| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>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) |
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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, 2 of 3 (Residents #13 and #19) reviewed for physical abuse. 1. The facility Administrator failed to implement their abuse policy by removing the alleged perpetrator when the ADON and RN A reported to her on 5/26/2026 that Resident #13 stated CNA B pinched her and was rough with her. 2. The facility Administrator failed to implement their abuse policy by removing the alleged perpetrator during the week of 5/25/2026-5/28/2026 when Resident #19 told RN A and LVN C that CNA B was rough with her when providing care and told her she did not care if she was fired from this job because she could go work somewhere else. 3. RN A identified a bruise on Resident 13's right forearm and failed to report it to the Administrator. 4. The Administrator failed to investigate allegations of abuse made by Resident #13 and Resident #19, and report allegations of abuse to HHSC during the week of 5/25/2026-5/28/2026. 5. The facility to follow their abuse policy when they continued to allow CNA B to work with assigned residents including Resident #13 and Resident #19 until the surveyor's intervention on 5/31/2026. An IJ was identified on 06/01/26. The IJ template was provided to the facility on [DATE] at 6:00 p.m. While the IJ was removed on 06/02/26, 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. These deficient practices could place residents at risk of unreported and continued abuse and neglect, fear, harm, and a decreased quality of life.<br><br>Findings included:<br><br>Record review of the facility's policy, Abuse and Neglect, from the Nursing Policy and Procedure Manual revised 03/29/2018, indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment .Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff.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.Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. 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 including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | harm.Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident.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. 7. 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.Mistreatment: means inappropriate treatment or exploitation of a resident.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. 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. 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 19-17 dated 7/10/19. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation.<br><br>1. Record review of Resident #13's face sheet, dated 06/04/26, reflected Resident #13 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included senile degeneration of brain (progressive decline in mental abilities due to physical brain deterioration in older age).<br><br>Record review of Resident #13's quarterly MDS assessment, dated 03/12/26, reflected Resident #13 made herself understood and understood others. Resident #13's BIMS score was a 7, which reflected her cognition was severely impaired. Resident #13 required partial/moderate assistance with sit to stand and bed to chair transfer mobility.<br><br>Record review of Resident #13's undated comprehensive care plan, reflected Resident #13 had an ADL self-care performance deficit related to activity tolerance, fatigue (tiredness), limited mobility and low back pain. The care plan interventions included: independent with bed mobility.<br><br>Record review of Resident #13's electronic medical records did not reflect a skin assessment completed on 05/26/26 until state surveyor intervention on 05/31/26.<br><br>During an observation and interview on 05/31/26 at 1:28 p.m., with Resident #13 a bruise was observed on Resident #13's right forearm. When Resident #13 was asked about the bruise, she stated the CNA caused it when she made her go to bed. Resident #13 stated the CNA grabbed her by the right forearm and forced her to sit down to make her stay in bed which resulted in a bruise to her forearm. Resident #13 stated she tried to pull away when the CNA pushed her down and the CNA stated to her don't fight. Resident #13 stated the CNA had long fingernails and when she grabbed her, the mark came up. Resident #13 described the CNA as a black lady, heavy set, and her hair was curled to the<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | side, but was unable to state a name. Resident #13 stated she could not remember the date this incident happened or who she reported it to, but she did report it. Resident #13 stated, this is not the first time this has happened, ever since she has been here, she reaches out and grabs me. Resident #13 stated when she reported this, before, she was told the CNA was just that way. Resident #13 stated, I was really scared.<br><br>During an interview on 05/31/2026 at 1:05 PM, RN A stated when she was assessing Resident #13 for shingles (a viral infection that caused a painful rash), Resident #13 stated to her I must tell you something that needs to stay between me and you. RN A stated Resident #13 reported to her that the CNA who put her to bed the night before was ruff and pinched her. RN A stated Resident #13 told her she was being forced to go to bed and she was not ready, the CNA insisted it was her bedtime and she put her to bed. RN A stated Resident #13 stated the CNA told her it was her fault because she was fighting her about going to bed. RN A stated Resident #13 did not provide her any names, but said it was a black woman. RN A stated she reported it immediately to the ADON and Administrator the day Resident #13 reported it to her, and the Administrator told her it would be a self-report to state, and she would talk to Resident #13. RN A stated she did not mention the bruise to anyone, but she did not notice the bruise when Resident #13 reported the incident, but she was focused on the shingles.<br><br>During an interview on 06/01/26 at 9:50 a.m., the ADON stated, on 05/25/26 as she was making rounds prior to supper, she noticed Resident #13 lying in bed. The ADON stated she asked her why she was in bed so early and Resident #13 stated she told me I had to go to bed because everyone else was in bed. The ADON stated she told her she did not have to go to bed early if she did not want to. The ADON stated she offered to get her back up. The ADON stated she did not report the incident to anyone because she did not feel like it was abuse or neglect. The ADON stated the next day (26th) RN A came to her and reported Resident #13 told her a CNA was ruff and pinched her. The ADON stated her and RN A immediately went to the Abuse Coordinator which was the Administrator, and RN A told her what Resident #13 reported, which was the CNA was ruff and pinched her. The ADON stated the Administrator stated, Ok, I will investigate.<br><br>During an interview on 06/01/26 at 10:22 a.m., the Administrator stated around 5/18/26 forward, the ADON notified her about a complaint that Resident #13 stated she was made to go to bed. The Administrator stated her and the ADON went down to Resident #13 room and informed her it was her right when she wanted to go to bed. The Administrator stated as Resident #13 was mentioning about the CNA making her go to bed, Resident #13 showed her the rash that was identified as shingles (a viral infection that caused a painful rash) under her right side. The Administrator stated she asked Resident #13 if she could identify the CNA and she stated a regular-sized black lady that normally worked that hall. The Administrator stated she looked at the ADON and asked her who the CNA was that worked yesterday, and the ADON stated she would look at the schedule. The Administrator stated after she left Resident #13's room, her and the ADON went to look at the schedule and saw CNA B worked the hall that night before. The Administrator stated she thought she had conducted an in-service on resident rights but could not find the documentation. The Administrator stated CNA B never was suspended or spoken to about the incident and was able to continue to work with Resident #13. The Administrator stated she was not aware of the second incident that involved the CNA been ruff or pinching Resident #13. The Administrator stated the ADON nor RN A reported to her about Resident #13 being pinched or ruff during transfer on 05/25/26. The Administrator stated she was not aware of the bruise to Resident #13's right forearm until after the state surveyor's intervention. The Administrator stated she went down to Resident #13's room on 05/31/26 to start an investigation and when she spoke to Resident #13 about the bruise, Resident #13 stated it happened, when she put me to bed.<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/01/26 at 10:46 a.m., the ADON stated she did not notify the Administrator about a complaint herself. The ADON stated when RN A reported Resident #13's allegation to her, they both went to the Administrator's office, and RN A reported the allegation to the Administrator. The ADON stated she did not recall speaking with Resident #13 with the Administrator.<br><br>2. Record review of Resident #19's face sheet dated 06/01/2026 indicated she was an [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), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), and essential primary hypertension (high blood pressure).<br><br>Record review of Resident #19's MDS assessment dated [DATE] indicated she was understood by others and understood others. Resident #19 had a BIMS score of 15, which indicated her cognition was intact. Resident #19 was dependent on staff for toileting hygiene. Resident #19 was frequently incontinent of urine and bowel.<br><br>Record review of Resident #19's care plan reviewed 04/21/2026 indicated she had impaired though processes to engage in simple, structured activities that avoided overly demanding tasks and to provide her with a homelike environment. Resident #19's care plan indicated she had bowl and bladder incontinence to provide perineal care after each incontinent episode. Resident #19 had an ADL self-care performance deficit related to fatigue and limited mobility and required assistance of one staff member for toilet use, bathing, bed mobility, and dressing.<br><br>During an interview on 05/31/2026 at 10:02 AM, Resident #19 said there was an African American CNA who wore brown glasses and worked the 2 PM- 10 PM shift that was rough when she provided care to her. Resident #19 said the CNA did not identify herself and did not wear a name badge, so she did not know her name. Resident #19 said the CNA grabbed her arm roughly and was rough when turning her to provide care. Resident #19 said she told the CNA she needed to stop grabbing her arm so roughly and the CNA told her that's the way she was. Resident #19 said she was scared of the CNA and had reported her to everybody. Resident #19 said the CNA did not work this past weekend, but she provided care to her every day. Resident #19 said one of the girls upfront told her they were trying to figure out who it was, but she was unable to provide a name. Resident #19 said one day last week me and her had it out. Resident #19 said she told the CNA to stop treating her roughly and the CNA told her she did not care if they fired her, she could always work elsewhere. One of the nurses she reported it to was LVN C.<br><br>During an interview on 05/31/2026 at 1:05 PM, RN A said Resident #19 reported to her yesterday (05/30/2026) morning that an African American woman who wore glasses on the 2 PM-10 PM shift was really rough with her, and she never wanted her to be her CNA again. RN A said she notified the Administrator immediately via text message and she said it would be a self-report to state and to send the DON a text message. RN A said the way Resident #19 was treated was abuse and abuse should be reported to the Administrator immediately to protect the residents from further abuse.<br><br>During an interview on 05/31/2026 at 1:47 PM, the ADON said CNA B was the CNA that usually provided care to Resident #19 on the 2 PM-10 PM shift and she matched the description provided by Resident #19. The ADON said she did not think CNA B was mean, but she was very demanding and wanted things done her way. The ADON said the Administrator called her yesterday, 05/30/2026, and told her she was filing a grievance because Resident #19 felt her ADLs were rushed by CNA B, but she was not involved in any of the process. The ADON said if a resident reported a CNA was rough it (continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | should be reported to the Abuse Coordinator, the Administrator, immediately because it could be considered abuse, and then the CNA should be removed and spoken with. The ADON said it was important for abuse to be reported and investigated because the residents needed to be safe, and if they did not feel safe with a CNA the CNA did not need to be providing their care. The ADON said none of the CNAs were suspended and this places the residents at risk for further abuse.<br><br>During an interview on 05/31/2026 at 2:06 PM, the DON said she had not received any reports from the residents or staff about any staff being rough with the residents or mistreating them. The DON said yesterday evening, 05/30/2026, she was notified by the Administrator that Resident #19 had reported a CNA was rough with her, but she did not talk to Resident #19. The DON said if a resident reported a staff member was rough with them it should be reported to the Abuse Coordinator, the Administrator, immediately. The DON said the Administrator would then see what the resident was saying and get a statement from the staff member involved, and if deemed reportable follow the abuse policy process. The DON said the staff member would be suspended to protect the residents from further abuse. The DON said an allegation of staff being rough could be considered abuse. The DON said she was not aware of Resident #13 having a bruise or being mistreated. The DON said nothing regarding Resident #13 had been reported to her. The DON said if the staff noticed a new bruise, they should complete a skin assessment, open an incident, monitor the bruise, notify the family and the doctor, and the Administrator usually was notified during the daily clinical morning meetings. The DON said she reviewed the staffing schedule and identified the CNA involved in Resident #19 and Resident #13's incidents as CNA B. The DON said the CNA was working today, 05/31/2026, for her 2 PM-10 PM shift, but would be moved to a different hall. The DON said it was important for abuse to be reported per the facility's abuse policy and for the proper measures to be taken to not place other residents at risk for abuse.<br><br>During an interview on 05/31/2026 at 2:19 PM, the Administrator said last night (05/30/2026) at 7 PM, LVN C called her and reported to her that Resident #19 reported to her that the CNA from Thursday, 05/28/2026, was rough with her and rushed her when she provided care. The Administrator said she went to the facility approximately 15-20 minutes after she was notified by LVN C to talk to Resident #19. The Administrator said when she spoke to Resident #19, she felt like it was more that CNA B had rushed her. She said Resident #19 told her CNA B rushed her and pushed her over when she was turning her on her side. The Administrator said Resident #19 told her she did not want CNA B back in her room. The Administrator said she filed a grievance and moved CNA B to a different hall. She said CNA B would start her shift today, 05/31/2026, at 2 PM, but would be on a different hall. The Administrator said Resident #19 had no injuries from CNA B being rough with her. The Administrator said RN A reported to her yesterday (05/30/2026) that Resident #19 told her CNA B had been rough with her. The Administrator said she told RN A to report it to the DON. The Administrator said she was not sure if Resident #19 told her CNA B was rough or rushed her. The Administrator said the allegation Resident #19 made should have been reported for abuse and neglect within 2 hours. The Administrator said not reporting allegations of abuse placed the residents at risk for continued abuse. The Administrator said it had not been reported to her that CNA B pinched Resident #13 or any allegations made by Resident #13. The Administrator said if Resident #13 alleged she had been pinched by the CNA it should have been reported to her and she would have reported it to HHSC within 2 hours. The Administrator said if there was an unidentified bruise it should be reported to her and she would report to HHSC within the required timeframe of 2 hours. The Administrator said it was not reported to her that Resident #13 had a bruise on her arm. The Administrator said the staff should not force the residents to go to bed early because it went against resident rights. The Administrator said not reporting allegations of abuse and neglect, unidentified bruises, and not following their abuse policy placed the residents at risk for continued abuse.<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 05/31/2026 at 2:49 PM, CNA B said she had been working at the facility for close to a month. CNA B said if a resident was not ready to go to bed, she would notify the nurse and let the nurse handle it because it was the residents right not to go to bed. CNA B said she had not forced any residents to go to bed. CNA B said she did not rush the residents when she provided care, and she had not received any complaints that she was rough. CNA B said there were no residents' rooms she was not allowed to go in. CNA B said she usually worked on the hall where Resident #13 and Resident #19 resided. CNA B said Resident #19 did not require a lot of assistance with her care that she allowed her to roll herself just gave her a little boost. CNA B said Resident #13 required assistance from one person for rolling and for standing up. She said usually she held her when she was getting up from under her arms to help her push up on her walker to get her to stand up. CNA B said she had never told any residents if she got fired, she could go work somewhere else. She said she was not aware of Resident #13 having any bruises.<br><br>During an observation and interview on 05/31/2026 at 3:11 PM, RN A showed the surveyor the text message she sent to the Administrator and DON. The message to the Administrator dated 05/30/2026 at 10:08 AM indicated Resident #19 says she never wants the 2-10 aide back in her room, because her aide is being too rough with her. It happens every time she's been on the hall. The Administrator responded, send to DON and let her know. RN A said she took a screenshot of what she sent to the Administrator and the response and sent it to the DON. RN A showed the surveyor the message sent to the DON on 05/20/2026 at 11:02 AM, and it was the screenshot of what she sent the Administrator. RN A said she did not hear from the DON or the Administrator after this.<br><br>During an interview on 06/01/2026 at 9:58 AM, LVN C said Resident #19 complained to her about one of the CNA's Thursday, 05/28/2026, being rough with her. She said Resident #19 did not report it to her until Saturday, 05/30/2026, at 7:00 PM. She said Resident #19 reported to her the CNA had been rough with her, rolled her over so hard, she hit her head against the bed rail. LVN C said Resident #19 told her it was a CNA with glasses that worked the 2 PM-10 PM shift, and the description fit CNA B. LVN C said she immediately reported what Resident #19 told her to the Administrator, and the Administrator went to the facility. LVN C said she conducted a skin assessment on Resident #19, and she had no injuries. LVN C said she had not received any complaints from the residents or staff about CNA B or any other staff mistreating the residents. LVN C said allegations of abuse should be reported to the Administrator immediately to protect the residents from further abuse.<br><br>During an interview on 06/01/2026 at 10:40 AM, the Administrator said she was notified by RN A the morning of 05/30/2026 that Resident #19 alleged CNA B was rough with her. The Administrator said she identified it as abuse and told RN A to notify the DON because she was in an area where she did not have good signal and was not receiving messages and calls in a timely manner. The Administrator said she expected the DON to follow up, but the DON said RN A had not notified her of the allegation Resident #19 made. The Administrator said when LVN C reported the allegation Resident #19 made to her the evening of 05/30/2026, she was back in town and decided to go to the facility to speak with Resident #19. The Administrator said since she told RN A to report it to the DON, she assumed the DON had taken care of the situation. She said as the Abuse Coordinator she should have called the DON to follow up and ensure she had taken care of the situation. The Administrator said Resident #19 made an allegation of abuse, and it should have been reported within two hours to HHSC.<br><br>During an interview on 06/04/2026 at 6:08 PM, the DON said when the Administrator called her the evening of 05/30/2026, she went back to review her messages and realized RN A sent her a screenshot of the message the morning of 05/30/2026 that she sent to the Administrator to report the allegation Resident #19 made. The DON said if she had noticed it when it was sent, she would have<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | called the Administrator, removed the staff member, ensured the resident was safe, conducted a skin assessment, called the family and done all the things per the abuse policy, and reported the abuse to HHSC. The DON said not following the abuse policy placed the residents at risk for abuse and neglect.<br><br>This was determined to be an Immediate Jeopardy (IJ) on 06/01/2026 at 5:56 PM the Area Director of Operations was notified. The Area Director of Operations was provided with the IJ template on 06/01/2026 at 6:00 PM and a Plan of Removal was requested.<br><br>The facility's plan of removal was accepted on 06/01/2026 at 7:34 PM and included the following:<br><br>Date: 6/1/26<br><br>Plan of Removal<br><br>Problem: F607 Implement Abuse Policy<br><br>Interventions:<br><br>CNA B was suspended on 5/31/26 by the administrator.<br><br>Resident #13 and #19 was interviewed by the Administrator and Regional Compliance Nurse. No further allegations of abuse were disclosed. Completed 5/31/26.<br><br>Resident #13 and #19 had a head-to-toe assessment completed by the charge nurse. No injuries or signs of abuse were noted. Completed 5/31/26.<br><br>A Trauma informed care assessment was completed by Regional Compliance Nurse on resident #13 and #19 documented in the chart. No new findings were assessed. Completed 5/31/26.<br><br>On 5/31/26, safe surveys were completed for all residents who can be interviewed by the Administrator and Regional Compliance Nurse. No additional allegations of abuse from staff or residents were disclosed. Completed 5/31/26.<br><br>On 5/31/26 staff interviews were conducted by the Administrator and Regional Compliance Nurse. No additional allegations of abuse towards residents were disclosed. Completed 5/31/26<br><br>The medical director was notified of the immediate jeopardy by the Administrator on 6/1/26.<br><br>An ADHOC QAPI meeting was completed with the Administrator, Regional Compliance Nurse, IDT Team and Medical Director to discuss the immediate jeopardy and plan of removal. Completed 6/1/26.<br><br>The policy for Abuse/Neglect was reviewed by the [NAME] President of Clinical Services, ADO, and Compliance Nurse. No changes were made to the Abuse/Neglect policy. Completed 6/1/26<br><br>The Administrator, DON and ADON were in-serviced 1:1 by the Regional Compliance Nurse on the following policy. Completed 6/1/26.<br><br>o Abuse and Neglect Policy reporting all allegations of abuse to the Administrator immediately. All alleged perpetrators will be suspended pending investigation. Allegations of abuse must be<br>(continued on next page) |

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|---|---|---|---|
| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>Mount Pleasant, TX 75455 |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | investigated immediately by the Administrator or designee to ensure the proper measures are implemented to keep residents safe and from abuse. The alleged perpetrator will remain suspended until the investigation has been completed.<br><br>o Reporting Allegations of Abuse and Neglect- all allegations of abuse and neglect must be reported to HHSC immediately or within 2 hours.<br><br>In-services:<br><br>The following in-services were initiated by Regional Compliance Nurse, Administrator, DON, and ADON for all staff. Any staff member not present or in-serviced as of 6/1/26 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All PRN, agency staff, or staff on leave will in serviced prior to assuming their next assignment<br><br>Abuse and Neglect Policy- Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Any suspicious injury of unknown sources.<br><br>o Reporting Allegations of Abuse and Neglect- all allegations of abuse and neglect must be reported to the Administrator immediately.<br><br>The surveyor confirmed the following actions had been implemented sufficiently to remove the immediacy by:<br><br>Record review of the facility employee disciplinary report dated 05/31/2026 indicated CNA was suspended on 05/31/2026.<br><br>Record review of the facility EMR for Resident #13 and Resident #19 indicated both residents were interviewed by the facility administrator and no further allegations of abuse were noted.<br><br>Record review of Resident #13 and Resident #19's head to toe skin assessments dated 05/31/2026 completed by the DON indicated neither resident had any skin issues that suggested abuse.<br><br>Record review of Resident #13 and Resident #19's Trauma Informed PRN Assessments completed on 05/31/2026 by the Regional Compliance Nurse indicated no trauma associated with incidents.<br><br>Record review of the resident safe surveys completed on 05/31/2026 by the DON and the Regional Compliance Nurse indicated no allegations of abuse or neglect were reported by residents.<br><br>Record review of the staff interviews completed by the Administrator and the Regional Compliance Nurse on 05/31/2026 indicated no allegations of abuse or neglect were reported by staff members.<br><br>Record review of the ADHOC QAPI meeting completed on 06/01/2026 by the Administrator, Regional Compliance Nurse, IDT Team and Medical Director to discuss the immediate jeopardy and plan of removal.<br><br>Record review of the one-on-one in-services completed by the Regional Compliance Nurse on 06/01/2026 with the Administrator, DON and ADON included the abuse and neglect policy and<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | reporting allegations.<br><br>Record review of the in-service completed by the Administrator, Regional Compliance Nurse, the DON, and the ADON completed on 06/01/2026 indicated they had been in-serviced on the abuse and neglect policy and when to report abuse and neglect allegations.<br><br>During an interview on 06/02/2026 at 9:53 AM the Medical Director said he was notified of the immediate jeopardy by the Administrator on 6/1/2026.<br><br>During interviews conducted on 06/02/2026 between 9:55 AM-12:37 PM of staff across different shifts, the Area Coordinator of Medical Records and Supply, MDS Coordinator, Social Worker, Dietary Manager, Business Office Manager, Maintenance Director, Housekeeping Su |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure residents were free from abuse for 2 of 3 residents (Residents #13 and #19) reviewed for resident abuse. 1. The facility failed to protect Resident #13 from abuse during the week of 5/25/2026- 5/28/2026, when CNA B grabbed her by the right forearm and forced her to sit down to make her stay in bed which resulted in a bruise to her forearm. 2. The facility failed to protect Resident #19 from abuse during the week of 5/25/2026- 5/28/2026, when CNA B was rough with her when providing care and told her she did not care if she was fired from this job because she could go work somewhere else during the week of 5/25/2026- 5/28/2026. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.<br><br>Findings included:<br><br>1. Record review of Resident #13's face sheet, dated 06/04/26, reflected Resident #13 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included senile degeneration of brain (progressive decline in mental abilities due to physical brain deterioration in older age).<br><br>Record review of Resident #13's quarterly MDS assessment, dated 03/12/26, reflected Resident #13 made herself understood and understood others. Resident #13's BIMS score was a 7, which reflected her cognition was severely impaired. Resident #13 required partial/moderate assistance with sit to stand and bed to chair transfer mobility.<br><br>Record review of Resident #13's undated comprehensive care plan, reflected Resident #13 had an ADL self-care performance deficit related to activity tolerance, fatigue (tiredness), limited mobility and low back pain. The care plan interventions included: independent with bed mobility.<br><br>Record review of Resident #13's electronic medical records did not reflect a skin assessment completed on 05/26/26 until state surveyor intervention on 05/31/26.<br><br>During an observation and interview on 05/31/26 at 1:28 p.m., with Resident #13 a bruise was observed on Resident #13's right forearm. When Resident #13 was asked about the bruise, she stated the CNA caused it when she made her go to bed. Resident #13 stated the CNA grabbed her by the right forearm and forced her to sit down to make her stay in bed which resulted in a bruise to her forearm. Resident #13 stated she tried to pull away when the CNA pushed her down and the CNA stated to her don't fight. Resident #13 stated the CNA had long fingernails and when she grabbed her, the mark came up. Resident #13 described the CNA as a black lady, heavy set, and her hair was curled to the side, but was unable to state a name. Resident #13 stated she could not remember the date this incident happened or who she reported it to, but she did report it. Resident #13 stated, this is not the first time this has happened, ever since she has been here, she reaches out and grabs me. Resident #13 stated when she reported this, before, she was told the CNA was just that way. Resident #13 stated, I was really scared.<br><br>During an interview on 05/31/2026 at 1:05 PM, RN A stated when she was assessing Resident #13 for shingles (a viral infection that caused a painful rash), Resident #13 stated to her I must tell you something that needs to stay between me and you. RN A stated Resident #13 reported to her that the (continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | CNA who put her to bed the night before was ruff and pinched her. RN A stated Resident #13 told her she was being forced to go to bed and she was not ready, the CNA insisted it was her bedtime and she put her to bed. RN A stated Resident #13 stated the CNA told her it was her fault because she was fighting her about going to bed. RN A stated Resident #13 did not provide her any names, but said it was a black woman. RN A stated she reported it immediately to the ADON and Administrator the day Resident #13 reported it to her, and the Administrator told her it would be a self-report to state, and she would talk to Resident #13. RN A stated she did not mention the bruise to anyone, but she did not notice the bruise when Resident #13 reported the incident, but she was focused on the shingles.<br><br>During an interview on 06/01/26 at 9:50 a.m., the ADON stated, on 05/25/26 as she was making rounds prior to supper, she noticed Resident #13 lying in bed. The ADON stated she asked her why she was in bed so early and Resident #13 stated she told me I had to go to bed because everyone else was in bed. The ADON stated she told her she did not have to go to bed early if she did not want to. The ADON stated she offered to get her back up. The ADON stated she did not report the incident to anyone because she did not feel like it was abuse or neglect. The ADON stated the next day (26th) RN A came to her and reported Resident #13 told her a CNA was ruff and pinched her. The ADON stated her and RN A immediately went to the Abuse Coordinator which was the Administrator, and RN A told her what Resident #13 reported, which was the CNA was ruff and pinched her. The ADON stated the Administrator stated, Ok, I will investigate.<br><br>During an interview on 06/01/26 at 10:22 a.m., the Administrator stated around 5/18/26 forward, the ADON notified her about a complaint that Resident #13 stated she was made to go to bed. The Administrator stated her and the ADON went down to Resident #13 room and informed her it was her right when she wanted to go to bed. The Administrator stated as Resident #13 was mentioning about the CNA making her go to bed, Resident #13 showed her the rash that was identified as shingles (a viral infection that caused a painful rash) under her right side. The Administrator stated she asked Resident #13 if she could identify the CNA and she stated a regular-sized black lady that normally worked that hall. The Administrator stated she looked at the ADON and asked her who the CNA was that worked yesterday, and the ADON stated she would look at the schedule. The Administrator stated after she left Resident #13's room, her and the ADON went to look at the schedule and saw CNA B worked the hall that night before. The Administrator stated she thought she had conducted an in-service on resident rights but could not find the documentation. The Administrator stated CNA B never was suspended or spoken to about the incident and was able to continue to work with Resident #13. The Administrator stated she was not aware of the second incident that involved the CNA been ruff or pinching Resident #13. The Administrator stated the ADON nor RN A reported to her about Resident #13 being pinched or ruff during transfer on 05/25/26. The Administrator stated she was not aware of the bruise to Resident #13's right forearm until after the state surveyor's intervention. The Administrator stated she went down to Resident #13's room on 05/31/26 to start an investigation and when she spoke to Resident #13 about the bruise, Resident #13 stated it happened, when she put me to bed.<br><br>During an interview on 06/01/26 at 10:46 a.m., the ADON stated she did not notify the Administrator about a complaint herself. The ADON stated when RN A reported Resident #13's allegation to her, they both went to the Administrator's office, and RN A reported the allegation to the Administrator. The ADON stated she did not recall speaking with Resident #13 with the Administrator.<br><br>2. Record review of Resident #19's face sheet dated 06/01/2026 indicated she was an [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 (continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | changes in behavior and personality), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), and essential primary hypertension (high blood pressure).<br><br>Record review of Resident #19's MDS assessment dated [DATE] indicated she was understood by others and understood others. Resident #19 had a BIMS score of 15, which indicated her cognition was intact. Resident #19 was dependent on staff for toileting hygiene. Resident #19 was frequently incontinent of bladder and bowel.<br><br>Record review of Resident #19's care plan reviewed 04/21/2026 indicated she had impaired though processes to engage in simple, structured activities that avoided overly demanding tasks and to provide her with a homelike environment. Resident #19's care plan indicated she had bowel and bladder incontinence to provide perineal care after each incontinent episode. Resident #19 had an ADL self-care performance deficit related to fatigue and limited mobility and required assistance of one staff member for toilet use, bathing, bed mobility, and dressing.<br><br>During an interview on 05/31/2026 at 10:02 AM, Resident #19 said there was an African American CNA who wore brown glasses and worked the 2 PM- 10 PM shift that was rough when she provided care to her. Resident #19 said the CNA did not identify herself and did not wear a name badge, so she did not know her name. Resident #19 said the CNA grabbed her arm roughly and was rough when turning her to provide care. Resident #19 said she told the CNA she needed to stop grabbing her arm so roughly and the CNA told her that's the way she was. Resident #19 said she was scared of the CNA and had reported her to everybody (staff). Resident #19 said the CNA did not work over the past weekend, but she provided care to her every day. Resident #19 said one of the girls upfront told her they were trying to figure out who it was, but she was unable to provide a name. Resident #19 said one day last week me and her had it out. Resident #19 said she told the CNA to stop treating her roughly and the CNA told her she did not care if they fired her, she could always work elsewhere. One of the nurses she reported it to was LVN C.<br><br>During an interview on 05/31/2026 at 1:05 PM, RN A said Resident #19 reported to her yesterday (05/30/2026) morning that an African American woman who wore glasses on the 2 PM-10 PM shift was really rough with her, and she never wanted her to be her CNA again. RN A said she did not have a way of figuring out who the CNA was. RN A said Resident #19 told her the CNA never wore a name tag. RN A said she notified the Administrator immediately via text message and she said it would be a self-report to state and to send the DON a text message. RN A said the way Resident #19 was treated was abuse and the facility was the residents' home. RN A stated the residents were someone's loved one, they should be treated with respect and dignity, trust the staff, feel safe in their home, and not be afraid to ask to be changed.<br><br>During an interview on 05/31/2026 at 1:47 PM, the ADON said CNA B was the CNA that usually provided care to Resident #19 on the 2 PM-10 PM shift and she matched the description provided by Resident #19. The ADON said she did not think CNA B was mean, but she was very demanding and wanted things done her way. The ADON said the Administrator called her yesterday, 05/30/2026, and told her she was filing a grievance because Resident #19 felt her ADLs were rushed by CNA B, but she was not involved in any of the process. The ADON said if a resident reported a CNA was rough it should be reported to the Abuse Coordinator, the Administrator, immediately because it could be considered abuse.<br><br>During an interview on 05/31/2026 at 2:06 PM, the DON said she had not received any reports from the residents or staff about any staff being rough with the residents or mistreating them. The DON<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | said yesterday evening, 05/30/2026, she was notified by the Administrator that Resident #19 had reported a CNA was rough with her, but she did not talk to Resident #19. The DON said if a resident reported a staff member was rough with them it should be reported to the Abuse Coordinator, the Administrator, immediately. The DON said the Administrator would then see what the resident was saying and get a statement from the staff member involved, and if deemed reportable follow the abuse policy process. The DON said an allegation of staff being rough could be considered abuse. The DON said she was not aware of Resident #13 having a bruise or being mistreated. The DON said nothing regarding Resident #13 had been reported to her. The DON said if the staff noticed a new bruise, they should complete a skin assessment, open an incident, monitor the bruise, notify the family and the doctor, and the Administrator usually was notified during the daily clinical morning meetings. The DON said she reviewed the staffing schedule and identified the CNA involved in Resident #19 and Resident #13's incidents as CNA B. The DON said the CNA was working today, 05/31/2026, for her 2 PM-10 PM shift, but would be moved to a different hall.<br><br>During an interview on 05/31/2026 at 2:19 PM, the Administrator said last night (05/30/2026) at 7 PM, LVN C called her and reported to her that Resident #19 reported to her that the CNA from Thursday, 05/28/2026, was rough with her and rushed her when she provided care. The Administrator said she went to the facility approximately 15-20 minutes after she was notified by LVN C to talk to Resident #19. The Administrator said when she spoke to Resident #19, she felt like it was more that CNA B had rushed her. She said Resident #19 told her CNA B rushed her and pushed her over when she was turning her on her side. The Administrator said Resident #19 told her she did not want CNA B back in her room. The Administrator said she filed a grievance and moved CNA B to a different hall. She said CNA B would start her shift today, 05/31/2026, at 2 PM, but would be on a different hall. The Administrator said Resident #19 had no injuries from CNA B being rough with her. The Administrator said RN A reported to her yesterday (05/30/2026) that Resident #19 told her CNA B had been rough with her. The Administrator said she told RN A to report it to the DON. The Administrator said she was not sure if Resident #19 told her CNA B was rough or rushed her. The Administrator said it had not been reported to her that CNA B pinched Resident #13 or any allegations made by Resident #13. The Administrator said if there was an unidentified bruise it should be reported to her. The Administrator said it was not reported to her that Resident #13 had a bruise on her arm. The Administrator said the staff should not force the residents to go to bed early because it went against resident rights.<br><br>During an interview on 05/31/2026 at 2:49 PM, CNA B said she had been working at the facility for close to a month. CNA B said if a resident was not ready to go to bed, she would notify the nurse and let the nurse handle it because it was the residents right not to go to bed. CNA B said she had not forced any residents to go to bed. CNA B said she did not rush the residents when she provided care, and she had not received any complaints that she was rough. CNA B said there were no residents' rooms she was not allowed to go in. CNA B said she usually worked on the hall where Resident #13 and Resident #19 resided. CNA B said Resident #19 did not require a lot of assistance with her care that she allowed her to roll herself just gave her a little boost. CNA B said Resident #13 required assistance from one person for rolling and for standing up. She said usually she held her when she was getting up from under her arms to help her push up on her walker to get her to stand up. CNA B said she had never told any residents if she got fired, she could go work somewhere else. She said she was not aware of Resident #13 having any bruises.<br><br>During an observation and interview on 05/31/2026 at 3:11 PM, RN A showed the surveyor the text message she sent to the Administrator and DON. The message to the Administrator dated 05/30/2026 at 10:08 AM indicated Resident #19 says she never wants the 2-10 aide back in her room, because her aide is being too rough with her. It happens every time she's been on the hall. The Administrator<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | responded, send to DON and let her know. RN A said she took a screenshot of what she sent to the Administrator and the response and sent it to the DON. RN A showed the surveyor the message sent to the DON on 05/30/2026 at 11:02 AM, and it was the screenshot of what she sent the Administrator. RN A said she did not hear from the DON or the Administrator after this.<br><br>During an interview on 06/01/2026 at 9:58 AM, LVN C said Resident #19 complained to her about one of the CNA's Thursday, 05/28/2026, being rough with her. She said Resident #19 did not report it to her until Saturday, 05/30/2026, at 7:00 PM. She said Resident #19 reported to her the CNA had been rough with her, rolled her over so hard, she hit her head against the bed rail. LVN C said Resident #19 told her it was a CNA with glasses that worked the 2 PM-10 PM shift, and the description fit CNA B. LVN C said she immediately reported what Resident #19 told her to the Administrator, and the Administrator went to the facility. LVN C said she conducted a skin assessment on Resident #19, and she had no injuries. LVN C said she had not received any complaints from the residents or staff about CNA B or any other staff mistreating the residents.<br><br>During an interview on 06/01/2026 at 10:40 AM, the Administrator said she was notified by RN A the morning of 05/30/2026 that Resident #19 alleged CNA B was rough with her. The Administrator said she identified it as abuse and told RN A to notify the DON because she was in an area where she did not have good signal and was not receiving messages and calls in a timely manner. The Administrator said she expected the DON to follow up, but the DON said RN A had not notified her of the allegation Resident #19 made. The Administrator said when LVN C reported the allegation Resident #19 made to her the evening of 05/30/2026, she was back in town and decided to go to the facility to speak with Resident #19. The Administrator said since she told RN A to report it to the DON, she assumed the DON had taken care of the situation.<br><br>During an interview on 06/04/2026 at 6:08 PM, the DON said when the Administrator called her the evening of 05/30/2026, she went back to review her messages and realized RN A sent her a screenshot of the message the morning of 05/30/2026 that she sent to the Administrator to report the allegation Resident #19 made. The DON said if she had noticed it when it was sent, she would have called the Administrator, removed the staff member, ensured the resident was safe, conducted a skin assessment, called the family and done all the things per the abuse policy, and reported the abuse to HHSC.<br><br>Record review of the facility's policy, Abuse and Neglect, from the Nursing Policy and Procedure Manual revised 03/29/2018, indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment .Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff.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.Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. 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.Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | their hearing distance, regardless of their age, ability to comprehend, or disability . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident.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. 7. 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.Mistreatment: means inappropriate treatment or exploitation of a resident. |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of the bladder and had an indwelling urinary catheter received appropriate treatment and services for 3 of 4 residents (Resident #2, Resident #45, and Resident #57) reviewed for urinary catheters. 1. The facility failed to ensure Resident #57 was provided with proper foley catheter and incontinent care on 06/03/2026.The facility failed to ensure the split in Resident #57's penis was routinely assessed.The facility failed to ensure Resident #57's physician and family were notified of the split in his penis. 2.The facility failed to ensure Resident #2 had on a catheter strap (urinary drainage bag straps) and CNA N wiped correctly and performed hand hygiene while providing incontinent care on 06/02/26. 3. The facility failed to ensure Resident #45's catheter bag was off the ground. These failures could place residents at risk of injury, urinary tract infections, and a decreased quality of life.<br><br>Findings included:<br><br>1. Record review of Resident #57's face sheet dated 06/04/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (weakness and paralysis of the right side of the body after a stroke), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory).<br><br>Record review of Resident #57's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. Resident #57 had a BIMS score of 15, which indicated his cognition was intact. Resident #57 had an indwelling catheter. Resident #57 was dependent on staff for toileting.<br><br>Record review of Resident #57's care plan reviewed 05/12/2026 indicated, he had an foley catheter to change the catheter as ordered, check the tubing for kinks and maintain the drainage bag off the floor, monitor for signs and symptoms of discomfort on urination and frequency. The care plan indicated he required assistance of one staff member for toilet use and bed mobility. Resident #57's care plan did not address providing catheter care, securing the catheter, or care for the split in his penis.<br><br>Record review of Resident #57's Order Summary Report dated 06/03/2026, indicated the following orders:<br><br>*Change Foley Catheter using 18 Fr foley catheter every night shift starting on the 7th and ending on the 7th of every month for urinary retention with an order start date of 09/07/2025.<br><br>*Ensure catheter strap in place and holding every shift for catheter use with an order start date of 06/25/2025.<br><br>*Ensure foley bag is in privacy bag while in bed or wheelchair every shift for catheter use with an order start date of 06/25/2025.<br><br>*Monitor foley catheter every shift for leakage, blockage, sediment buildup, or low output for catheter<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | use with an order start date of 06/25/2025.<br><br>*Provide catheter care every shift for catheter use with an order start date of 03/19/2026.<br><br>*Urinary Catheter 18 Fr to gravity drainage with an order date of 06/23/2025.<br><br>Record review of Resident #57's admission Nurse Note, completed by LVN P, dated 02/07/2025 indicated Resident #57 was continent of urine and did not have any genital abnormalities. Resident #57 did not have a foley catheter.<br><br>Record review of Resident #57's initial skin assessment with an effective date of 02/07/2025 and completed by LVN P, indicated Resident #57 had multiple scattered bruising to bilateral upper extremities, skin tear to left antecubital (inner bend of arm), and an abrasion to right above the knee stump. The assessment did not indicate Resident #57 had penile erosion or penile abnormalities when he admitted to the facility.<br><br>Record review of Resident #57's Weekly Skin Assessments dated from 02/2025- 06/2026 did not indicate Resident #57 had any penile abnormalities.<br><br>Record review Resident #57's event note dated 02/28/2025 at 2:16 PM and signed by RN OO, indicated Shower aide reported observing res (resident) with minimal amt (amount) of bleeding from his penis when she removed his brief when she was getting ready to give him a shower. Affected area assessed for any trauma and no scratches, skin tears or lacerations noted.<br><br>Record review of Resident #57's progress notes dated 03/10/2025- 06/04/2026 did not indicate Resident #57 had any penile abnormalities.<br><br>Record review of Resident #57's TARs dated 02/2025-05/2026 did not indicate Resident #57's received treatment for penis injuries or penile erosion.<br><br>Record review of Resident #57's TARs dated 08/2025 and 05/2026 indicated Resident #56 received catheter care every shift and the catheter strap was ensured it was in place.<br><br>During an observation and interview on 06/03/2026 starting at 2:42 PM, CNA F put on gloves and a gown, unfastened Resident #57's brief pulled it down in front of him and provided catheter care. Resident #57 had brownish residue/spots from discharge coming from his penis. Resident #57's penis had a tear (split) from the top of his penis down to the base (bottom) of his penis. There was redness noted at the base (bottom) of the penis. CNA F used one wipe and circled around Resident #57's penis multiple times using the same wipe. CNA F grabbed another wipe and circled around his penis multiple times and then down the foley catheter tube. CNA F fastened the same brief back onto Resident #57, touched his covers, and repositioned him in the bed using the same gloves. CNA F failed to change her gloves and perform hand hygiene after completing the foley catheter care. CNA F exited the room. CNA F said she was finished. CNA F said she noticed the spots on Resident #57's brief but did not change it because it was just discharge from his penis. After surveyor intervened, CNA F said she would provide incontinent care to Resident #57. CNA F entered Resident #57's room applied gown and gloves, and unfastened Resident #57's brief. CNA F grabbed a wipe and cleaned Resident #57's penis in a circle motion multiple times with one wipe. Resident #57 complained of his penis hurting when CNA F was cleaning it. CNA F said she would notify the nurse. CNA F repeated this with another wipe and then wiped down the catheter tube. CNA F grabbed a clean brief with her dirty gloves and laid it<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | on the bed. CNA F turned Resident #57 on his side but did not ensure the foley catheter was not pulling on his penis. Surveyor intervened, and CNA F placed Resident #57's foley catheter bag on his bed and readjusted the catheter tubing to prevent it from pulling. Resident #57 had flattened, dried stool on his buttocks. CNA F grabbed a wipe and wiped multiple times with the same wipe. CNA F grabbed another wipe and wiped Resident #57's buttocks multiple times to get the stool off. CNA F repeated this with another wipe. CNA F removed her gloves and applied new ones. CNA F failed to perform hand hygiene after removing her dirty gloves. CNA F applied the clean brief, removed her gloves, covered and repositioned Resident #57 with her bare hands.<br><br>During an interview on 06/03/2026 at 2:57 PM, CNA M said she did not provide catheter care to Resident #57 during her shift because she had to leave at 1:00 PM. CNA M said she was not aware the CNAs could provide catheter care. She said she thought the nurses were responsible for providing catheter care. CNA M said she was not aware Resident #57 had a split in his penis. CNA M said it was important for catheter care to be provided to prevent skin breakdown and infection.<br><br>During an interview on 06/03/2026 at 3:05 PM, CNA F said hand hygiene should be performed before providing care and when exiting the resident's room. CNA F said gloves should be changed if they were visibly soiled. CNA F said hand hygiene should be performed after removing her gloves. CNA F said when she was providing catheter care and incontinent care, she should only wipe in one swiping motion. She said the same wipe should not be used to wipe multiple times. CNA F said the clean brief and the residents' clean items should not be touched with dirty gloves. CNA F said she should not have touched Resident #57's covers and repositioned him with bare hands because he required enhanced barrier precautions. CNA F said it was important to change gloves for infection control. CNA F said not applying gloves when necessary and not performing adequate hand hygiene could result in the spread of infection. CNA F said not providing proper catheter care and incontinent care could result in an infection. CNA F said she had been working at the facility for nine years but usually did not provide care to Resident #57. CNA F said she had not noticed Resident #57 had a tear in his penis. CNA F said she should have ensured Resident #57's foley catheter was not pulling when she turned him over. She said the foley catheter pulling could cause an injury to his penis.<br><br>During an interview on 06/03/2026 at 3:17 PM, the ADON said she was aware CNA M left at 1 PM, but CNA M did not inform her Resident #57 had not been checked on since before lunch and she did not perform catheter care. The ADON said the CNAs were supposed to provide foley catheter care at least once a shift and as needed. The ADON said the charge nurses were responsible for ensuring foley catheter care was performed. She said she was the charge nurse for Resident #57, and CNA M told her she had already completed the foley catheter care and she took her word for it. The ADON said when providing foley catheter care and incontinent care the CNAs should wash their hands prior to providing care and after. She said hand hygiene should be performed after glove removal. The ADON said the CNAs should not wipe more than once with the same wipe. They should wipe once, discard the wipe, and then get a clean wipe. The ADON said gloves should be changed prior to touching any clean items. The ADON said if a resident's brief was soiled it should be changed. The ADON said Resident #57 required enhanced barrier precautions and CNA F should not have touched his covers and repositioned him without gloves. The ADON said not performing hand hygiene and glove changes as required could result in cross contamination. The ADON said not providing proper foley catheter and incontinent care could result in UTIs. The ADON said not following enhanced barrier precautions could result in the spread of infection. The ADON said she thought Resident #57 had a foley catheter since he was admitted to the facility. The ADON said she noticed his penis was torn the end of last year (2025) but was unable to provide a date. The ADON said she did not document it because he already had it. She said it should have been documented so they could monitor to see if it had<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | worsened. The ADON said CNA F should have placed Resident #57's catheter bag on the bed with him to prevent it from pulling when she turned him on his side. The ADON said the foley catheter pulling on Resident #57's penis could lead to an injury to his penis.<br><br>During an observation on 06/03/2026 at 3:41 PM, the ADON measured the tear to Resident #57's penis from the top to the bottom and it was approximately 4 cm long.<br><br>During a telephone interview on 06/03/26 at 4:14 PM, Resident #57's Representative #1 stated Resident #57 had a foley catheter on and off for about a year. They stated when he was first admitted he did not have a catheter and was able to urinate on his own. They stated they were not aware Resident #57 had a split in his penis.<br><br>During an interview on 06/03/2026 at 4:15 PM, LVN P said she admitted Resident #57, and she did not remember him having a split penis. LVN P said she was the unit manager until the end of March 2026, and she did not recall it ever mentioned that he had a split penis.<br><br>During a telephone interview on 06/03/26 at 4:20 PM, Resident #57's Representative #2 stated Resident #57 was not admitted to the facility with a catheter, and they were not aware of Resident #57 having a split on his penis.<br><br>During an interview on 06/03/2026 at 4:52 PM, LVN FF said since she started providing care to Resident #57 in August 2025, she noticed he had a split on his penis. LVN FF said Resident #57 had no complaints about it.<br><br>During an interview on 06/03/2026 at 4:38 PM, CNA D said she had been working at the facility for a couple of months. CNA D said Resident #57 complained of pain when she was changing him and she reported it to the nurses, but she was not sure if the nurses were following up. CNA D said she reported it again yesterday, 06/02/2026, to LVN E, and she said she would check on him. CNA D said she was not aware of Resident #57 having any abnormalities to his penis.<br><br>During an interview on 06/03/2026 at 5:32 PM, the facility's NP said Resident #57's foley catheter was placed 02/18/2025 and then he had it off and on until it was left permanently due to urinary retention. The NP said it had not been reported to him that Resident #57 had a tear in his penis. The NP said if he had been notified, he would have had them remove the foley catheter or do in and out catheterization to allow it to heal up or he would have referred him to the urologist to see if he would qualify for a suprapubic catheter. The NP said he was under the assumption Resident #57 had been to the urologist but could not remember. The NP said pulling the foley catheter could make the tear larger.<br><br>During an interview on 06/03/2026 at 5:55 PM, LVN C said she did not admit Resident #57 to the facility, but she had been providing care to him since his admission. LVN C said she was aware Resident #57 had a split in his penis. LVN C said it had been there for a long time, but she was not sure how long he had it. LVN C said she did not remember if she had documented the split in Resident #57's penis. LVN C said if a resident had a split in their penis it should be documented in a nurses note with a description and measurement and the doctor and family should be notified.<br><br>During an interview on 06/04/2026 at 8:49 AM, the facility's Medical Director said he had not been notified of Resident #57 having a split in his penis. The Medical Director said it depended on the circumstance if he would have recommended intermittent catheterization or referral to the urologist<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | for a suprapubic catheter. The Medical Director said he was under the impression Resident #57 had seen a urologist, but he was not sure.<br><br>During an interview on 06/04/2026 at 9:16 AM, Resident #57 said he did not have a catheter prior to entering the facility. Resident #57 said the foley catheter was placed after he was admitted to the facility, and it had been about a year since he had it placed. Resident #57 was not aware of having any injuries to his penis. He said it was sore when they cleaned his penis, but he was not having ongoing pain.<br><br>During an interview on 06/04/2026 at 3:35 PM, LVN E said the CNA reported to her on 06/02/2026 that Resident #57 reported pain to his penis when she provided incontinent care. LVN E said she went to check on him and he was sleeping, and she planned to go back later in her shift, but she did not make it back to him. LVN E said she should have followed up with Resident #57 and assessed him and notified the doctor to see if there were any new orders. LVN E said she usually did not work with Resident #57, so she had not noticed he had a split on his penis. LVN E said if a resident had split on their penis, it should be documented in the nurses' notes, and the doctor and resident representative should be notified.<br><br>During an interview on 06/04/2026 at 4:34 PM, the Administrator said she was not aware of Resident #57 having a split in his penis. The Administrator said if a resident had a split in their penis she expected for the CNA to notify the nurse, and the nurse notify the doctor and family and document it. The Administrator said she expected the residents to be changed if they were dirty, and she expected the CNAs to follow the rules for proper perineal care and catheter care. The Administrator said the DON was responsible for ensuring the staff provided proper perineal/catheter care. The Administrator said proper perineal care and catheter care were necessary to prevent skin breakdown and infections. The Administrator said the CNAs should ensure the catheter was not pulled when they provided incontinent care. The Administrator said the catheter pulling placed the residents at risk for injury.<br><br>During an interview on 06/04/2026 at 5:39 PM, the DON said she was not aware Resident #57 had a split in his penis. The DON said if a resident had a split in their penis, it should be documented and monitoring of it should be documented. The DON said the doctor and the resident representative should be notified. The DON said when providing catheter and incontinent care a wipe should be used in one motion and then a new wipe should be used. The DON said if the CNA noticed the brief was dirty it should have been changed. The DON said hand hygiene should be performed upon entering the resident's room and when exiting the room. The DON said gloves should be changed before touching a clean brief. The DON said when providing care to a resident with a catheter the catheter should be unhooked from the bed frame before rolling the resident, so it would not pull and cause trauma to the penile area or dislodgement of the catheter. The DON said if a resident reported pain during care the CNA should stop, notify the nurse, and the nurse should notify the doctor for any new orders. The DON said she and the charge nurses were responsible for ensuring the CNAs provided proper incontinent/catheter care. She said she monitored by completing competency checks and conducting random checks.<br><br>2.Record review of Resident #2's face sheet, dated 06/04/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses to include senile dementia (mental deterioration or loss of intellectual ability that is associated with or the characteristics of old age), obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract), parkinsonism (description for body movements that have become slow, small, stiff, shaky, and unsteady), and muscle weakness.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of Resident #2's significant change MDS assessment, dated 03/11/26, indicated Resident #2 understood and was understood by others. Resident #2's BIMS score was 12, which indicated his cognition was moderately impaired. The MDS indicated Resident #2 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and set up for eating. The MDS indicated he had an indwelling catheter and was frequently incontinent with bowels.<br><br>Record review of Resident #2's physician orders, dated 06/15/25, indicated: Ensure catheter strap in place and holding every shift and change as needed.<br><br>Record review of Resident #2's physician orders, dated on 01/10/26, indicated: Urinary Catheter 16french (refers to the diameter of the tube)/10 milliliters (refers to the capacity of the sterile water balloon that holds the catheter) coude (a specialized urinary catheter featuring a curved or bent tip) to gravity drainage every shift.<br><br>Record review of Resident #2's hospital record dated 02/10/26 through 02/13/26 revealed Ertapenem (Invanz) intravenous daily for 8 days for Urinary Tract Infection also known as UTI (an infection anywhere in your urinary system (kidneys, bladder, or urethra) caused by bacteria).<br><br>Record review of Resident #2's comprehensive care plan, revised on 03/17/26, indicated Resident #2 had an indwelling catheter related to obstructive uropathy. The interventions were for staff to monitor/record/report to MD for signs or symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, and position catheter bag tubing below the level of the bladder and in a privacy bag.<br><br>Record review of Resident #2's comprehensive care plan, revised on 03/17/26, indicated Resident #2 had an ADL Self Care Performance Deficit. The care plan interventions were for staff to provide assistance x 1 with toileting.<br><br>During an observation and interview on 05/31/26 at 10:30 a.m., Resident #2 was lying in his bed with an indwelling catheter. Resident #2 showed the surveyors his indwelling catheter without a catheter strap noted. He said he usually had a catheter strap.<br><br>During an observation on 06/02/26 at 9:29 a.m., CNA N provided incontinent care for Resident #2 who had an indwelling catheter without a catheter strap and was incontinent with bowel. CNA N wiped his front area and then wiped his indwelling catheter tubing only in the middle; she did clean the head of his penis to the middle of the catheter tubing. CNA N changed her gloves but did not perform hand hygiene. CNA N and CNA D assisted Resident #2 to his left side while keeping the indwelling catheter hooked to the bed frame which caused the indwelling catheter to be pulled. The state surveyor intervened and CNA N disconnected the indwelling catheter bag from the bed frame and laid it on his bed. CNA N wiped his buttock which contained feces, using front to back and back to front motion. CNA N changed her gloves but did not perform hand hygiene before grabbing and applying a clean brief, reconnecting his indwelling catheter to the bed frame, pulling up his pants, and straightening his linen. CNA N then removed her gloves, gathered her equipment, left the room, and then performed hand hygiene.<br><br>During an interview on 06/02/26 at 9:41 a.m., CNA N said she did not realize she did not perform hand hygiene after wiping Resident #2's front side, his backside, or before touching the clean brief, linen, and pulling up his pants. She said she realized after she had completed cleaning Resident #2 that she (continued on next page) |

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|---|---|---|---|
| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>Mount Pleasant, TX 75455 |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | wiped front to back and back to front, did not clean his penis, or wipe down the whole catheter tubing. She said the proper way to wipe his indwelling catheter was to start at the tip of his penis and wipe in a circular motion and then wiping down the catheter tubing. CNA N said she should have disconnected his indwelling catheter bag from the bed frame before turning him to prevent it from pulling. She said the risk could have been pulling out the indwelling catheter. She said she should have wiped from front to back only to prevent urinary tract infections. She said she was supposed to wash her hands when she changed her gloves. She said she knew that without proper incontinent care, or hand hygiene, she could cause cross-contamination and infection.<br><br>During an interview on 06/02/26 at 10:00 a.m., RN H said she was Resident #2's nurse. She said he should have a catheter strap to prevent pulling or dislodgement. She said she was not aware Resident #2 did not have a catheter strap. She said she had not checked the placement of his catheter strap since she started her 6am shift. She said it was nursing's responsibility for ensuring he had on a catheter strap. She said she would apply a catheter strap.<br><br>During an interview on 06/04/26 at 3:01 p.m., the DON said she expected the staff to perform incontinent care correctly. She said she expected staff to wipe front to back and not back to front. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes. She said staff should ensure residents who had an indwelling catheter had on a catheter strap to prevent pulling or dislodgement. She said staff should clean a male resident who had an indwelling catheter from the tip of the penis, cleaning in a circular motion, using a different wipe each time and then wiping the catheter tubing. The DON said they went over incontinence care, indwelling catheter care, and hand washing on hire, and as needed. She said she was the overseer of infection control. She said staff should wipe front to back, clean the indwelling catheter the correct way, change gloves and practice hand hygiene from dirty to clean to prevent urinary tract infections, and cross-contamination.<br><br>During an interview on 06/04/26 at 5:20 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON was responsible for ensuring staff were trained on incontinent care, indwelling catheter care, and infection control. She said improper incontinent care, indwelling catheter care, and hand hygiene could place residents at risk for cross-contamination.<br><br>Record review of CNA N's proficiency skills check off on perineal care with and without an indwelling catheter was successfully completed on 12/08/25.<br><br>3. Record review of face sheet dated 06/04/2026 revealed Resident #45 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of other pericardial effusion (heart does not pump blood effectively), benign prostatic hyperplasia with lower urinary tract symptoms (inflammation of the prostate) and obstructive and reflux uropathy (blockage of urine flow).<br><br>Record review of Quarterly MDS dated [DATE] revealed Resident #45 was able to make himself understood to others and he understood others. MDS assessment indicated Resident #45 had a BIMS score of 15 indicating no cognitive impairment. MDS assessment indicated Resident #45 was occasionally incontinent of bladder.<br><br>Record review of care plan dated 06/04/2026 revealed Resident #45 was care planned for a catheter for urinary retention with the intervention of check tubing for kinks and maintaining the drainage bag off the floor.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of order summary report dated 06/04/2026 revealed Resident #45 had an order for catheter care every shift started on 05/22/2026.<br><br>During an observation on 05/31/2026 at 10:50 a.m., Resident #45 catheter bag was lying on the ground.<br><br>During an observation on 05/31/2026 at 1:15 p.m., it was revealed Resident #45 catheter bag was lying on the ground and had not been emptied.<br><br>During an interview on 05/31/2026 at 2:45 p.m., the CNA Q stated that she was responsible for emptying the catheter bag every shift. CNA Q stated that he performed rounds every two hours to check on the resident to ensure the catheter bag was up off the ground. CNA Q stated that the catheter bag must have fallen off of the bed rail and she was unaware of the bag on the ground at that time. The CNA Q stated she went in to help assist Resident #45 get dressed for the day when she found the catheter bag on the ground. The CNA Q stated Resident #45 was at risk of contamination.<br><br>During an interview on 06/04/2026 at 3:30 p.m., the LVN K stated that he and all nursing staff were responsible for ensuring Resident #45's catheter bag was off of the ground. LVN K stated that he was not aware that Resident #45's catheter bag was on the ground. LVN K stated that Resident #45 was at risk of urinary tract infection and injury.<br><br>During an interview on 06/04/2026 4:03 p.m., the DON stated Resident #45's catheter bag should not be on the ground. The DON stated Resident #45 was at risk of infection and contamination. The DON stated that it was all nursing staff's responsibility for checking Resident #45's catheter and ensuring it was not on the ground. The DON stated CNAs were responsible for checking the bag when emptying the catheter bag.<br><br>During an interview on 06/04/2026 at 4:58 p.m., the Administrator stated that it was nursing's responsibility to ensure that Resident #45's catheter bag was off the ground. The Administrator stated that she expected nursing staff to follow policy and procedures on catheter care. The Administrator stated that Resident #45 was at risk of urinary tract infection and urinary injury.<br><br>Record review of the facility's policy titled, Perineal care, dated 05/2022, indicated, Policy: 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. Procedure Content:17) Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area – CLEAN to DIRTY! Male resident: If applicable, gently wash the juncture of the Foley catheter tubing from the urethra down the catheter about three inches. Pull back the foreskin on uncircumcised males. Hold penis by the shaft. Wash in a circular motion from the tip down to the base. Continue perineal care to the scrotum and inner thigh. Reposition foreskin of uncircumcised males. Use a clean area of the washcloth or pre-moistened cleansing wipes for each stroke.<br><br>Record review of the facility's undated policy, Catheter Care, indicated, Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site.Provide perineal care to the incontinent resident to prevent skin rashes and breakdown.Be sure the catheter tubing and drainage bag are kept off the floor.Report to the supervisor any complaints the resident may have of burning, tenderness, or pain in the urethral area. 11. Wash your hands thoroughly with soap and water or<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | alcohol 12. Apply gloves 13. Providing as much privacy as possible, expose the residents genitalia 14. Hold catheter tubing to one side and support against leg to avoid traction or unnecessary movement of the catheter while washing perineum. 15. Keep drainage bag below level of bladder when cleaning the urethral area: 16. Gently wash, rinse and dry around the juncture of the catheter and meatus. If using Pre-moistened no-rinse disposable wash cloths, rinsing is not required) 17. Then wash the catheter from the meatus down the tube about 3 inches. 18. Dispose of wash cloths 19. Remove gloves 20. Straiten [sic] clothing or bedding 21. Wash Hands 22. Observe for and report to charge nurse: a. Problems or complaints related to procedure b. Skin changes such as rash, redness, irritation, bruising, swelling, discoloration, skin breakdown, drainage, foul odors c. Skin complaints such as burning, itching, tingling, numbness, pain. d. Problems at catheter-meatal junction such as redness, irritation, swelling, crusting, drainage, bleeding or pain e. Urinary complaints such as dysuria, burning, urgency, frequency, or flank pain f. Other significant observations. |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on observation, interviews, and record review, the facility failed to provide a private meeting space for residents' monthly council meetings for 8 of 8 confidential residents who were reviewed for resident rights. The facility failed to ensure staff or visitors did not disturb the resident council meetings.This failure could place residents at risk of not being able to voice concerns, fear of retaliation, and discomfort due to a lack of privacy. Findings included: During a resident council meeting held by the state surveyor on 06/02/26 at 10:40 a.m., 1 staff member and the facility's medical doctor came into the activity room and stated they needed to see two residents that were attending the meeting in a loud tone. During an observation on 06/02/26 at 10:45 a.m., a sign posted on the activity door stating a meeting was in progress.During an interview on 06/02/26 at 10:50 a.m., with 8 alert and orientated residents who attended resident council meeting, they stated the resident council met in the activity room. They stated staff came in and out with no privacy at times, and they filtered what they said due to staff's presence. They could not recall how often they were interrupted but knew it occurred. Residents stated the Activity Director placed a large sign at the entrance to the activity room asking staff not to enter the dining room due to resident council being held. However, staff did not respect the sign.During an interview on 06/03/26 at 10:30 a.m., the Activities Director said she had only been employed for a month but was told the resident council meetings were held in the activity room. She said she posted a sign on the door stating a meeting was in progress for the one meeting they had since her employment. She said she was not aware of staff coming in and out during the resident council meetings. She said she knew staff or visitors could only come to the resident council meeting if they were invited.During an interview on 06/04/26 at 5:00 p.m., LVN E said that the resident council meetings were a closed meeting. She said staff should not come to the meeting unless invited. She said she and the doctor came into the meeting because he needed to see 2 residents. She said one resident had an allergic reaction, and she thought it would be best to interrupt the meeting to meet the residents' needs. During an interview on 06/04/26 at 5:20 p.m., the Administrator said she had only been at the facility for over two months. She said she was not aware of staff coming into the resident council meetings. She said staff had to be invited to come to the resident council meetings and if they were not invited it was against resident rights. Record review of the facility's undated policy titled, 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 residents. Privacy and confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal and medical records.1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that the resident environment remains as free of accident hazards as possible for 4 of 6 residents (Resident's #2, #53, #39, and #52) reviewed for accidents.1.The facility failed to ensure Resident #2 had his fall mat down on 06/01/26, 06/03/26 and 06/04/26.2. The facility failed to ensure CNA Q and CNA O locked the mechanical lift during a transfer for Resident #53 on 05/31/26.3.The facility did not ensure Alcohol Wipes and sanitizing spray were not stored on Resident #39's dresser. 4.The facility failed to ensure Resident #52 room was free from a knife. These failures could place residents at risk of injury or harm.<br><br>Findings included:<br><br>1.Record review of Resident #2's face sheet, dated 06/04/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses to include senile dementia (mental deterioration or loss of intellectual ability that is associated with or the characteristics of old age), obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract), parkinsonism (description for body movements that have become slow, small, stiff, shaky, and unsteady), and muscle weakness.<br><br>Record review of Resident #2's significant change MDS assessment, dated 03/11/26, indicated Resident #2 understood and was understood by others. Resident #2's BIMS score was 12, which indicated his cognition was moderately impaired. The MDS indicated Resident #2 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and set up for eating. The MDS indicated he had a history of falling.<br><br>Record review of Resident #2's comprehensive care plan, last reviewed on 03/17/26, indicated Resident #2 was at risk for falls related to impaired cognition, and impaired mobility. The intervention was for staff to place a Call don't fall sign, ensure floor mat was beside the bed, bed in low position, anticipate and meet the resident's needs, and be sure the resident's call light was within reach and encourage the resident to use it.<br><br>Record review of Resident #2's comprehensive care plan, last reviewed on 03/17/26, indicated Resident #2 had an ADL Self Care Performance Deficit. The care plan intervention was for staff to transfer the resident using a mechanical lift and required one staff member to assist with bed mobility.<br><br>Record review of Resident 2's incident report revealed Resident #2 had a fall from his bed on 3/16/25, 06/01/25, and 06/04/26. The incident report from 06/04/26 indicated he received two skin tears to his 3rd and 4th toes. No other injuries were noted.<br><br>During an observation and interview on 06/01/26 at 8:59 a.m., Resident #2 was in bed with fall mat noted on the wall in front of his bed. Resident #2 said he was not aware if he needed the fall mat beside his bed.<br><br>During an observation on 06/03/26 at 11:23 a.m., Resident #2 was in bed with fall mat noted on the wall in front of his bed.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/04/26 at 2:02 p.m., CNA Q said she was Resident #2's aide on 06/01/26 and she did not place his fall mat down. She said she did not know he was a fall risk. She said she was new to the facility. She said if she did not know how to care for a resident she would ask and look in their Kardex (provided a snapshot of a resident's current status and care requirements). She looked in his Kardex and did not see where Resident #2 had a floor mat care plan. She said she was Resident #2's aide today (06/04/26) and he had a floor mat because he had a fall either late last night (06/03/26) or early this morning (06/04/26).<br><br>During an interview on 06/04/26 at 2:12 p.m., the Regional Nurse Consultant said the aides were supposed to look at the Kardex to see about the care of a resident. She looked at the Kardex for Resident #2 and did not see the floor mat on his Kardex. She said it should be there because he had a fall this morning (06/04/26). She said she was not aware prior to the fall that he should have had the floor mat in place. She said she would get his floor mat placed on his Kardex.<br><br>During an interview on 06/04/26 at 2:23 p.m., LVN K said he was the charge nurse for Resident #2. He said he expected floor mats to be in place for the residents who were at risk for falls. He said as far as he knew Resident #2 was not a fall risk. He said Resident #2 did not have a floor mat down prior to fall today (06/04/26). He said he was unaware Resident #2 had a floor mat on his care plan. He said he had access to Resident #2's care plan but had not seen the floor mat until mentioned by the state surveyor. He said he does have a floor mat down today (06/04/26).<br><br>Record review of Resident #2's Kardex on 06/04/26 at 3:37 p.m., did not reveal the Kardex had been updated to reflect his fall mat at bedside.<br><br>2. Record review of Resident #53's face sheet, dated 06/04/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory), Chronic Obstructive Pulmonary Disease also known as COPD (is a progressive, incurable lung disease that restricts airflow and makes breathing difficult depression(sadness), and high blood pressure.<br><br>Record review of Resident #53's quarterly MDS dated [DATE] indicated she rarely understood and was rarely understood by others. The MDS indicated she had a BIMS score of 00 which meant she was severely cognitively impaired. The MDS indicated Resident #53 required total assistance with her ADLs including transfer.<br><br>Record review of Resident #53's comprehensive care plan last reviewed date of 04/28/26, indicated Resident #53 was at risk for falls related to deconditioning and cognitive impairment. Resident #53 used a wheelchair for mobility and required 2-person mechanical lift for all transfers. The interventions were to use a mechanical lift, anticipate and meet the resident's needs, apply a bolster mattress, and keep furniture in locked position.<br><br>Record review of Resident #53's physician order dated 06/04/26 did not reveal an order for a mechanical lift.<br><br>During an observation on 05/31/26 at 11:31 a.m., Resident #53 was in her bed. CNA Q and CNA O explained to Resident #53 that they were going to assist her to her chair using the mechanical lift. CNA Q and CNA O started connecting the slings to the mechanical lift without locking the wheels of the mechanical lift. CNA Q and CNA O then transported Resident #53 from her bed to her chair and started disconnecting the sling from the mechanical lift without locking the wheels.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/01/26 at 3:11 p.m., CNA O said she thought they locked the mechanical lift prior to getting Resident #53 out of bed and when they placed her in her chair and before they removed the sling from the mechanical lift. She said they should have locked the wheels on the mechanical lift when they connected and disconnected the mechanical lift sling for the safety of Resident #53.<br><br>During an interview on 06/01/26 at 4:19 p.m., CNA Q said they did not lock the wheels of the mechanical lift when they connected and disconnected the mechanical lift sling for Resident #53. She said they should have locked the wheels on the mechanical lift when connecting and disconnecting for the safety of Resident #53.<br><br>During an interview on 06/04/26 at 2:55 p.m., LVN K said he was Resident #53's day shift nurse and was responsible for random checks of the CNAs to ensure they were locking the mechanical lift during the transfer process. He said it was important to lock the wheels of the mechanical lift because the residents' weight could shift and cause the residents to fall out of the slings.<br><br>During an interview on 06/04/26 at 3:01 p.m., the DON said she expected the staff to lock the mechanical lift during the transfer's process. She said they trained on how to use the mechanical lift on hire, annually and as needed. She said she was the overseer of nursing. She said it was important to lock the mechanical lift wheels during the connection and disconnection of the sling to prevent it from moving. She said if the sling moved it could cause the resident to get hurt by falling out or hitting a resident in the head. She said if a resident has an order or if the floor mat was on the care plan she expected the floor mat to be beside the resident's bed. She said nursing staff were responsible for ensuring the floor mat was in place. She said the floor mat was placed beside the bed to prevent further injury. She said the CNAs had access to Kardex. She said Kardex was a communication tool used for staff to see what needs the residents needed for their care. She said she was unaware Resident #2's floor mat was not listed on his Kardex.<br><br>During an interview on 06/04/26 at 5:20 p.m., the Administrator said she expected the staff to use the mechanical lift as they had been trained. She said when staff used the mechanical lift it should be two staff members and they should lock the wheels to prevent the lift from rolling or causing an injury. She said if a resident had an order or care plan for a floor mat then she expected it to be beside the bed when the resident was in bed to prevent injury. She said the DON was the overseer of nursing.<br><br>3. Record review of Resident #39's face sheet, dated 06/04/26, reflected Resident #39 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Parkinson's (brain disorder that causes unintended or uncontrollable movements).<br><br>Record review of Resident #39's significant change in status MDS assessment, dated 04/15/26, reflected Resident #39 made herself understood and usually understood others. Resident #39's BIMS score was 7, which reflected his cognition was severely impaired.<br><br>Record review of Resident #39's comprehensive care plan, revised on 07/08/25, reflected Resident #39 had impaired cognitive function/dementia and impaired thought processes due to Alzheimer's. The care plan interventions included: keep the resident's routine consistent and try to provide consistent care as much as possible to decrease confusion.<br><br>During an observation and interview on 05/31/26 at 10:13 a.m., there was a plastic container labeled alcohol wipes, and a bottle labeled sanitizing on Resident #39's dresser. An attempted interview with (continued on next page) |

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| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>Mount Pleasant, TX 75455 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #39, reflected she was non-interview able due to resident was Spanish speaking only.<br><br>During an interview on 06/03/26 at 9:03 a.m., CNA M stated all staff were responsible for ensuring items were stored properly and securely. CNA M stated she normally did not work this hall and had not noticed the alcohol wipes nor the sanitizing spray on Resident #39's dresser. CNA M stated the wipes should be stored in the storage room and she did not know if the sanitizing spray was allowed in the facility. CNA M stated it was important to ensure items were not left on the resident's dresser for residents' safety.<br><br>During a telephone interview on 06/03/26 at 1:59 p.m., RN A stated all staff were responsible for ensuring items were stored properly and securely. RN A stated she never noticed the items on Resident #39's dresser. RN A stated if she had noticed the items, she would have removed the items and gave them to the ADON or DON. RN A stated she was new and did not know where the items should be stored. RN A stated it was important to ensure items were not left on the resident's dresser for residents' safety.<br><br>During an interview on 06/04/26 at 3:14 p.m., the MDS Coordinator stated she was responsible for daily champion rounds for Resident #39. The MDS Coordinator stated during champion rounds she looked for items that should not be in the resident's room. The MDS Coordinator stated she did not notice the wipes and spray during her rounds this morning. The MDS Coordinator stated the wipes, and spray should be stored in the supply cart or on the nurse's/housekeeping cart. The MDS Coordinator stated it was important to ensure items were not left on the resident's dresser for residents' safety.<br><br>During an interview on 06/04/26 at 3:30 p.m., the DON stated she expected the sanitizing spray to be stored on the housekeeping cart, and wipes to be stored either on the nurses' cart or storage room. The DON stated all staff were responsible for ensuring items were stored properly and securely. The DON stated she monitored compliance by ensuring champion rounds were completed by the assigned department head and random spot checks. The DON stated it was important to ensure items were not left on the resident's dresser for residents' safety.<br><br>During a telephone interview on 06/04/26 at 4:06 p.m., the Administrator stated she expected wipes and sanitizing spray to be behind a locked door or not in the facility. The Administrator stated she did random spot checks, but she expected champions rounds to be done daily by the assigned department head. The Administrator stated it was important to ensure items were not left on the resident's dresser for residents' safety.<br><br>4.<br><br>Record review of face sheet dated 06/04/2026 revealed Resident #52 was a [AGE] year-old female admitted to the facility on [DATE] with the primary diagnosis of heart failure.<br><br>Record review of Quarterly MDS dated [DATE] revealed Resident #52 was able to make herself understood and understood others. MDS assessment revealed Resident #52 had a BIMs score of 15 indicating no cognitive impairment.<br><br>Record review of care plan dated 04/14/2026 revealed Resident #52 was care planned for resident<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | has family bring food and knife. An intervention was listed as staff will remove knife from room when brought and ensure to assist with cutting food if needed.<br><br>During an observation and interview on 05/31/2026 at 11:20 a.m. Resident #52 had a kitchen knife on her bedside table. Resident #52 stated that her daughter brought her fruits and vegetables that she uses the knife to cut with.<br><br>During an interview on 05/31/2026 at 12:00 p.m., LVN K stated that he did not know there was a knife in Resident #52's room. LVN K stated that it was his responsibility to monitor Resident #52's room for hazard items. LVN K stated that Resident #52 was at risk of harming herself with the knife. LVN K stated that he removed the knife from the room and reported it to the DON and Administrator.<br><br>During an interview on 06/04/2026 at 3:36 p.m., the Social Worker stated that facility staff conduct daily Champion Rounds to ensure residents possess only authorized items and that potentially hazardous items are identified and removed. The SW stated champion rounds were not completed on Sunday, 05/31/2026. The SW stated family members bring items into the facility that are not allowed and stated unauthorized items have previously been found in the resident's room. The SW stated Resident #52 was not supposed to have a knife in her room because she was at risk for harm.<br><br>During an interview on 06/04/2026 at 3:41 p.m., the Housekeeping Supervisor stated she entered Resident #52's room daily and was expected to observe the environment for safety concerns including sharp objects and other hazards. The housekeeping supervisor stated room inspections occur while cleaning rooms and emptying trash and are intended to identify environmental hazards that Resident #52 was at risk for injury.<br><br>During an interview on 06/04/2026 at 3:43 p.m., the CNA Q stated he performs rounds every two hours to check on Resident #52 to monitor and identify hazardous materials. The CNA Q stated the resident was not permitted to possess a knife in her room. CNA Q stated she was at risk of harming herself or another resident. The CNA Q stated all staff were responsible for monitoring residents' rooms for safety concerns.<br><br>During an interview on 06/04/2026 at 3:47 p.m., the ADON stated she was not aware of the knife in the room. The ADON stated she found out Resident #52 had a knife in her room after surveyor intervention. The ADON stated that no residents were allowed to have a knife in their room. The ADON stated that Resident #52 was at risk of harming herself. ADON expected all nursing staff and the Champion rounds to ensure Resident #52's room was free of hazards.<br><br>During an interview on 06/04/2026 at 4:01 p.m., the DON stated that Resident #52 should not have had a knife in her room. The DON stated that Resident #52 was at risk of harming herself and others. The DON stated that it was the responsibility of nursing staff to check Resident #52's room for the knife.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/04/2026 at 4:56 p.m., the Administrator stated that she was not aware that Resident #52 had a knife in her room until staff brought it to her attention. The Administrator stated that Resident #52 was not allowed to have a knife in her room and she could injure herself or others. The Administrator stated it was ultimately her responsibility to ensure Resident #52's room was safe and clear of hazards.<br><br>During an interview on 06/04/2026 at 6:33 p.m., the Regional Nurse Consultant stated they do not have a policy for accidents and hazards. The Regional Nurse Consultant stated that they use an admission packet with a list of prohibited items.<br><br>Record review of the Safety Data Sheet .revised on 06/03/2020 reflected. 2. Hazard(s) identification. Classification: serious eye damage/eye irritation, specific target organ toxicity, flammable liquids. 15. Regulatory Information. keep out of reach of children.<br><br>Record review of the Safety Data Sheet .revised on 10/15/19 reflected. Hazard Identification.keep out of reach of children.<br><br>Record review of the facility's policy titled, Hydraulic Lift, undated, indicated, The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance. The number of staff to provide assistance with the transfer should be determined by the manufacturer's recommendations. Goals: #1.The resident will achieve safe transfer to bed or chair via a mechanical lift device. 2.The caregiver will demonstrate safe and correct transfer of the residents to the bed or chair via the hydraulic lift. Procedure: #6. Place the chair next to the head of the bed with the front facing the foot . Lock the wheelchair or Geri chair. #7. Raise the bed to accommodate the lift under the bed. #8. Prepare the lift by setting the adjustable base to the widest possible position. Lock the base wheels according to the lift manufacturer's recommendations.<br><br>Record review of the facility's policy titled, Fall, undated, indicated, Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. Procedure:.Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Reassessment will occur after each fall. Interventions will be resident centered. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 6 residents (Resident #67), 2 of 3 medication carts (A/B MA Medication Cart and C/D Nurse Medication Cart) and 1 of 1 Medication Storage Room reviewed for drugs and biologicals. 1. The facility failed to ensure Resident #67's medication labels for his gabapentin (medication used for nerve pain and seizures) and metoclopramide (medication used to treat nausea, vomiting, and improves stomach emptying) matched his physician orders. 2. The facility failed to ensure a bottle of Active Liquid Protein on the A/B MA Medication Cart was dated when opened. 3. The facility failed to ensure one insulin lispro pen, one Breztri (inhaler used to manage breathing problems), and 2 saline nasal sprays on the C/D Nurse Medication Cart were dated when opened. 4. The facility failed to ensure a multi-dose vial of Aplisol (test administered to diagnose TB) 1 ml in the Medication Storage Room refrigerator was dated when opened. 5. The facility failed to ensure a bottle of liquid Ativan (controlled medication used for the treatment of anxiety) was stored in a permanently affixed lock box in the refrigerator in the Medication Storage Room. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.Findings included: 1. Record review of Resident #67's face sheet dated 06/02/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness of the right side of the body after a stroke) and dysphagia (difficulty swallowing). Record review of Resident #67's Quarterly MDS assessment dated [DATE] indicated he was rarely/never understood and rarely/never understood others. Resident #67 had a short-term and long-term memory problem. Resident #67 was dependent on staff for eating. Resident #67's MDS assessment did not indicate a feeding tube. Record review of Resident #67's Order Summary Report dated 06/02/2026 indicatedGabapentin 100 mg give 100 mg via g-tube three times a day with a start date of 05/28/2026Metoclopramide 10 mg give 10 mg via g-tube four times a day with a start date of 05/29/2026. Record review of Resident #67's care plan initiated 05/28/2026 indicated he had a g-tube related to dysphagia and was NPO. During an observation of medication administration with RN H on 06/01/2026 starting at 4:10 PM, the pharmacy label on the medication card for Resident #67's metoclopramide 10 mg instructed give 10 mg by mouth four times a day, and the pharmacy label on the medication card for Resident #67's gabapentin 100 mg instructed to give 1 tablet by mouth three times a day. RN H administered Resident #67's medications via g-tube. RN H said Resident #67 had gone to the hospital about a week ago and had a g-tube placed. RN H said Resident #67 was NPO and received all his medications and nutrition via g-tube. RN H said when the order was changed to g-tube a change of direction sticker should have been placed on Resident #67's medication cards to indicate the route of administration had changed. RN H said the route was one of the rights of medications so it was important it was correct and somebody that did not know Resident #67 was NPO could try to give his medications by mouth. 2. During an observation and interview with MA L on 06/02/2026 at 10:06 AM, the A/B MA Medication Cart had a bottle of Active Liquid Protein that was opened and there was no date indicating when it was opened. The label of the Active Liquid Protein indicated it had a 3-month shelf life from date opened. MA L said she had been instructed that the liquid protein did not have to be dated when opened. MA L said she could not remember who told her she did not have to date it when it was opened. 3. During an observation and interview with RN H on 06/02/2026 at 10:14 AM, the C/D Nurse Medication Cart had one insulin lispro pen, one Breztri inhaler, and 2 saline nasal sprays with no date opened. RN H said the nurse who opened the<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medication was responsible for dating it. She said she randomly went through the medications on the medication cart and threw away the ones with no open date. RN H said it was important to date these medications when they opened them because they could become ineffective or lose their potency. 4. During an observation and interview with LVN K on 06/03/2026 at 8:42 AM, in the facility's only medication storage room, the refrigerator with medications in it had an open vial of Aplisol 1 ml with no open date on it. LVN K said whoever opened the medication should place an open date on it. LVN K said it was important for medications like Aplisol to be dated when opened because once it was opened it only lasted certain days, and administering past the designated number of days could result in it being ineffective. 5. During an observation and interview with the ADON on 06/03/2026 at 9:07 AM, in the facility's only medication storage room, the locked refrigerator had a lock box with a bottle of liquid Ativan inside of it. The lock box had a chain to it but was not bolted to the refrigerator. The lock box was easily removed from the inside of the refrigerator. The ADON said the lock box had always been detachable. The ADON said the DON was responsible for ensuring controlled medications were stored properly. The ADON said the lock box not being permanently affixed to the refrigerator could result in somebody stealing the lock box and leaving with the controlled medications inside it. During an interview on 06/04/2026 at 4:43 PM, the Administrator said she expected medications to be labeled and dated properly. The Administrator said the DON was responsible for monitoring this. The Administrator said the residents could get expired medications if they were not dated properly. The Administrator said she expected controlled medications to be stored properly. The Administrator said someone could walk away with the lock box if it was not permanently affixed to the refrigerator. The Administrator siad the DON was responsible for ensuring controlled medications were stored properly. During an interview on 06/04/2026 at 5:25 PM, the ADON said insulin pens, the liquid protein, nasal sprays, and inhalers should be dated immediately when opened. The ADON said she and the DON monitored for this, but she was not sure on how frequently they monitored. The ADON said when there was a medication change a change of direction label should be placed on the medication card. The ADON said the label not matching the medication order could result in the wrong medication being administered or the wrong route. During an interview on 06/04/2026 at 5:53 PM, the DON said insulin pens, the liquid protein, nasal sprays, and inhalers should all be dated when opened, so the staff knew when they would expire after being opened and they could be discarded. The DON said she had only been at the facility a couple of weeks, but she tried to spot check the medication carts. The DON said she currently did not have a system in place for monitoring for labeling and dating of medications. The DON said a sticker indicating the route had changed should have been placed on Resident #67's medications. The DON said the charge nurse was responsible for doing this. The DON said the medication could have been administered via the wrong route. The DON said the lock box containing the Ativan should have been permanently affixed to the refrigerator because if it was not somebody could just pick it up and take it out. She said she was not aware it was not permanently affixed, and she, the ADON, and nurses were responsible for ensuring the lock box was affixed to the refrigerator. During an interview on 06/04/2026 at 6:30 PM, the Regional Compliance Nurse said there was no policy for dating medications when opened. Record review of the facility's policy, Ordering Schedule II Controlled Medications, form the Pharmacy Policy & Procedure Manual 2003, indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations. The policy did not further address the storage of controlled medications in a lock box. Record review of the facility's policy, Physician Orders, from the Medical Records Manual 2015, indicated, To monitor and ensure the accuracy and completeness of the medication orders.The receiving nurse will contact any other department or external facilities as required, i.e. dietary department, pharmacy. The policy did not further address labeling medication cards after an order change. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services. The facility did not ensure:1. Food items were labeled and dated.2. [NAME] restraints were worn. 3. The dome covers were not stacked with water pooled between them. 4. The microwave was clean and free of food debris.5. The deep fryer was clean. 6. The ice scoop holder was clean. 7. Food was discarded after 7 days per facility policy or by best by date. These failures could place residents at risk for foodborne illness.Findings included: During an initial tour observation and interview with [NAME] T on 05/31/26 beginning at 9:16 a.m. until 9:45 a.m. the following was revealed: 1.Cook T was not wearing a beard restraint. The state surveyor observed facial beard hair. He stated he forgot to put one on. 2. A bag of turkey breast dated 05/20/26. 3. A bag of crumble feta cheese with a best by date 11/18/25 with green substance noted. 4. A box of cream cheese undated. 5. A clear bag with onion that was identified by [NAME] T unlabeled and undated. 6. 2 chocolate pies unlabeled and undated. 7. (4) 16 oz of cool whip undated. 8. A bag of mixed berries that was identified by [NAME] T unlabeled and undated. 9. 3 loaves of Texas toast bread undated. 10. 1 loave of cinnamon bread undated. 11. Inside the microwave was a brown buildup. 12. The deep fryer had golden food crumbs of various sizes observed on the inside surfaces. 13. The dome covers were stacked and remained wet with water pooled in between. 14. The ice machine scoop holder had several black pieces floating in the bottom. 15. The water, juice and tea that was located at the beverage station was labeled 05/30/26. During an interview on 06/04/26 at 1:23 p.m., Dietary Aide V stated all staff were responsible for labeling and dating. Dietary Aide V stated all staff were responsible for cleaning the microwave. Dietary Aide V stated the beverage at the beverage station should be discarded every 24 hours by the dietary aide. Dietary Aide V stated the failures put residents at risk for food borne illness and cross contamination. During an interview on 06/04/26 at 1:32 p.m., Dietary Aide U stated all staff were responsible for labeling and dating. Dietary Aide U stated she was the person that washed the dishes, which was her responsibility for ensuring the dome covers were air dried before stacking. Dietary Aide U stated the failures could potentially put residents at risk for foodborne illness and cross contamination. During a telephone interview at 06/04/26 at 1:45 p.m., the Dietician stated the turkey breast should have been discarded between 3-7 days. The Dietician stated the crumble cheese should have been discarded by the best by date once it was taken out of the freezer. The Dietician stated the deep fryer should be cleaned once a week and as needed. The Dietician stated the microwave should be cleaned daily and as needed. The Dietitian stated all staff were responsible for labeling and dating. The Dietitian stated the dome covers should be air dried before stacking. The Dietitian stated she was not sure what the policy was on the ice scoop holder, but she believed it should be cleaned weekly at the minimum. The Dietitian stated bear guard should be worn while in the kitchen. The Dietitian stated the beverage station should be discarded every 24 hours. The Dietician stated she monitored by monthly observations. The Dietician stated the failures could potentially put residents at risk for foodborne illness and cross contamination. During an interview on 06/09/26 at 1:55 p.m., [NAME] T stated all staff were responsible for labeling and dating. [NAME] T stated the cook was responsible for ensuring food was discarded after 7 days of the best by date. [NAME] T stated the microwave should be cleaned daily and as needed. [NAME] T stated the deep fryer should be cleaned at least twice a week. [NAME] T stated Maintenance was responsible for cleaning the ice scoop holder. [NAME] T stated these failures could potentially put residents at risk for foodborne illness and cross contamination. During an interview on 06/04/26 at 2:04 p.m., the Maintenance Supervisor stated he was responsible for cleaning the ice scoop holder. The Maintenance Supervisor stated it should be cleaned monthly. The Maintenance Supervisor stated a dirty ice scoop holder could contaminate the ice. During an interview<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | on 06/04/26 at 2:51 p.m., the Dietary Manager stated all food should be labeled and dated by the date received and the date it was opened. The Administrator stated kitchen equipment should be cleaned daily for sanitization purposes. The Dietary Manager stated the turkey breast should have been discarded within 7 days and the crumble cheese by the best by date after removing it from the freezer. The Dietary Manager stated dome covers should be air dried before stacking. The Dietary Manager stated the juice station should be discarded every night. The Dietary Manager stated beard restraints should be worn while in the kitchen. The Dietary Manager stated she was responsible for monitoring and overseeing daily walk throughs and when there was an issue staff were verbally in service. The Dietary Manager stated the failures could potentially put residents at risk for cross contamination and foodborne illness. During a telephone interview on 06/04/26 at 4:06 p.m., the Administrator stated she expected food to be labeled/dated properly, discarded by the end of the 7th date and best by date. The Administrator stated kitchen equipment should be cleaned after use and as needed for sanitization purposes. The Administrator stated the drome covers should be air dried prior to stacking. The Administrator stated the beverage bar should be discarded after 24 hours. The Administrator stated the beard restraint should be worn while in the kitchen. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing the kitchen. The Administrator stated she did do daily rounds in the kitchen and has not noticed any issues. The Administrator stated the failures could potentially put residents at risk for cross contamination, and food borne illness. Record review of FDA 2-402.11, dated 2022, revealed FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE_SERVICE and SINGLE-USE ARTICLES. Record review of the facility's policy titled, Dietary Food Service Personnel Policy and Procedures dated 2012 reflected. Sanitation and Food Handling: 2. [NAME] guards are required for facial hair.11. All unused food must be securely covered. All items are to be dated and labeled as to their content. Store items in their original container unless instructed to do otherwise. Record review of the facility's policy titled, Food Storage and Supplies dated 2012 reflected. All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies.6. When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Record review of the facility's policy titled, Food Safety dated 2012 reflected. 2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly. Perishable opened foods shall be used within 7 days or less, in compliance with the Texas Food Establishment rules. 5. Place scoop in a separate container with the handle up. It is to be washed daily. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 7 of 22 residents (Resident #67, #2, #13, #57, #21, #19, and # 45) reviewed for infection control.1.The facility did not ensure LVN E performed hand hygiene when providing wound care for Resident #67's who had methicillin-resistant staphylococcus aureus also known as MRSA (is a type of staph that can be resistant to several antibiotics) and who put dirty wipes on his bed linen on 06/02/26.2. The facility failed to ensure CNA N performed hand hygiene while providing incontinent care for Resident #2 on 06/02/26.3. The facility failed to ensure the Housekeeping Supervisor followed contact precautions while cleaning Resident #13's room. 4. The facility failed to ensure the Social Worker followed contact precautions while placing Resident #13's lunch tray on her bedside table5.The facility failed to ensure CNA O followed enhanced barrier precautions when she provided direct care to Resident #57, who had a catheter, on 06/04/2026 and did not wear a gown. 6.The facility failed to ensure MA G performed hand hygiene and cleaned the blood pressure cuff during medication administration on 06/01/2026. 7.The facility failed to ensure EBP was worn while providing care to Resident #45. These failures could place any resident at the facility at risk for cross-contamination and the spread of infection.<br><br>Finding included:<br><br>1. Record review of Resident #67's face sheet, dated 06/04/26, reflected Resident #67 was an [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis which included stroke, malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it actually consumes), dysphagia (difficulty or discomfort in swallowing), diabetes (high blood sugars), and high blood pressure.<br><br>Record review of Resident #67's quarterly MDS assessment, dated 05/11/26, reflected Resident #67 rarely made himself understood, and was rarely understood by others. Resident #67's had severe cognitive skills for daily decision making. The MDS indicated he required total assistance with his ADL's including toileting. The MDS indicated he was frequently incontinent of bladder and always incontinent with bowls. The MDS indicated he had venous and/or arterial ulcers and skin tears.<br><br>Record review of Resident #67's comprehensive care plan, revised on 06/02/22, indicated Resident #67 had an ADL Self Care Performance Deficit related to his stroke. The care plan interventions were for staff to provide assistance x 1 with toileting.<br><br>Record review of Resident #67's comprehensive care plan revised date of 05/12/26 reflected Resident #67 had arterial/ischemic ulcers (a sore caused by poor blood flow, usually on the legs or feet) related to arteriosclerosis (a broad term for the thickening, hardening, and loss of elasticity in the walls of your arteries). He had arterial wounds on his bilateral heels. The intervention was for staff to monitor/document wound size, depth, margins: peri wound skin, and signs or symptoms of infection. Provide wound care as ordered, obtain lab as ordered, and see wound physician.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #67's physician;s orders dated 05/12/26 indicated: Right heel arterial ulcer: Clean w/wound cleaner; pat dry, apply calcium alginate with silver to the wound bed, and cover with optifoam heel (non-adhesive foam) dressing and secure with Coban self-adherent wrap until resolved. every day shift for wound care.<br><br>Record review of Resident #67's physician's orders dated 05/14/26 indicated: Cleanse wound to the right buttocks with wound cleanser, pat dry with gauze, and prepare wound with skin prep, place collagen sheet to the wound bed, place calcium alginate with silver on top of collagen, and cover with a border gauze dressing daily and as needed every day for wound care.<br><br>Record review of Resident #67's physician's order dated 05/19/26 indicated: contact isolation related to MRSA in the right heel wound.<br><br>Record review of Resident #67's comprehensive care plan revised date of 05/31/26 reflected Resident #67 had contact precautions related to MRSA in his right heel wound. The intervention was for staff to put gown and gloves prior to entering the resident's room, after resident care, remove gown and gloves in the resident's room and place in the container for soiled PPE, and perform hand hygiene after removing gown and gloves.<br><br>During an observation on 06/02/26 at 1:00 p.m., revealed LVN E performed wound care for Resident #67. LVN E removed the old wound dressing from his right heel, then cleaned area with wound cleanser and applied new dressing without performing hand hygiene after removing the dirty dressing. She then pulled down his linen with the same dirty gloves. LVN E then assisted Resident #67 to turn on his side while touching his skin and clothing with the same dirty gloves. Resident #67 had a bowel movement and LVN E cleaned him while placing the dirty wipes on the bed. LVN E then grabbed a clean brief and applied it while still having on the same dirty gloves. She then removed the old dressing from his right buttock, cleaned the area, and applied clean a dressing while still having on the same dirty gloves from the right heel treatment and incontinent episode of bowel. LVN E then gathered her equipment, removed her gloves, and performed hand hygiene.<br><br>During an interview on 06/02/26 at 1:54 p.m., LVN E said she did not realize she did not perform hand hygiene or change her gloves after removing Resident #67's old dressing or providing incontinent care. She said she was nervous. She said she should have removed his old dressing, removed her gloves, performed hand hygiene, and applied new gloves before cleaning and applying his new dressing. She said she should have removed her gloves and performed hand hygiene and applied new gloves after she provided incontinent care and before she applied his clean brief. She said she should have placed the dirty wipes in the trash and not on his bed. She said anytime she went from dirty to clean she should have changed her gloves and performed hand hygiene to prevent cross-contamination, infection, and/or further spread of infection.<br><br>2.Record review of Resident #2's face sheet, dated 06/04/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses to include senile dementia (mental deterioration or loss of intellectual ability that is associated with or the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | characteristics of old age), obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract), parkinsonism (description for body movements that have become slow, small, stiff, shaky, and unsteady), and muscle weakness.<br><br>Record review of Resident #2's significant change MDS assessment, dated 03/11/26, indicated Resident #2 understood and was understood by others. Resident #2's BIMS score was 12, which indicated his cognition was moderately impaired. The MDS indicated Resident #2 required assistance with toileting. The MDS indicated he had an indwelling catheter and was frequently incontinent with bowels.<br><br>Record review of Resident #2's physician's orders, dated on 01/10/26, indicated: Urinary Catheter 16french (refers to the diameter of the tube)/10 milliliters (refers to the capacity of the sterile water balloon that holds the catheter) coude (a specialized urinary catheter featuring a curved or bent tip) to gravity drainage every shift.<br><br>Record review of Resident #2's comprehensive care plan, revised on 03/17/26, indicated Resident #2 had an indwelling catheter related to obstructive uropathy. The interventions were for staff to position catheter bag and tubing below the level of the bladder and in a privacy bag.<br><br>Record review of Resident #2's comprehensive care plan, revised on 03/17/26, indicated Resident #2 had an ADL Self Care Performance Deficit. The care plan interventions were for staff to provide assistance x 1 with toileting.<br><br>During an observation on 06/02/26 at 9:29 a.m., revealed CNA N provided incontinent care for Resident #2 who had an indwelling catheter. and was incontinent with bowel. CNA N wiped his front area and then wiped his indwelling catheter tubing only in the middle; she did clean the head of his penis to the middle of the catheter tubing. CNA N changed her gloves but did not perform hand hygiene. CNA N and CNA D assisted Resident #2 to his left side. while keeping the indwelling catheter hooked to the bed frame. CNA N disconnected the indwelling catheter bag from the bed frame and laid it on his bed. CNA N wiped Resident #2's buttock which contained bowel using front to back and back to front motion. CNA N changed her gloves but did not perform hand hygiene before grabbing and applying a clean brief, reconnecting his indwelling catheter to the bed frame, pulling up his pants, and straightening his linen. CNA N then removed her gloves, gathered her equipment, left the room, and then performed hand hygiene.<br><br>During an interview on 06/02/26 at 9:41 a.m., CNA N said she did not realize she did not perform hand hygiene after wiping Resident #2, front side, his backside, or before touching the clean brief, linen, and pulling up his pants. She said she was supposed to wash her hands when she changed her gloves. She said she knew that without proper incontinent care, or hand hygiene, she could cause cross-contamination and infection.<br><br>During an interview on 06/04/26 at 2:23 p.m., LVN K said he was the charge nurse for Resident #2. He (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | said he expected staff to use proper techniques when providing incontinent or indwelling catheter care. He said for incontinent care they should change gloves and hand hygiene when going from front to back, and they should only wipe front to back. He said he expected them to do those things to prevent infections. He said if he saw staff doing something wrong, he would correct and educate them.<br><br>During an interview on 06/04/26 at 3:01 p.m., the DON said she expected the staff to perform incontinent care correctly. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes. The DON said she expected the treatment nurse to perform wound care the correct way without contamination. She said when performing wound care, staff should remove the old dressing (if present), remove the dirty gloves, perform hand hygiene, and apply new gloves. The DON said they went over incontinence care, hand washing, and wound care on hire, and as needed. She said she was the overseer of infection control. She said staff should not put dirty wipes on residents beds, change gloves and practice hand hygiene from dirty to clean to prevent infection, and cross-contamination.<br><br>During an interview on 06/04/26 at 5:20 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON was responsible for ensuring staff were trained on incontinent care, wound care, and infection control. She said improper incontinent care, wound care, and hand hygiene could place residents at risk for cross-contamination.<br><br>3.Record review of Resident #13's face sheet, dated 06/04/26, reflected Resident #13 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included senile degeneration of brain (progressive decline in mental abilities due to physical brain deterioration in older age).<br><br>Record review of Resident #13's quarterly MDS assessment, dated 03/12/26, reflected Resident #13 made herself understood and understood others. Resident #13's BIMS score was a 7, which reflected his cognition was severely impaired.<br><br>Record review of Resident #13's undated comprehensive care plan, reflected Resident #13 was on contact precautions related to shingles (a viral infection that causes a painful rash). The care plan interventions included: put on a gown and gloves prior to entering the resident's room.<br><br>Record review of Resident #13's order summary dated 06/04/26 reflected an active contact isolation order related to shingles diagnosis every shift for infection control with a start date 05/28/26.<br><br>During an observation and interview on 05/31/26 at 1:15 p.m., revealed the Housekeeping Supervisor was observed coming out of Resident #13's bathroom without wearing a gown. The Housekeeping Supervisor removed her gloves, performed hand hygiene and reapplied gloves, and went to open Resident #13's window blinds. The Housekeeping Supervisor stated while in the bathroom she cleaned Resident #13's toilet, bathroom sink, swept, mop and took out the trash can. The Housekeeping Supervisor stated she only had to wear a gown and mask if she was touching the resident.<br><br>During an observation and interview on 05/31/26 at 1:18 p.m., the DON approached where the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Housekeeping Supervisor was being interviewed. The DON was asked what PPE the Housekeeping Supervisor should wear while in Resident #13's room and she stated gloves because she was not providing care to Resident #13.<br><br>During an observation on 05/31/26 at 1:20 p.m., the Social Worker took Resident #13's lunch tray and placed it on her bedside table without wearing a gown and gloves.<br><br>During an interview on 06/03/26 at 3:34 p.m., the Social Worker stated she was not aware Resident #13's was on contact precautions. The Social Worker stated she thought if she was not touching Resident #13 a gown and gloves did not have to be worn. The Social Worker stated it was important to ensure infection control practices were done to prevent the spread of infection.<br><br>During an interview on 06/4/26 at 3:30 p.m., the DON stated she was the Infection Control Preventionist for the facility. The DON stated she was caught off guard on 05/31/26 when she asked what PPE should be worn with contact precautions. The DON stated after she thought about it, she immediately went and did a verbal in-service with the Housekeeping Supervisor. The DON stated a gown and gloves should be worn prior to entering the room. The DON stated she monitored infection control practices by random spot checks, skill checks and in-services. The DON stated it was important to ensure infection control practices were followed to prevent the spread of infection.<br><br>During a telephone interview on 06/04/26 at 4:06 p.m., the Administrator stated she expected a gown and gloves to be worn prior to entering Resident #13's room. The Administrator stated the DON and ADON were responsible for monitoring infection control practices. The Administrator stated it was important to ensure infection control practices were followed to prevent the spread of infection.<br><br>4. During an observation and interview of medication administration on 06/01/2026 beginning at 7:50 AM, MA G checked Resident #21's blood pressure and returned the blood pressure cuff to the top of her medication cart. MA G did not clean the blood pressure cuff. MA G administered medications to Resident #21. MA G did not perform hand hygiene. MA G checked Resident #19's blood pressure with the same blood pressure cuff she used on Resident #21 returned the blood pressure cuff to the top of her medication cart. MA G did not clean the blood pressure cuff. MA G prepared and administered medications to Resident #19. MA G said hand hygiene should be performed before and after providing care to the residents. MA G said she should have performed hand hygiene when she finished administering medications to Resident #21 and before administering medications to Resident #19. MA G said the blood pressure cuff should be sanitized between residents. MA G said not performing adequate hygiene could result in the residents catching what the other resident had. MA G said the blood pressure cuff needed to be sanitized because it could get germs on it.<br><br>Record review of Resident #57's face sheet dated 06/04/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (weakness and paralysis of the right side of the body after a stroke), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory).<br><br>Record review of Resident #57's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. Resident #57 had a BIMS score of 15, which indicated his cognition was intact. Resident #57 had an indwelling catheter. Resident #57 was dependent on<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | staff for toileting.<br><br>Record review of Resident #57's Order Summary Report dated 06/03/2026 indicated urinary catheter 18 fr to gravity with a start date of 06/23/2025. Resident #57's Order Summary Report did not indicate the use of enhanced barrier precautions.<br><br>Record review of Resident #57's care plan reviewed 05/12/2026 indicated, he required enhanced barrier precautions related to a foley catheter. Resident #57's care plan indicated gloves and gown should be donned if any of the following activities were to occur linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, catheter care, bathing or other high-contact activity.<br><br>During an observation on 06/04/2026 at 9:13 AM, CNA O entered Resident #57's room, put on gloves, unbuckled his brief, and was touching his brief, penis, and foley catheter for the surveyor to make an observation of Resident #57's penis and foley catheter insertion site. CNA O failed to put on a gown.<br><br>During an interview on 06/04/2026 at 1:18 PM, CNA O said enhanced barrier precautions should be followed if the resident had a foley catheter. CNA O said she should have put on a gown when she went into Resident #57's room. CNA O said she was in a hurry and forgot to put the gown on. CNA O said it was important for enhanced barrier precautions to be followed to avoid transmitting infections to others.<br><br>During an interview on 06/04/2026 at 4:49 PM, the Administrator said she expected the staff to follow enhanced barrier precautions and wear the appropriate PPE when providing care to the residents. The Administrator said the facility's infection control preventionist was responsible for ensuring this happened. The Administrator said not wearing the proper PPE could cause an infection. The Administrator said she expected the staff to perform hand hygiene as required, and if they did not it could cause an infection to travel. The Administrator said the DON and nurse management were responsible for monitoring to ensure hand hygiene was performed. The Administrator said the blood pressure cuff should be wiped down between residents. The Administrator said the DON and nurse management were responsible for monitoring to ensure this happened. The Administrator said no cleaning the blood pressure cuff between residents could lead to an infection.<br><br>During an interview on 06/04/2026 at 5:19 PM, the ADON said a gown and gloves should be applied when entering the room of a resident requiring enhanced barrier precautions. The ADON said a resident with a foley catheter required the use of enhanced barrier precautions. The ADON said the charge nurses and nurse administration were responsible for ensuring enhanced barrier precautions were followed. The ADON said she monitored by making observations when she was walking through the halls. The ADON said not following enhanced barrier precautions could result in infection being spread. The ADON said hand hygiene should be performed before starting medication administration, after preparing the medications, before giving the resident their medications, and when finished administering medications. The ADON said nursing administration was responsible for ensuring proper hand hygiene was taking place during medication administration and she monitored by making observations when she was walking around the facility. The ADON said not performing hand hygiene as required could result in infection being passed from one resident to another. The ADON said the blood pressure cuff should be cleaned between residents. The ADON said the nurses were responsible for ensuring this happened and it was monitored when she walked through the halls. The ADON said not cleaning the blood pressure cuff between residents was an infection control issue.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/04/2026 at 5:46 PM, the DON said a resident with a foley catheter required enhanced barrier precautions when providing direct care. The DON said gown and gloves should be worn when touching the patient in any kind of way. The DON said she was responsible for monitoring, and she randomly checked when she was walking through the facility to see if the staff were following the enhanced barrier precautions. The DON said if a gown and gloves were not worn, they could transfer infections or bugs to other residents. The DON said wearing the gown and gloves protected the residents from infection. The DON said hand hygiene should be performed before starting medication administration and then after, before they moved on to the next resident. The DON said she was responsible for ensuring the staff was performing hand hygiene adequately, and she monitored by checking randomly when she was walking through the facility. The DON said hand hygiene was necessary for infection control because if hand hygiene was not performed when needed they could give germs from resident to resident. The DON said the blood pressure cuff should be sanitized after use, and she was responsible for monitoring to ensure this happened. The DON said she made random observations to ensure the staff were properly sanitizing the blood pressure cuffs. The DON said not sanitizing the blood pressure cuff between residents was an infection control issue.<br><br>5. Record review of face sheet dated 06/04/2026 revealed Resident #45 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of other pericardial effusion (heart does not pump blood effectively), benign prostatic hyperplasia with lower urinary tract symptoms (inflammation of the prostate) and obstructive and reflux uropathy (blockage of urine flow).<br><br>Record review of Quarterly MDS dated [DATE] revealed Resident #45 was able to make himself understood to others and he understood others. MDS assessment indicated Resident #45 had a BIMS of 15 indicating no cognitive impairment. MDS assessment indicated Resident #45 was occasionally incontinent of bladder.<br><br>Record review of care plan dated 06/04/2026 revealed Resident #45 was care planned for a catheter for urinary retention with the invention of check tubing for kinks and maintaining the drainage bag off the floor.<br><br>Record review of order summary report dated 06/04/2026 revealed Resident #45 had an order for catheter care every shift started on 05/22/2026.<br><br>Observation on 06/03/2026 at 9:43 a.m., it was revealed Shower Aide R did not wear EBP when showering Resident #45.<br><br>Interview on 06/03/2026 at 10:40 a.m., Resident #45 stated that staff did not wear a gown and gloves for EBP when proving him with a shower.<br><br>Interview on 06/03/2026 at 10:45 a.m., Shower Aide R revealed that she was unaware she needed to wear a gown and gloves when showering Resident #45 with a catheter. Shower Aide R stated it was her job to shower Resident #45.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 06/04/2026 at 11:11 a.m., the LVN K stated Resident #45 was on EBP and he expected all nursing staff to wear a gown and gloves when providing direct contact care to Resident #45. The LVN K stated EBP was to prevent the spread of infection and contamination.<br><br>Interview on 06/04/2026 at 3:49 p.m., the ADON revealed she expected Shower Aide R to wear PPE when showering Resident #45. The ADON stated Resident #45 was at risk of infection with his catheter. The ADON stated that she was not aware staff were not wearing PPE when providing showers to residents with catheters.<br><br>Interview on 06/04/2026 at 4:00 p.m., the DON stated she expected all staff to wear a gown and gloves when providing direct contact care to Resident #45 who is on EBP. The DON stated that she expected Shower Aide R to wear a gown and gloves when showing Resident #45. The DON stated that she had spoken to nursing staff about wearing gowns and gloves in the shower but had not had a formal in-service since taking on her role. The DON stated that the gown and gloves were to prevent the spread of infection.<br><br>Interview on 06/04/2026 4:59 p.m., the Administrator stated that she expected Shower Aide R to wear gown and gloves when showering Resident #45 with a catheter to prevent the spread of infection. The Administrator stated that it was the DON responsibility to ensure nursing staff were aware of the policy and procedures regarding infection prevention. The administrator stated that all direct care staff were supposed to wear a gown and gloves when they provided care to Resident #45.<br><br>Record review of the facility's policy titled Wound Treatment Management, undated, indicated, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. -Policy Explanation and Compliance Guidelines: #1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.<br><br>Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, undated, indicated, Policy: A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. #1. Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: When coming on duty; When hands are visibly soiled (hand washing with soap and water);Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); Before and after performing any invasive procedure (e.g., fingerstick blood sampling); Before and after entering isolation precaution settings; Before and after assisting a resident with personal care (e.g., oral care, bathing); Before and after inserting indwelling catheters; Before and after changing a dressing; Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident);.Before and after assisting a resident with toileting (hand washing with soap and water);After contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans, catheters and urinals; After handling soiled equipment or utensils; After removing gloves or aprons; (continued on next page) |

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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>Mount Pleasant, TX 75455 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and After completing duty. Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant. Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infection.<br><br>Record review of the facility's undated policy, Enhanced Barrier Precautions, indicated, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. Indwelling medical device examples include urinary catheters. Changing briefs or assisting with toileting, Dressing a resident, Any other high-contact activity that includes close bodily contact or coming into contact with the indwelling medical device don gloves and gown. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 21 residents (Resident #19) reviewed for resident rights. The facility failed to ensure CNA B treated Resident #19 with dignity and respect, when she failed to identify herself and ensured she wore a name badge while providing care to Resident #19. This failure could place residents at risk of decreased self-worth, loss of dignity and trust, and a diminished quality of life.Findings included: Record review of Resident #19's face sheet dated 06/01/2026 indicated she was an [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), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), and essential primary hypertension (high blood pressure). Record review of Resident #19's MDS assessment dated [DATE] indicated she was understood by others and understood others. Resident #19 had a BIMS score of 15, which indicated her cognition was intact. Resident #19 was dependent on staff for toileting hygiene. Record review of Resident #19's care plan reviewed 04/21/2026 indicated she had impaired thought processes to engage in simple, structured activities that avoided overly demanding tasks and to provide the residents with a homelike environment. Resident #19's care plan indicated she had an ADL self-care performance deficit and required assistance of one staff member for bathing, bed mobility, dressing, toilet use and transfers. During an interview on 05/31/2026 at 10:02 AM, Resident #19 said there was an African American CNA with brown glasses that did not identify herself and did not wear a name badge. Resident #19 said she did not like that the CNA did not identify herself and did not wear a name badge because she did not know who she was. During an observation and interview on 05/21/2026 at 2:49 PM, CNA B was not wearing a name badge. CNA B said when she provided care, she identified herself and explained to the residents what she was going to do. CNA B said she had worked at the facility for about a month and she had not been provided with a name badge, so she had not been wearing one. She said when she was hired the human resources person told her they were going to provide a name badge for her, but it had not been provided, and she had not asked about it again. CNA B said it was important to identify herself when she provided care and wore a name badge because it was the resident's right to know who she was. During an interview on 06/04/2026 at 4:29 PM, the Administrator said she expected the staff to always introduce themselves and always wear a name tag in a visible area. The Administrator said it was her responsibility to ensure the staff were doing that. The Administrator said usually the name tag was obtained from the human resources coordinator, but they currently did not have one. She said she thought CNA B received a name tag upon hire, but it could have been an oversight. The Administrator said the staff identifying themselves and wearing a name tag was important for the staff to be identified by the residents and this could make the residents feel unsafe. During an interview on 06/04/2026 at 5:03 PM, the Regional Human Resources Specialist said the staff were provided with a name tag in orientation, and if they lost it they could go to them to have it replaced. The Regional Human Resources Specialist said she was not at the facility for CNA B's orientation, and she did not know who was supposed to give CNA B her name tag. The Regional Human Resources Specialist said she was in the facility because the facility currently did not have a human resources coordinator, and the staff could go to her office anytime for a name tag. The Regional Human Resources Specialist said it was important for staff to wear a name tag for everybody to identify what their job title was and what they did and residents would not know who they were or what the care they should be providing was. During an interview on 06/04/2026 at 5:14 PM, the ADON said staff should always identify themselves and wear name tags. The ADON said she, the DON, and the<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administrator verified staff were identifying themselves and wearing name tags when they walked around the facility daily. The ADON verified Resident #19's description matched that of CNA B, and she was aware CNA B did not wear name tags as a means of identifying herself to the residents. The ADON said she did not know if CNA B was identifying herself during care, but she was aware she was not wearing a name tag, and she had instructed her to get one from human resources, but she never got it. The ADON said the staff identifying themselves and wearing a name tag was important because the residents would not be able to identify them if they did something to them or they could think it was anybody off the street. During an interview on 06/04/2026 at 5:35 PM, the DON said she expected the staff to introduce themselves and have a name badge on when they walked into the room, so the residents could see who they were and know what they were there for. The DON said she was responsible for ensuring the staff identified themselves and wore a name badge, and she checked this when she was rounding the halls. The DON said she was aware CNA B did not have a name badge and they were not able to get her one because they did not have human resources in the building. The DON said the residents had a right to know who was going into their room and providing care to them, and seeing the staff's name on the name tag may help them to remember who provided care to them. Record review of the facility's undated policy, Resident Rights, indicated, 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 right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care . |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 21 residents (Resident #41) reviewed for resident rights. The facility failed to ensure Resident #41's call light was reasonably accommodated to her needs, and her call light was within reach. This failure could place residents at risk for a delay in assistance and a decreased quality of life. Findings include: Record review of Resident #41's face sheet dated 06/04/2026 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified symptoms and signs involving cognitive functions following cerebral infarction (cognitive impairment after a stroke), repeated falls, and essential primary hypertension (high blood pressure). Record review of Resident #41's MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #41 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #41 required partial/moderate assistance with toileting hygiene, dressing, transfers, and supervision or touching assistance with personal hygiene. Record review of Resident #41's care plan reviewed 04/07/2026 indicated she was at risk for falls to be sure her call light was within reach and encourage her to use it for assistance as needed. During an interview on 05/31/2026 at 10:20 AM, Resident #41 said she did not like the current red button (call light) because it was too hard for her to find and she had difficulty activating it. Resident #41 said she reported to 2-3 different staff that she had difficulty activating the current call light but was unable to provide specific names. Resident #41 said she was told by one of the staff (but could not remember their name) they would change her call light out, but it still had not been done. During an observation and interview on 06/03/2026 at 9:39 AM, Resident #41 was sitting in her room in her wheelchair, and her call light was observed on the floor under her bed by the head of the bed behind her. Resident #41 said she did not know where her call light was and she needed water. Resident #41 said since she could not locate her call light she would yelled for help until someone came. During an interview on 06/04/2026 at 2:06 PM, CNA M said she was responsible for ensuring Resident #41 had her call light within reach. CNA M said she was not sure why it was not within Resident #41's reach on 06/03/2026. CNA M said Resident #41 mentioned to her she was having difficulty with the call light with a red button. CNA M said she thought it had been changed to a call light you tap on to activate it, so she was not sure why she had the one with the red button. CNA M said it was important for the residents to have a call light they could use and have it within reach so they could call for help when they needed it. During an interview on 06/04/2026 at 4:32 PM, the Administrator said residents' call lights should be within reach at all times, and the CNAs should be making sure they placed them within reach anytime they were in the residents' rooms. The Administrator said she was not aware Resident #41 was having difficulty activating the call light with a red button. She said they had flat ones, and the call light should have been switched out to accommodate her needs. The Administrator said not having the call light within reach and not having a call light they could easily activate could affect the resident's safety. During an interview on 06/04/2026 at 5:16 PM, the ADON said the residents' call lights should always be within reach, and whoever puts them in their room should ensure the call light was within reach. The ADON said she was not aware Resident #41 was having difficulty pressing her call light. She said they had call light buttons the residents could tap on, and when Resident #41 reported it to the staff they should have switched the call light. The ADON said Resident #41 not having her call light in her room and not having a call light she could easily use could result in her falling or being in any kind of emergency and them not being able to help her. During an interview on 06/04/2026 at 5:37 PM, the DON said she was not aware Resident #41 was having difficulty with her current call light. The DON said she expected the call light to be in reach at all times. The DON said the staff should<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | have provided resident #41 with a touch light she could tap on. The DON said all staff were responsible for ensuring the call light was within reach. The DON said Resident #41 would not be able to call for help if she needed it and it would delay her care or intervention she was needing. During an interview on 06/04/2026 at 6:30 PM, the Regional Compliance Nurse said the facility did not have a policy regarding call lights and ensuring the call lights met the residents' needs. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from chemical restraints (the use of medication to restrict a person's movement or behavior) that were not required to treat the residents' medical symptoms for 1 of 5 residents (Resident #39) reviewed for unnecessary medications. The facility failed to ensure Resident #39 had an appropriate diagnosis on entered orders for her Seroquel, also known as Quetiapine (an antipsychotic medication that treats several kinds of mental health conditions, including schizophrenia and bipolar disorder.) This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications.Findings included:Record review of Resident #39's face sheet, dated 06/04/26, reflected Resident #39 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Alzheimer's (progressive disease that destroys memory and other important mental functions), and depression (sadness that interferes with daily life). Record review of Resident #39's consent for the use of antipsychotic medication, Seroquel was documented in the chart signed 04/20/24 as the following psychiatric condition and/or maladaptive behavior Alzheimer's. Record review of Resident #39's significant change in status MDS assessment, dated 04/15/26, reflected Resident #39 made herself understood and usually understood others. Resident #39's BIMS score was 7, which reflected her cognition was severely impaired. The assessment reflected Resident #39 received an antipsychotic and antidepressant medication.Record review of Resident #39's comprehensive care plan, revised on 08/13/24, reflected Resident #39 required an antipsychotic medication related to night terrors. The care plan interventions included to discuss with the MD, and family regarding ongoing need for use of medication and monitor/record/report to the MD as needed regarding side effects and adverse reactions of psychoactive medications. Record review of Resident #39's order summary report, dated 06/04/26, reflected an active physician's order for Seroquel 50 mg: 1 tablet by mouth one time a day for sleep with a start date 08/28/25. Record review of Resident #39's medication administration record dated from 05/01/26 through 05/31/26 revealed, Resident#39 received Seroquel oral tablet 50 MG (Quetiapine) Give 1 tablet by mouth one time a day for sleep. Record review of Resident #39's consent for the use of antipsychotic medication, Seroquel was documented in the chart signed 04/20/24 as the following psychiatric condition and/or maladaptive behavior Alzheimer's. During a telephone interview on 06/02/26 at 10:20 a.m., Resident #39's family member stated she was aware of the Seroquel being taken for night terrors. Resident #39's family member stated Resident #39 Parkinson's physician had prescribed her the medication.During a telephone interview on 06/04/26 at 1:59 p.m., RN A stated she was not aware Resident #39 had an Alzheimer's diagnoses for her Seroquel. RN A stated she did not know what diagnosis could be used. RN A stated the nurse that obtained the order should verify with the physician what diagnosis was indicated for the medication. RN A stated it was important to ensure the correct diagnosis was used for the resident safety. During an interview on 06/04/26 at 3:30 p.m., the DON stated Alzheimer's was not an appropriate diagnosis for Seroquel. The DON stated the previous DON was responsible for ensuring the consent had the appropriate diagnosis. The DON stated Resident #39's diagnosis should have been reviewed to see if there was an appropriate diagnosis to meet the criteria and if there was not the MD should have been notified for a GDR (tapering of a medication's dosage over time). The DON stated she had only been in her position for three weeks and time had not allowed her to complete an audit. The DON stated it was important to ensure the correct diagnosis was used to prevent unnecessary medication which could cause heavily sedated. During a telephone interview on 06/04/26 at 4:06 p.m., the Administrator stated she expected the appropriate diagnosis to be used for psychotropic medication use. The Administrator stated she had no clue if Alzheimer's could be used for Seroquel. The Administrator stated the DON<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was responsible for overseeing and monitoring consents. The Administrator stated it was important to ensure the correct diagnosis was used to prevent unnecessary medication. During a telephone interview on 06/04/26 at 5:26 p.m., the Nurse Practitioner stated Seroquel could be used for sundowners (increased confusion, anxiety, and agitation that peaks in the late afternoon and continues into the night) related to Alzheimer's, but other diagnosis would be reviewed to see what would be most appropriate. The Nurse Practitioner stated the diagnosis should reflect as to why the residents was on the medication and he expected them to have the proper diagnosis. The Nurse Practitioner stated it was important to follow stimulations related to Seroquel but could be a great medication if used correctly. Record review of the facility policy for Psychotropic Medication, revised 02/12/25 reflected. Based on a comprehensive assessment of a resident, the facility will ensure that:<br>a. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 2 of 3 (Residents #13 and #19) residents reviewed for reporting physical abuse. 1. The facility failed to ensure the Administrator reported to HHSC, within 2 hours during the week of 5/25/2026- 5/28/2026 when CNA B grabbed Resident #13 by the right forearm and forced her to sit down to make her stay in bed which resulted in a bruise to her right forearm. 2. The facility failed to ensure the Administrator reported to HHSC, within 2 hours on 05/30/2026, when RN A and LVN C reported to her that Resident #19 alleged CNA B was rough with her while providing care. These failures could place the residents at risk for continued physical abuse.<br><br>Findings included:<br><br>1. Record review of Resident #13's face sheet, dated 06/04/26, reflected Resident #13 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included senile degeneration of brain (progressive decline in mental abilities due to physical brain deterioration in older age).<br><br>Record review of Resident #13's quarterly MDS assessment, dated 03/12/26, reflected Resident #13 made herself understood and understood others. Resident #13's BIMS score was a 7, which reflected her cognition was severely impaired. Resident #13 required partial/moderate assistance with sit to stand and bed to chair transfer mobility.<br><br>Record review of Resident #13's undated comprehensive care plan, reflected Resident #13 had an ADL self-care performance deficit related to activity tolerance, fatigue (tiredness), limited mobility and low back pain. The care plan interventions included: independent with bed mobility.<br><br>Record review of Resident #13's electronic medical records did not reflect a skin assessment completed on 05/26/26 until state surveyor intervention on 05/31/26.<br><br>During an observation and interview on 05/31/26 at 1:28 p.m., with Resident #13 a bruise was observed on Resident #13's right forearm. When Resident #13 was asked about the bruise, she stated the CNA caused it when she made her go to bed. Resident #13 stated the CNA grabbed her by the right forearm and forced her to sit down to make her stay in bed which resulted in a bruise to her forearm. Resident #13 stated she tried to pull away when the CNA pushed her down and the CNA stated to her don't fight. Resident #13 stated the CNA had long fingernails and when she grabbed her, the mark came up. Resident #13 described the CNA as a black lady, heavy set, and her hair was curled to the side, but was unable to state a name. Resident #13 stated she could not remember the date this incident happened or who she reported it to, but she did report it. Resident #13 stated, this is not the first time this has happened, ever since she has been here, she reaches out and grabs me. Resident #13 stated when she reported this, before, she was told the CNA was just that way. Resident #13 stated, I was really scared.<br><br>During an interview on 05/31/2026 at 1:05 PM, RN A stated when she was assessing Resident #13 for shingles (a viral infection that caused a painful rash), Resident #13 stated to her I must tell you<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | something that needs to stay between me and you. RN A stated Resident #13 reported to her that the CNA who put her to bed the night before was ruff and pinched her. RN A stated Resident #13 told her she was being forced to go to bed and she was not ready, the CNA insisted it was her bedtime and she put her to bed. RN A stated Resident #13 stated the CNA told her it was her fault because she was fighting her about going to bed. RN A stated Resident #13 did not provide her any names, but said it was a black woman. RN A stated she reported it immediately to the ADON and Administrator the day Resident #13 reported it to her, and the Administrator told her it would be a self-report to state, and she would talk to Resident #13. RN A stated she did not mention the bruise to anyone, but she did not notice the bruise when Resident #13 reported the incident, but she was focused on the shingles.<br><br>During an interview on 06/01/26 at 9:50 a.m., the ADON stated, on 05/25/26 as she was making rounds prior to supper, she noticed Resident #13 lying in bed. The ADON stated she asked her why she was in bed so early and Resident #13 stated she told me I had to go to bed because everyone else was in bed. The ADON stated she told her she did not have to go to bed early if she did not want to. The ADON stated she offered to get her back up. The ADON stated she did not report the incident to anyone because she did not feel like it was abuse or neglect. The ADON stated the next day (26th) RN A came to her and reported Resident #13 told her a CNA was ruff and pinched her. The ADON stated her and RN A immediately went to the Abuse Coordinator which was the Administrator, and RN A told her what Resident #13 reported, which was the CNA was ruff and pinched her. The ADON stated the Administrator stated, Ok, I will investigate.<br><br>During an interview on 06/01/26 at 10:22 a.m., the Administrator stated around 5/18/26 forward, the ADON notified her about a complaint that Resident #13 stated she was made to go to bed. The Administrator stated her and the ADON went down to Resident #13 room and informed her it was her right when she wanted to go to bed. The Administrator stated as Resident #13 was mentioning about the CNA making her go to bed, Resident #13 showed her the rash that was identified as shingles (a viral infection that caused a painful rash) under her right side. The Administrator stated she asked Resident #13 if she could identify the CNA and she stated a regular-sized black lady that normally worked that hall. The Administrator stated she looked at the ADON and asked her who the CNA was that worked yesterday, and the ADON stated she would look at the schedule. The Administrator stated after she left Resident #13's room, her and the ADON went to look at the schedule and saw CNA B worked the hall that night before. The Administrator stated she thought she had conducted an in-service on resident rights but could not find the documentation. The Administrator stated CNA B never was suspended or spoken to about the incident and was able to continue to work with Resident #13. The Administrator stated she was not aware of the second incident that involved the CNA been ruff or pinching Resident #13. The Administrator stated the ADON nor RN A reported to her about Resident #13 being pinched or ruff during transfer on 05/25/26. The Administrator stated she was not aware of the bruise to Resident #13's right forearm until after the state surveyor's intervention. The Administrator stated she went down to Resident #13's room on 05/31/26 to start an investigation and when she spoke to Resident #13 about the bruise, Resident #13 stated it happened, when she put me to bed.<br><br>During an interview on 06/01/26 at 10:46 a.m., the ADON stated she did not notify the Administrator about a complaint herself. The ADON stated when RN A reported Resident #13's allegation to her, they both went to the Administrator's office, and RN A reported the allegation to the Administrator. The ADON stated she did not recall speaking with Resident #13 with the Administrator.<br><br>2. Record review of Resident #19's face sheet dated 06/01/2026 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included senile degeneration (continued on next page) |

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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>Mount Pleasant, TX 75455 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of the brain (deterioration of the brain which leads to cognitive decline, memory impairment, and changes in behavior and personality), anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), and essential primary hypertension (high blood pressure).<br><br>Record review of Resident #19's MDS assessment dated [DATE] indicated she was understood by others and understood others. Resident #19 had a BIMS score of 15, which indicated her cognition was intact. Resident #19 was dependent on staff for toileting hygiene. Resident #19 was frequently incontinent of urine and bowel.<br><br>Record review of Resident #19's care plan reviewed 04/21/2026 indicated she had impaired though processes to engage in simple, structured activities that avoided overly demanding tasks and to provide her with a homelike environment. Resident #19's care plan indicated she had bowl and bladder incontinence to provide perineal care after each incontinent episode. Resident #19 had an ADL self-care performance deficit related to fatigue and limited mobility and required assistance of one staff member for toilet use, bathing, bed mobility, and dressing.<br><br>During an interview on 05/31/2026 at 10:02 AM, Resident #19 said there was an African American CNA who wore brown glasses and worked the 2 PM- 10 PM shift that was rough when she provided care to her. Resident #19 said the CNA did not identify herself and did not wear a name badge, so she did not know her name. Resident #19 said the CNA grabbed her arm roughly and was rough when turning her to provide care. Resident #19 said she told the CNA she needed to stop grabbing her arm so roughly and the CNA told her that's the way she was. Resident #19 said she was scared of the CNA and had reported her to everybody. Resident #19 said the CNA did not work this past weekend, but she provided care to her every day. Resident #19 said one of the girls upfront told her they were trying to figure out who it was, but she was unable to provide a name. Resident #19 said one day last week me and her had it out. Resident #19 said she told the CNA to stop treating her roughly and the CNA told her she did not care if they fired her, she could always work elsewhere. One of the nurses she reported it to was LVN C.<br><br>During an interview on 05/31/2026 at 1:05 PM, RN A said Resident #19 reported to her yesterday (05/30/2026) morning that an African American woman who wore glasses on the 2 PM-10 PM shift was really rough with her, and she never wanted her to be her CNA again. RN A said she notified the Administrator immediately via text message and she said it would be a self-report to state and to send the DON a text message. RN A said the way Resident #19 was treated was abuse and abuse should be reported to the Administrator immediately to protect the residents from further abuse.<br><br>During an interview on 05/31/2026 at 1:47 PM, the ADON said CNA B was the CNA that usually provided care to Resident #19 on the 2 PM-10 PM shift and she matched the description provided by Resident #19. The ADON said she did not think CNA B was mean, but she was very demanding and wanted things done her way. The ADON said the Administrator called her yesterday, 05/30/2026, and told her she was filing a grievance because Resident #19 felt her ADLs were rushed by CNA B, but she was not involved in any of the process. The ADON said if a resident reported a CNA was rough it should be reported to the Abuse Coordinator, the Administrator, immediately because it could be considered abuse, and then the CNA should be removed and spoken with. The ADON said it was important for abuse to be reported and investigated because the residents needed to be safe, and if they did not feel safe with a CNA the CNA did not need to be providing their care. The ADON said none of the CNAs were suspended and this places the residents at risk for further abuse.<br><br>During an interview on 05/31/2026 at 2:06 PM, the DON said she had not received any reports from<br>(continued on next page) |

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| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the residents or staff about any staff being rough with the residents or mistreating them. The DON said yesterday evening, 05/30/2026, she was notified by the Administrator that Resident #19 had reported a CNA was rough with her, but she did not talk to Resident #19. The DON said if a resident reported a staff member was rough with them it should be reported to the Abuse Coordinator, the Administrator, immediately. The DON said the Administrator would then see what the resident was saying and get a statement from the staff member involved, and if deemed reportable follow the abuse policy process. The DON said the staff member would be suspended to protect the residents from further abuse. The DON said an allegation of staff being rough could be considered abuse. The DON said she was not aware of Resident #13 having a bruise or being mistreated. The DON said nothing regarding Resident #13 had been reported to her. The DON said if the staff noticed a new bruise, they should complete a skin assessment, open an incident, monitor the bruise, notify the family and the doctor, and the Administrator usually was notified during the daily clinical morning meetings. The DON said she reviewed the staffing schedule and identified the CNA involved in Resident #19 and Resident #13's incidents as CNA B. The DON said the CNA was working today, 05/31/2026, for her 2 PM-10 PM shift, but would be moved to a different hall. The DON said it was important for abuse to be reported per the facility's abuse policy and for the proper measures to be taken to not place other residents at risk for abuse.<br><br>During an interview on 05/31/2026 at 2:19 PM, the Administrator said last night (05/30/2026) at 7 PM, LVN C called her and reported to her that Resident #19 reported to her that the CNA from Thursday, 05/28/2026, was rough with her and rushed her when she provided care. The Administrator said she went to the facility approximately 15-20 minutes after she was notified by LVN C to talk to Resident #19. The Administrator said when she spoke to Resident #19, she felt like it was more that CNA B had rushed her. She said Resident #19 told her CNA B rushed her and pushed her over when she was turning her on her side. The Administrator said Resident #19 told her she did not want CNA B back in her room. The Administrator said she filed a grievance and moved CNA B to a different hall. She said CNA B would start her shift today, 05/31/2026, at 2 PM, but would be on a different hall. The Administrator said Resident #19 had no injuries from CNA B being rough with her. The Administrator said RN A reported to her yesterday (05/30/2026) that Resident #19 told her CNA B had been rough with her. The Administrator said she told RN A to report it to the DON. The Administrator said she was not sure if Resident #19 told her CNA B was rough or rushed her. The Administrator said the allegation Resident #19 made should have been reported for abuse and neglect within 2 hours. The Administrator said not reporting allegations of abuse placed the residents at risk for continued abuse. The Administrator said it had not been reported to her that CNA B pinched Resident #13 or any allegations made by Resident #13. The Administrator said if Resident #13 alleged she had been pinched by the CNA it should have been reported to her and she would have reported it to HHSC within 2 hours. The Administrator said if there was an unidentified bruise it should be reported to her and she would report to HHSC within the required timeframe of 2 hours. The Administrator said it was not reported to her that Resident #13 had a bruise on her arm. The Administrator said the staff should not force the residents to go to bed early because it went against resident rights. The Administrator said not reporting allegations of abuse and neglect, unidentified bruises, and not following their abuse policy placed the residents at risk for continued abuse.<br><br>During an interview on 05/31/2026 at 2:49 PM, CNA B said she had been working at the facility for close to a month. CNA B said if a resident was not ready to go to bed, she would notify the nurse and let the nurse handle it because it was the residents right not to go to bed. CNA B said she had not forced any residents to go to bed. CNA B said she did not rush the residents when she provided care, and she had not received any complaints that she was rough. CNA B said there were no residents' rooms she was not allowed to go in. CNA B said she usually worked on the hall where Resident #13 (continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and Resident #19 resided. CNA B said Resident #19 did not require a lot of assistance with her care that she allowed her to roll herself just gave her a little boost. CNA B said Resident #13 required assistance from one person for rolling and for standing up. She said usually she held her when she was getting up from under her arms to help her push up on her walker to get her to stand up. CNA B said she had never told any residents if she got fired, she could go work somewhere else. She said she was not aware of Resident #13 having any bruises.<br><br>During an observation and interview on 05/31/2026 at 3:11 PM, RN A showed the surveyor the text message she sent to the Administrator and DON. The message to the Administrator dated 05/30/2026 at 10:08 AM indicated Resident #19 says she never wants the 2-10 aide back in her room, because her aide is being too rough with her. It happens every time she's been on the hall. The Administrator responded, send to DON and let her know. RN A said she took a screenshot of what she sent to the Administrator and the response and sent it to the DON. RN A showed the surveyor the message sent to the DON on 05/20/2026 at 11:02 AM, and it was the screenshot of what she sent the Administrator. RN A said she did not hear from the DON or the Administrator after this.<br><br>During an interview on 06/01/2026 at 9:58 AM, LVN C said Resident #19 complained to her about one of the CNA's Thursday, 05/28/2026, being rough with her. She said Resident #19 did not report it to her until Saturday, 05/30/2026, at 7:00 PM. She said Resident #19 reported to her the CNA had been rough with her, rolled her over so hard, she hit her head against the bed rail. LVN C said Resident #19 told her it was a CNA with glasses that worked the 2 PM-10 PM shift, and the description fit CNA B. LVN C said she immediately reported what Resident #19 told her to the Administrator, and the Administrator went to the facility. LVN C said she conducted a skin assessment on Resident #19, and she had no injuries. LVN C said she had not received any complaints from the residents or staff about CNA B or any other staff mistreating the residents. LVN C said allegations of abuse should be reported to the Administrator immediately to protect the residents from further abuse.<br><br>During an interview on 06/01/2026 at 10:40 AM, the Administrator said she was notified by RN A the morning of 05/30/2026 that Resident #19 alleged CNA B was rough with her. The Administrator said she identified it as abuse and told RN A to notify the DON because she was in an area where she did not have good signal and was not receiving messages and calls in a timely manner. The Administrator said she expected the DON to follow up, but the DON said RN A had not notified her of the allegation Resident #19 made. The Administrator said when LVN C reported the allegation Resident #19 made to her the evening of 05/30/2026, she was back in town and decided to go to the facility to speak with Resident #19. The Administrator said since she told RN A to report it to the DON, she assumed the DON had taken care of the situation. She said as the Abuse Coordinator she should have called the DON to follow up and ensure she had taken care of the situation. The Administrator said Resident #19 made an allegation of abuse, and it should have been reported within two hours to HHSC.<br><br>During an interview on 06/04/2026 at 6:08 PM, the DON said when the Administrator called her the evening of 05/30/2026, she went back to review her messages and realized RN A sent her a screenshot of the message the morning of 05/30/2026 that she sent to the Administrator to report the allegation Resident #19 made. The DON said if she had noticed it when it was sent, she would have called the Administrator, removed the staff member, ensured the resident was safe, conducted a skin assessment, called the family and done all the things per the abuse policy, and reported the abuse to HHSC. The DON said not reporting abuse placed the residents at risk for further abuse and neglect.<br><br>Record review of the facility's policy, Abuse and Neglect, from the Nursing Policy and Procedure Manual revised 03/29/2018, indicated, The resident has the right to be free from abuse, neglect, (continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment .Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff.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.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. 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. 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 19-17 dated 7/10/19. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish based on the comprehensive assessment and consistent with the resident's needs and choices for 1 of 5 residents (Resident #39) reviewed for quality of life. The facility failed to provide communication or translation assistance to effectively communicate with Resident #39. This failure could place residents at risk for declining and diminishing quality of life, and neglect. Findings included:Record review of Resident #39's face sheet, dated 06/04/26, reflected Resident #39 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Parkinson's (brain disorder that causes unintended or uncontrollable movements).Record review of Resident #39's significant change in status MDS assessment, dated 04/15/26, reflected preferred language was Spanish and she needed/wanted an interpreter to communicate with a doctor or health care staff. Resident #39 made herself understood and usually understood others. Resident #39's BIMS score was 7, which reflected her cognition was severely impaired. Resident #48 could repeat 3 words after the first attempt. Record review of Resident #39's comprehensive care plan, revised on 04/30/24, reflected Resident #39 had a communication problem related to the language barrier. Resident #39's primary language was Spanish. The care plan interventions included: anticipate/meet needs and provide translator as necessary to communicate with the resident. Record review of the facility's undated/untitled form reflected Resident #39 spoke in a non-dominant language. During an interview and observation on 05/31/26 at 10:13 a.m., Resident #39 was sitting on the side of the bed with her family member at bedside. The surveyor began talking to Resident #39 in English and asked if her needs were being met. Resident #39 never replied. Resident #39's family member stated she did not speak English. There was no communication board observed in her room. During a telephone interview on 06/02/26 at 10:20 a.m., Resident #39's family member stated Resident #39 preferred language was Spanish and her communication should be Spanish. Resident #39'ss family member stated at one point approximately six months ago staff (unable to recall names) would call her 2-3 times throughout the night to translate for Resident #38. Resident #38's family member stated it had come to the point where she told them they could not call her in the middle of night because it was hard for her to go back to sleep. Resident #38's family member stated she printed out a list in Spanish with things Resident #38 could want or need to help with providing care and had given it to a CNA (unable to recall name), but she never saw the list in the room. During an interview on 06/03/26 at 9:03 a.m., CNA M stated Resident #38 primary language was Spanish and Resident #38 understood very little English. CNA M stated she knew little Spanish words such as medicine, bathroom, and pain. CNA M stated she mentioned to the Administrator and charge nurse (unable to recall name) about a translator, or Spanish communication board because it was hard to understand what Resident #38 said at times. CNA M stated she was told to utilize staff that could speak Spanish. CNA M stated it was important to ensure effective communication to provide the best care. During a telephone interview on 06/03/26 at 1:59 p.m., RN A stated Resident #38's primary language was Spanish. RN A stated Resident #38 understood simple words in English. RN A stated if Resident #38's family member was not at bedside or there was no staff in the facility that spoke Spanish, she would notify her hospice nurse that spoke Spanish. RN A stated a communication board or translator would be effective for staff that only spoke English to meet Resident #38's needs. RN A stated it was important to effectively communicate with Resident #38 to ensure her wants/needs were met and if there was a problem she could communicate with staff. During an interview on 06/04/26 at 3:30 p.m., the DON stated she had never had a full conversation with Resident #38. The DON stated she spoke broken Spanish. The DON stated she expected Resident #38 to have a proper way of communication for her<br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | daily tasks/needs. The DON stated she had mentioned to the Administrator about a device to help translate for Resident #38, but she stated there were several staff members that could speak Spanish. The DON stated it was important to effectively communicate with Resident #38 to ensure her needs were being met.During a telephone interview on 06/04/26 at 4:06 p.m., the Administrator stated she never had a full conversation with Resident #38. The Administaor stated there was an incident she could recall about CNA M asking about how she should communicate with Resident #38 due to her primary language was Spanish. The Administrator stated she told her to utilize the staff in the building. The Administrator stated staff had the ability to use a translator but did not know if staff were aware, it was available. The Administrator stated it was important to ensure Resident #38 was able to communicate effectively to make sure her needs were met. Record review of facility's undated policy titled Resident Rights , reflected. 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. Information and communication. 1. The facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information may be made available to the patient at their request and expense in accordance with applicable law. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 3 residents (Resident #57) reviewed for quality of life. The facility failed to ensure Resident #57 was assisted with incontinent care in a timely manner after his brief had brownish residue/spots on it and he had a bowel movement on 06/03/2026. This failure could place residents at risk of not receiving the services and care needed, decreased self-esteem, and a decreased quality of life.Findings included: Record review of Resident #57's face sheet dated 06/04/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (weakness and paralysis of the right side of the body after a stroke), neuromuscular dysfunction of the bladder (problems due to disease or injury of the central nervous system or nerves involved in the control of urination), and vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory). Record review of Resident #57's Quarterly MDS assessment dated [DATE] indicated he was understood by others and understood others. Resident #57 had a BIMS score of 15, which indicated his cognition was intact. Resident #57 had an indwelling catheter. Resident #57 was dependent on staff for toileting. Resident #57 was always incontinent of bowel. Record review of Resident #57's Order Summary Report dated 06/03/2026 indicated provide catheter care every shift 03/19/2026. Record review of Resident #57's care plan reviewed 05/12/2026 indicated he had an ADL self-care performance deficit related to stroke and right above the knee amputation. Resident #57 required assistance from one staff for toilet use, bed mobility, and dressing. During an observation and interview on 06/03/2026 starting at 2:42 PM, CNA F unfastened Resident #57's brief pulled it down in front of him and provided catheter care. Resident #57's brief had brownish residue/spots on it from discharge he was having from his penis. After cleaning Resident #57's penis and catheter area, CNA F fastened the same brief back onto Resident #57 and exited the room. CNA F said she was finished. CNA F said she noticed the spots on Resident #57's brief but did not change it because it was just discharge from his penis. After surveyor intervened, CNA F said she would provide incontinent care to Resident #57. CNA F turned Resident #57 onto his side and he had flattened, dried stool on his buttocks. CNA F had to wipe multiple times to get the stool off due to it being dried on Resident #57's buttocks. CNA F said her shift started at 2:00 PM, and this was the first time she had provided incontinent care to Resident #57 since her arrival. CNA F said it was important to provide prompt incontinent care to the residents to prevent skin breakdown and so they could be clean. Resident #57 said CNA M did not change him during her shift. He said she had gone into his room and told him he did not need to be changed. Resident #57 was not aware he had a bowel movement. Resident #57 said he did not recall around what time CNA M had told him he did not need to be changed. During an interview on 06/03/2026 at 2:57 PM, CNA M said her shift was from 6 AM-2 PM, but today (06/03/2026) she had to leave at 1 PM. CNA M said she went in Resident #57's room twice on her shift and the last time she checked on him was before lunch, around 11 AM, and he was not soiled. CNA M said the residents should be checked on every two hours. CNA M said she notified the ADON, who was also the charge nurse for Resident #57's hall that she was leaving, and she assumed the ADON knew she was supposed to check on him because she did not have time to go back to check on Resident #57 before she left. CNA M said it was important to provide the residents with incontinent care to prevent skin breakdown and infections. During an interview on 06/03/2026 at 3:17 PM, the ADON said she was aware CNA M left at 1 PM, but CNA M did not inform her Resident #57 had not been checked on since before lunch. The ADON said the residents should be checked on every 2 hours. She said the CNAs should turn the residents to ensure they were not soiled when they<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | were checking the residents every 2 hours. The ADON said not providing prompt incontinent care could result in skin breakdown, UTIs, and could be considered neglect. During a confidential interview, Anonymous Staff Member #1, said some of the residents have reported to them that CNA M was not providing incontinent care. They said they noticed when starting their shift some of the residents were not changed or heavily soaked. Anonymous Staff Member #1 said they noticed CNA M did not turn the residents to check to see if they were soiled. They said Resident #57 was one of the residents that required being turned and checked because he was unable to tell them if he was soiled. Anonymous Staff Member #1 said they reported it to the ADON and DON multiple times, but nothing changed. They said it was important for the residents to be provided with incontinent care for their cleanliness and to prevent skin breakdown. During a confidential interview, Anonymous Staff Member #2, said they noticed CNA M was not providing incontinent care to the residents like she should. They said they probably should have reported it to the DON or ADON, but they did not report it because they just changed the residents when they noticed it. Anonymous Staff Member #2 said it was important for the residents to receive incontinent care so they did not have any skin issues and so they were clean. During an interview on 06/04/2026 at 4:34 PM, the Administrator said she expected the CNAs to provide proper and prompt incontinent care, and if a resident was dirty, they needed to change them for infection control. The Administrator said the DON was responsible for ensuring incontinent care was provided. The Administrator said not providing incontinent care could result in skin breakdown and infection. During an interview on 06/04/2026 at 5:31 PM, the ADON said within the past 6 weeks it was reported to her that CNA M worked the night shift and left the residents soiled, wet. She did not remember who reported it to her. The ADON said she had provided verbal education to CNA M about changing the residents but had not reported it to the DON or Administrator. The ADON said she was not sure if she was supposed to report it to the Administrator or DON. The ADON said the charge nurses should be ensuring the residents were provided with incontinent care. She said she was the charge nurse for Resident #57 on 06/03/2026, and she did not notice he was not changed. The ADON said if the residents were not provided with incontinent care, it could cause UTIs, skin breakdown, and dignity issues. During an interview on 06/04/2026 at 5:59 PM, the DON said she had not received any reports about residents not being changed from the staff or residents. The DON said she expected the staff to provide incontinent care promptly and to make sure the residents were very clean. The DON said the charge nurses should be monitoring to ensure the residents were provided with the care they required. The DON said if the residents were not provided with incontinent care, it was a dignity issue and could lead to skin breakdown. Record review of the facility's undated policy, Catheter Care, indicated, Provide perineal care to the incontinent resident to prevent skin rashes and breakdown. Record review of the facility's policy, Perineal Care, effective 05/11/2022, indicated, It is essential that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice. |

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| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

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| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>Mount Pleasant, TX 75455 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 1 resident (Resident #67) reviewed for enteral devices. The facility failed to ensure RN H did not administer Resident #67's gabapentin (medication used for nerve pain and seizures) and metoclopramide (medication used to treat nausea, vomiting, and improves stomach emptying) by pushing it through his g-tube (placement of a tube into the stomach used for nutrition and medication administration) with a syringe on 06/01/2026. This failure could affect residents receiving enteral nutrition, medications, and hydration by placing them at risk of health complications.Findings included: Record review of Resident #67's face sheet dated 06/02/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness of the right side of the body after a stroke) and dysphagia (difficulty swallowing). Record review of Resident #67's Quarterly MDS assessment dated [DATE] indicated he was rarely/never understood and rarely/never understood others. Resident #67 had a short-term and long-term memory problem. Resident #67 was dependent on staff for eating and toileting hygiene. Resident #67's MDS assessment did not indicate a feeding tube. Record review of Resident #67's Order Summary Report dated 06/02/2026 indicatedGabapentin 100 mg give 100 mg via g-tube three times a day with a start date of 05/28/2026Metoclopramide 10 mg give 10 mg via g-tube four times a day with a start date of 05/29/2026. Record review of Resident #67's care plan initiated 05/28/2026 indicated he had a g-tube related to dysphagia and was NPO. During an observation of medication administration with RN H on 06/01/2026 starting at 4:10 PM, RN H mixed Resident #67's metoclopramide 10 mg with water, drew it up in the syringe, and pushed it through his g-tube. Then she mixed his gabapentin 100 mg with water, drew it up in the syringe, and pushed it through his g-tube. RN H said she used the proper technique to administer Resident #67's medications through his g-tube. She said she was very comfortable administering medications in this manner. RN H said she did not have to administer the medications via gravity through his g-tube because she knew Resident #67 could tolerate the medications being pushed, if she did it slowly. RN H said pushing medications via g-tube could cause vomiting. During an interview on 06/04/2026 at 4:46 PM, the Administrator said she was not clinical therefore she was not familiar with medication administration via g-tubes. The Administrator said she expected the nurses to follow the policy, and the DON was responsible for ensuring the nurses administered medications via g-tube properly. During an interview on 06/04/2026 at 5:29 PM, the ADON said medications should not be pushed via the g-tube. She said the medications should be administered by gravity via g-tube. The ADON said she and the DON were responsible for monitoring to ensure the nurses administered medications correctly. She said they monitored them by walking through the facility randomly and watching them give medications. The ADON said pushing medications through the g-tube could result in aspiration. During an interview on 06/04/2026 at 5:58 PM, the DON said medications should be administered through the g-tube via gravity. The DON said they should not be pushed because it could cause abdominal distress, aspiration, nausea or vomiting. The DON said she was responsible for ensuring the nurses were administering medications properly, but she had not been monitoring because she was new and had only been at the facility for three weeks. Record review of the facility's policy titled, Enteral Medication Administration, revised 1/25/13, indicated, Do not force any medication or fluid into the tube. Allow gravity to work. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 2 of 4 residents (Resident #31 and Resident #34) reviewed for respiratory care. 1. The facility failed to ensure Resident # 31's nebulizer face mask was placed in a plastic bag, labeled, and dated. 2. The facility failed to ensure Resident #34 oxygen tubing and water humidifier was dated and changed. These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications.Findings included: 1.Record review of face sheet dated 06/04/2026 revealed Resident #31 was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (degeneration of the brain) and hypertension (high blood pressure). Record review of Quarterly MDS dated [DATE] revealed Resident #31 was usually understood by others and usually understood others. MDS assessment revealed Resident #31 had a BIMS score of 04 indicating severe cognitive impairment. Record review of care plan dated 06/04/2026 revealed Resident #31 had hypertension with the intervention to monitor and document difficulty breathing. Record review of order summary report revealed Resident #31 had an order for ipratropium-albuterol every 6 hours as needed for shortness of breath started on 10/12/2025. During an observation and interview on 05/31/2026 at 10:00 a.m., Resident #31 stated that she used her nebulizer face mask only as needed and she was not sure the last time she had a nebulizer treatment or that her face mask and tubing had been changed. 2.Record review of face sheet dated 06/04/2026 revealed Resident #34 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of vascular dementia (loss of memory and thinking skills) and chronic obstructive pulmonary disease (difficult to breath). Record review of Quarterly MDS dated [DATE] revealed Resident #34 was usually understood by others and able to understand others. MDS assessment indicated Resident #34 had a BIMS score of 06 indicating severe cognitive impairment. MDS assessment indicated Resident #34 was on respiratory treatment of oxygen therapy. Record review of care plan dated 06/04/2026 revealed Resident #34 was care planned for chronic obstructive pulmonary disease with the intervention of oxygen therapy via nasal cannula at 2 liters per minute. Record review of order summary report revealed Resident #34 had an order for oxygen via nasal cannula at 2 liters per min started on 02/23/2026. During an observation on 05/31/2026 at 1:00 p.m., Resident #34's oxygen tubing was undated or labeled. Resident #34's oxygen was running at 2 liters per minute by nasal cannula while Resident #34 was asleep in bed. During an interview on 05/31/2026 at 2:45 p.m., Resident #34 stated that she always wore her oxygen at all times and she was unsure when her oxygen tubing and nasal cannula was changed. During an interview on 06/04/2026 at 2:40 p.m., LVN K stated that he was not sure when Resident #31 and Resident #34's oxygen supplies had been changed. The LVN K stated that all oxygen supplies were supposed to be in a plastic bag, but he was unsure if it was supposed to be dated. LVN K stated that oxygen supplies were supposed to be placed in the bag for infection prevention. During an interview on 06/04/2026 at 3:59 p.m., the ADON stated she expected nurses to place oxygen supplies in a plastic bag after each use and the tubing and supplies to be changed weekly on every Sunday's evening shift. The ADON stated that each resident who has an oxygen order should have an order for the supplies to be changed weekly and labeled and dated to prevent the growth of bacteria. During an interview on 06/04/2026 at 4:04 p.m., DON stated she had been in her role for 3 weeks. The DON stated to her knowledge oxygen tubing and supplies should be changed as needed and she was unaware of the policy. The DON stated oxygen supplies were stored in a plastic bag for infection control. During an interview on 06/04/2026 at 4:59 p.m., the Administrator stated it was nursing's responsibility for ensuring all oxygen supplies our properly labeled and stored. The Administrator stated that she was unaware that Residents #31 and #34's oxygen supplies were not properly stored or labeled. The Administrator stated Resident #31 and Resident #34's oxygen supplies were stored in<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a bag for infection prevention and labeled to ensure it was changed routinely to prevent growth of bacteria. Record review of the Oxygen Administration policy undated revealed the facility should change oxygen tubing including the nasal cannula prongs and mask when visibility contaminated. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 1 of 6 residents (Resident #21) reviewed for pharmacy services. The facility failed to ensure MA G did not administer Resident #21's Vitamin C when there was no dosage listed in the physician's order on 06/01/2026. This failure could place the residents at risk of not having medications available for use, medication errors, and inaccurate records.Findings included: Record review of a face sheet dated 06/04/2026 indicated Resident #21 was a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness and paralysis of the right side of the body after a stroke), dementia (deterioration of memory, language, and other thinking abilities), and Stage 4 chronic kidney disease (decreased kidney function places patients at high risk for kidney failure). Record review of Resident #21's MDS assessment dated [DATE] indicated he had a BIMS score of 4, which indicated his cognition was severely impaired. Resident #21 required substantial/maximal assistance with toileting, showering, and setup or clean-up assistance with eating. Record review of Resident #21's Order Summary Report dated 06/04/2026 did not indicate an order for Vitamin C. Record review of Resident #21's May 2026 Medication Administration Record indicated Vitamin C give 1 tablet by mouth two times a day discontinue date 06/02/2026. Resident #21's May 2026 Medication Administration Record indicated he received Vitamin C twice a day every day for the month of May 2026. Resident #21's June 2026 Medication Administration Record indicated he received Vitamin C 06/01/2026. Record review of Resident #21's care plan with a target date of 06/01/2026 did not address administering Vitamin C. During an observation of medication administration with MA G on 06/01/2026 at 7:50 AM, MA G administered 1 tablet of Vitamin C 500 mg to Resident #21. During an interview on 06/04/2026 at 2:52 PM, MA G said she administered 500 mg of Vitamin C to Resident #21 because a different medication aide told her that was the dosage he should be receiving. MA G said she was aware the Vitamin C did not have a dose, and she should not have administered it. MA G said the proper procedure would have been for her to notify the charge nurse for clarification. MA G said Resident #21's Vitamin C should have been discontinued, but she did not know when it was discontinued. MA G said it was important to ensure that any medications and supplements have the correct dose because some people cannot take certain medications. During an interview on 06/04/2026 at 4:42 PM, the Administrator said she expected the staff to use the seven rights of medication, which included the right dose. The Administrator said the DON was responsible for ensuring the staff were administering medications as ordered. The Administrator said it was important because there was a possibility of under or overdosing the residents. During an interview on 06/04/2026 at 5:22 PM, the ADON said she could not remember the day, but MA G reported to her Resident #21's Vitamin C did not have a dose. The ADON said the DON told her Resident #21 was receiving Vitamin C 500 mg, but it should have been discontinued. She did not know when it should have been discontinued. The ADON said if there was no dose listed in the order the medication or supplement should not be administered until clarification on the order was received. The ADON said she and the DON reviewed the new orders daily, and the error should have been caught but it was missed somehow. The ADON said administering medications without an order could result in the resident getting the wrong medication or they may not need the medication. During an interview on 06/04/2026 at 5:49 PM, the DON said MA G should have followed the five rights of medication and notified her when she noticed Resident #21's Vitamin C did not have a dose prior to administering it.<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON said she was not the DON when the medication should have been discontinued so she did not know the exact date it should have been discontinued. The DON said she currently did not have a system in place for reviewing the orders. The DON said Resident #21's Vitamin C not having the dose could have resulted in him getting the wrong dose or not getting enough or getting too much. Record review of the facility's policy titled, Medication Administration Procedures, revised 10/25/2017, indicated, 11. All current medications and dosage schedules are to be listed on the resident's current medication administration record. 20. The 10 rights of medication should always be adhered to 1. Right patient 2. Right medication 3. Right dose 4. Right route 5. Right time 6. Right patient education 7. Right documentation 8. Right to refuse 9. Right assessment 10. Right evaluation. |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 1 of 7 residents (Resident #67) reviewed for laboratory services. The facility failed to ensure Resident #67's Microalbumin (Albumin is a protein needed for tissue growth and healing. It can leak into your urine when your kidneys aren't working as they should) was drawn every 6 months as ordered by the physician.These failures could place residents at risk of not receiving lab services as ordered, not receiving timely diagnosis and treatment, and not receiving appropriate monitoring for certain diseases. Findings included:Record review of Resident #67's face sheet, dated 06/04/26, reflected Resident #67 was an [AGE] year-old male, admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis which included stroke, malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it actually consumes), dysphagia (difficulty or discomfort in swallowing), diabetes (high blood sugars), and high blood pressure. Record review of Resident #67's quarterly MDS assessment, dated 05/11/26, reflected Resident #67 rarely made himself understood, and was rarely understood by others. Resident #67's had severe cognitive skills for daily decision making. The MDS did not indicate any weight loss. The MDS indicated he had arterial ulcers.Record review of Resident #67's comprehensive care plan reviewed 01/30/24 reflected Resident #67 was at risk for Malnutrition. The care plan interventions were for staff to monitor labs as ordered and monitor weights. Record review of Resident #67's physician's orders dated 09/27/24 indicated lab Microalbumin every 6 months in October and April.Record review of Resident #67's comprehensive care plan revised 05/13/26 reflected Resident #67 had arterial/ischemic ulcers related to arteriosclerosis (hardening of the arteries). The care plan interventions were for staff to monitor labs as ordered, do treatment as ordered and observe for any complications.Record review of Resident #67's electronic medical record did not indicate Resident #67 had a Microalbumin level since labs were ordered 09/27/24.During an interview on 06/03/26 at 2:29 p.m., LVN K said when labs were ordered the nurses filled out the lab slip and placed the new order on the 24-hour report for the nurses to follow up. He said he did not know if they had a monitoring system for the labs process but knew if it was a routine lab the lab company would fax over results. He said he felt the lab company should keep up with all routine labs once the lab slip was completed. He said she was not aware of Resident #67 missing labs any labs. He said failure to follow up on labs could potentially cause the residents to miss a medication or something else they might need.During a phone interview on 06/04/26 at 11:45 a.m., the facility's Nurse Practitioner said he expected labs to be done as ordered. He said he could not recall why the lab was ordered for Resident #67 but knew Microalbumin would be related to his nutrition and wounds.During an interview on 06/04/26 at 3:01 p.m., the DON said she expected labs to be drawn as ordered by the physician's order. The DON said the nurses were responsible for putting the order in the electronic system, filling out the lab slip and placing on the 24-hour report. She said the lab provider was responsible for coming the next day to draw the lab. She said nurses could see any pending lab on their electronic system. She said she monitored the labs daily by reviewing their electronic system. The DON said she was not aware Resident #67 had missed labs. The DON said it was important to ensure labs were drawn as ordered by the physician to ensure the resident's health had been monitored by those lab values. During an interview on 06/04/26 at 3:58 p.m., the Administrator said she expected labs to be drawn as ordered. She said the nurses were responsible for filling out the lab slip and following the physician's orders. She said nurse management were responsible for ensuring lab had been drawn as ordered. The Administrator said it was important for labs to be drawn as ordered by the physician for the welfare of the resident's health. Record review of the facility's policy titled Physician Orders, undated, indicated. Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident.Written Orders by the Physician or Nurse Practitioner.2.The nurse will enter the order into<br>(continued on next page) |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PCC for the resident and select prescriber written 4.The receiving nurse will contact any other department or external facilities as required, i.e. dietary department, pharmacy, lab provider, x-ray provider, etc . |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observations, and interviews, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 residents (Residents #26 and #46) reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 06/02/26. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss.Findings included:During an interview on 05/31/26 at 10:58 a.m., Resident #26 stated the food was served cold. Resident #26 stated she ate in her room mostly for lunch. During an interview on 05/31/26 at 11:21 a.m., Resident #36 stated the food could be a little warmer. Resident #36 stated she ate in her room for lunch. During an observation and interview on 06/02/26 at 12:58 p.m., revealed the lunch tray was sampled by the Dietary Manager and 4 surveyors. The sample tray consisted of barbecue chicken which was lukewarm and dry; the green beans were lukewarm and bland; the macaroni and cheese were lukewarm, bland, and needed more cheese. The Dietary Manager stated the barbecue chicken could have been warmer and more tender: the green beans could have been warmer and more salt added; and the macaroni and cheese could have been warmer and more salt added. During an interview on 06/02/26 at 4:45 p.m., Resident #26 stated her lunch meal could have been hotter. During an interview on 06/02/26 at 4:48 p.m., Resident #36 stated her lunch meal was not hot enough. During an interview on 06/03/26 at 9:03 a.m., CNA M stated no residents complained to her about food being cold or bland but if so, she would offer the resident an alternative. CNA M stated all food complaints would be reported to the nurse and dietary staff. CNA M stated residents not eating their food could potentially cause weight loss. During a telephone interview on 06/04/26 at 1:45 p.m., the Dietician stated she had not had any residents complain about food being cold or bland. The Dietician stated she got a test tray, and she monitored meal service monthly. The Dietician stated most of the residents were pleased with the meal service and if there were any preferences or isolated issues she reported it to the Dietary Manager. The Dietician stated a substitute was always available. The Dietitian stated residents not eating their food could potentially cause weight loss. During a telephone interview on 06/03/26 at 1:59 p.m., RN A stated she had not had any residents complain about food being cold or bland. RN A stated she would offer an alternative and report to the Dietary Manager. RN A stated residents not eating their food could potentially cause weight loss. During an interview on 06/04/26 at 2:51 p.m., the Dietary Manager stated she had not had any complaints about the food being bland, but she has had complaints about food being cold. The Dietary Manager stated there was no one specific, but she did notice the complaints were from residents that ate in their room. The Dietary Manager stated she had started a monitoring system by having additional staff on the halls to serve the residents. The Dietary Manager stated if food complaints were brought to her an alternative would be offered. The Dietary Manager stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss. During an interview on 06/04/26 at 3:30 p.m., the DON stated she expected food to be at the appropriate temperature and seasoned for palatability. The DON stated she had residents complain about the food being cold and bland but was not able to state any residents specific. The DON stated she would go to the kitchen and ask for an alternative or have the cook prepare a new plate. The DON stated she would report all complaints to the Administrator. The DON stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss and malnutrition.During a telephone interview on 06/04/26 at 4:06 p.m., the Administrator stated he expected food to be at the appropriate temperature and seasoned for palatability. The Administrator stated she had not had any complaints brought to her attention by staff nor residents about the food being bland or cold. The Administrator stated she had not had a test tray, but she did expect the cook to follow the recipe. The Administrator stated she monitored by rounds during meal service. The Administrator stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss. Record review of the facility's policy titled,<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pleasant Springs Healthcare Center | 2003 North Edwards Avenue<br>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.

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|---|---|
| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Preparation Food Production and Meal Service dated 2012 reflected. We will establish safe and nutritional preparation of food. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value.2. All food will be prepared by methods that preserve nutritive value, flavor, and appearance with a variety of color, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident. 6. The Dietary Service Manager and cooks will taste and test meals daily. The administrator and DON may taste test meals if requested. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 455532 | A. Building<br>B. Wing | 06/04/2026 |

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|---|---|
| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to accommodate residents' food preferences for 1 of 6 residents (Resident #4) reviewed for nutrition. The facility failed to honor Resident #4's preference for no bread for the lunch meal on 05/31/2026 This failure could place residents at risk for a decrease in resident choices, diminished interest in meals, and weight loss.Finding including: Record review of face sheet dated 06/04/2026 revealed Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of bipolar disorder (intense mood swings) and type 2 diabetes (metabolic effecting blood sugar control) Record review of Quarterly MDS dated [DATE] revealed Resident #4 was able to make herself understood and was able to understand others. MDS Assessment indicated Resident #4 had a BIMs score of 15 indicating no cognitive impairment. Record review of care plan reviewed on 06/03/2026 revealed Resident #4 had a potential for nutritional problems due to recent hospitalization with the intervention of provide and serve diet as ordered. Record review of order summary report revealed Resident #4 had a diet order of regular diet mechanical soft texture and regular consistency with the start date of 07/06/2025. Record review of meal ticket order revealed Resident #4 should have no bread. Observation, interview, and record review, on 05/31/2026 at 12:35 p.m., Resident #4 revealed she did not like bread and according to her meal ticket she was not supposed to receive bread on her tray. Resident #4's meal ticket revealed no bread. Interview on 06/04/2026 at 3:13 p.m., the [NAME] stated he was responsible for ensuring the plate was made according to the ticket. The [NAME] said nursing staff checked the tray before the tray went to the residents. The [NAME] said Resident #4 was at risk of receiving food she did not like. The [NAME] stated that it was an accident that Resident #4 received bread on her tray. The [NAME] stated that he looked at the meal ticket but made the mistake. Interview 06/04/2026 at 3:25 p.m., the Dietary Manager revealed that the cook or herself prints each meal tickets prior to each meal. The Dietary Manager stated she expected the ticket and the tray to match. The Dietary Manager stated she expected that the kitchen staff to not put a roll on the tray if that was the resident's preference. The Dietary Manager stated Resident # 4 was at risk of allergy, weight loss and the possibility of getting upset or skipping a meal. The Dietary Manager stated it was the nursing staff's responsibility for checking the trays prior to the resident receiving. The Dietary Manager stated the dietary aided prepared the tray according to the meal ticket. The Dietary Manager stated that cook prepared the plate, the aide placed the plate on the tray, the nurse checked the tray, and the CNA took the tray to the resident. Interview on 06/04/2026 at 3:54 p.m., the ADON stated she expected Resident #4 to not receive bread if that is stated on her meal ticket. The idea when stated resident number 4 was at risk of choking and it was her resident robot to not receive bread on her tray. The ADON stated that dietary prepared the trays and the nurse was responsible for checking the trade prior to reset receiving it. Interview on 06/04/2026 at 4:07 p.m., the DON stated she expected resident #4 to receive a tray that matches her ticket that stated no bread. The DON stated it was the nursing responsibility to check the tray prior to the Resident #4 receiving her meal. The DON stated the RN and LVN were responsible for checking the trays on Sunday and she was unaware resident #4 received bread. Interview on 06/04/2026 at 5:01 p.m., Administrative revealed that she expected resident #4 to receive what was on her meal ticket. Administrator stated it was the resident's right to receive her preference of no bread on her tray. The administrator stated she was unaware that resident #4 received a roll on Sunday. The administrator stated that Resident #4 was at risk of consumption a food allergy or something she does not prefer. Record review of the 19 Instruction for Food Preferences List policy, undated, revealed the facility should check the food for resident likes or dislikes. |