 at 8:06 AM, the Dietary Manager said bags of bread should be tied closed, after they were opened. The Dietary Manager said the carboard box with mushrooms in the refrigerator was stored properly. The Dietary Manager said dented cans should not be stored on the rack with the undented cans. The Dietary Manager said food should be stored properly for food safety, and if food items were not sealed properly, they could go bad and cause stomach issues and food borne illness. The Dietary Manager said dented cans altered the seams and could cause bacteria to get into the cans, and this could make the residents sick. The Dietary Manager said she looked through the kitchen to ensure food was properly stored daily, and she had not noticed any issues. During an interview on 02/23/2026 at 2:37 PM, [NAME] D said when a bag of bread was opened it should be stored with a twist tie on it or knotted off to ensure it was sealed properly and air was not allowed to enter the package. [NAME] D said he did not know why the loaves of bread were not properly stored. [NAME] D said the carboard box with mushrooms inside of it was stored properly in the refrigerator. [NAME] D said not properly sealing food items could result in them going bad and they did not want to make anybody sick. [NAME] D said dented cans should not be placed alongside the undented cans. He said they should be removed and returned to the vendor because dented cans could grow bacteria in the dents. [NAME] D said the cook in charge every shift or the Dietary Manager were responsible for ensuring food was stored properly. During an interview on 02/23/2026 at 8:17 PM, the Administrator said her expectations were cardboard boxes with food should not be stored on top of food items because cardboard boxes were dirty and could contaminate other items. The Administrator said everything in the refrigerator should be sealed and dated. The Administrator said dented cans should not be stored alongside the undented cans. The Administrator said the dietary manager was responsible for ensuring food was properly stored. The Administrator said it was important for the food to be stored properly for infection control and so the food did not get germs on it. Record review of the facility's policy titled, Food Storage and Supplies, from the Dietary Services Policy and Procedure Manual 2012, indicated, All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies.4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Record review of the FDA Food Code 2022, FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants. this section, storing the food in packages, covered containers, or Rusted and pitted or dented cans may also present a serious potential hazard.

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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 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 4 residents (Resident #5) and 1 of 3 shower rooms (Hall C shower room) reviewed for infection control practices. 1. The facility failed to ensure CNA S performed hand hygiene and changed gloves when she provided incontinent care to Resident #1 on 02/23/2026. 2. The facility failed to ensure the communal shower room located on Hall C had no soiled towels on the floor or soiled wash cloths on the shower railing, a gown laid folded upon an overflowed trash bin on 02/18/2026. 3. The facility failed to ensure CNA Y covered the 1 of 4 linen carts (Hall A's linen cart) on 02/23/2026. These failures could place residents and staff at risk for cross contamination and the spread of infection. Finding Included: 1. Record review of Resident #5's face sheet dated 02/18/26 indicated she was an [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (cognitive decline that effects daily life caused by brain cell damage), generalized anxiety disorder (excessive, persistent worry), depression (persistent sadness, loss of interest, fatigue, and change in sleep/appetite), diabetes mellitus (condition that causes the blood sugar to be elevated), and atrial fibrillation (fast heart rate). Record review of Resident #5's annual MDS assessment dated [DATE] indicated she was able to make herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. Record review of Resident #5's comprehensive care plan revised on 02/04/26 indicated she had an ADL self-care deficit and impaired cognitive function related to dementia with interventions that included she required 1 staff assistance for bathing, 2 staff assistance with a mechanical lift for transfers, and staff to supervise as needed for toileting, bed mobility, dressing, and eating. The care also indicated Resident #5 had bladder incontinence, impaired mobility, and physical limitations with interventions to apply barrier cream after incontinent episodes. Record review of Resident #5's comprehensive care plan dated 02/23/26 after surveyor intervention indicated she had a potential psychosocial well-being problem related to an allegation of verbal abuse with interventions to allow resident time to answer questions and to verbalize feelings, perceptions, and fears. During an observation and interview on 02/23/2026 at 4:32 PM, CNA S provided incontinent care to Resident #1. CNA S entered Resident #1's room, washed her hands and put on gloves. CNA S tugged Resident #1's brief loose. CNA S tucked Resident #1's brief underneath Resident #1's legs. Resident #1 rolled onto her right side. CNA S wiped Resident #1's buttocks several times removing smears of feces and disposing of each wipe in the trash. Then CNA S rolled up the soiled brief under Resident #1's hip and tucked the clean brief underneath. CNA S then reached out her hand with the soiled glove and assisted Resident #1 to roll to the left side. CNA S failed to use hand hygiene and change her gloves prior to applying the clean brief. CNA S removed the dirty brief and placed it in the trash. CNA S proceeded to apply the clean brief with the dirty gloves. CNA S continued to reposition Resident #1 in the bed, straighten her gown up, and touch Resident #1's clean linens with her dirty gloves. CNA S said she did not notice any feces on the wipe when she provided incontinent care to Resident #1. CNA S said she should have performed hand hygiene and changed gloves when she went from dirty to clean during the incontinent care. CNA S said the resident would be at risk of cross contamination which could result in an infection when incontinent care was not performed properly. During an interview on 02/23/2026 at 04:52 PM, RN V said she expected the CNAs to provide proper incontinent care to the residents to prevent cross contamination and decrease the risk of infection such as a urinary tract (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. RN V said she was working Hall C and helped the CNAs at times but had not noticed any concerns with hand washing or with incontinent care that had been provided. During an interview on 02/23/2026 at 6:04 PM, the DON said she expected all staff to follow the proper procedures and techniques for incontinent care and handwashing to prevent cross contamination and the risk of infections. She said staff should change their gloves between dirty and clean and wash their hands. The DON said that all staff were responsible for ensuring the proper procedures and techniques for incontinent care were followed. The DON said that she and the ADON were always on the floor to observe, monitor and instruct staff as needed. During an interview on 02/23/2026 at 07:11 PM, the Administrator said it was important for incontinent care to be done properly to prevent cross contamination. The Administrator said she expected the clinical management staff to oversee and monitor the direct care staff to ensure proper procedures were followed while incontinent care was provided to decrease the chances of the residents developing an infection. 2. During an observation on 02/18/2026 at 10:32 PM, the communal shower room located on Hall C door was open and unoccupied. There were four wet towels spread out on the floor. The shower stall railing had two soiled wet wash cloths hanging off of it. The lidded trash bin was unable to close due to trash hanging out at the top and sides, with a folded gown laying on top of the lid. During an interview on 02/18/2026 at 10:40 PM, LVN U said she was not aware of any resident that had received a bath/shower since she arrived for her shift at 6:00 PM. LVN U said the baths/showers were not scheduled on the 6PM -6AM shift. LVN U said the used supplies should have been picked up and the shower room cleaned after use to prevent cross contamination by the aide that had completed the resident's shower. During an interview on 02/18/2026 at 10:45 PM, CNA T said she worked Hall C. CNA T said she had not assisted any residents with any baths/showers on her shift. CNA T said she had no knowledge of the shower room being used. CNA T said dirty supplies should be picked up to prevent cross contamination. CNA T said the aide that completed the resident's shower would pick up and properly dispose of the dirty/soiled items. During an interview on 02/23/2026 at 6:04 PM, the DON said she had noticed upon her arrival the evening of 02/18/2026, evening the shower room had soiled linens on the floor and was not aware why or when that had occurred. The DON said she expected the nursing staff to pick up and dispose of any dirty supplies properly immediately after using them to prevent the spread of infections. The DON said that all staff were responsible for ensuring the facility was clean. During an interview on 02/23/2026 at 07:11 PM, the Administrator said items should not be left in the shower room due to cross contamination and risk of infections. The Administrator said clinical staff were responsible for ensuring dirty linens were picked up properly. 3. During an observation and interview on 02/23/2026 at 12:06 PM, the linen cart was uncovered on Hall A. CNA Y said she may have gotten busy and forgot to close the cover over the linen cart on Hall A. CNA Y said the linen cart should remain covered to prevent cross contamination and decrease the chances of the residents getting an infection. During an interview on 02/23/2026 at 6:04 PM, the DON said she expected all staff to prevent cross contamination by keeping the linen carts covered. The DON said that she and the ADON were always on the floor to observe, monitor and instruct staff as needed. During an interview on 02/23/2026 at 07:11 PM, the Administrator said all clinical staff were responsible for ensuring the linen carts remained covered when not in use to prevent cross contamination. Record review of the facility policy Perineal Care with or without a catheter, effective 05/11/2022 indicated, An incontinent resident of urine and/or bowel should be identified, assessed, and provided appropriate treatment and services. This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. If heavily (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled, use an incontinence pad, brief, towel, or wipes to remove soiling, from front to back, prior to performing perineal care Do not wipe more than once with the same surface Doffing and discarding of gloves are required if visibly soiled Always perform hand hygiene before and after glove use. Record review of the facility policy Infection Control Plan: Overview updated on 3/2024 indicated, The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Linens - Personnel will handle, store, process and transport linens so as to prevent the spread of infection.