STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455579	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sulphur Springs Health and Rehabilitation	411 Airport Rd Sulphur Springs, TX 75482

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to exercise their rights and to be treated with respect and dignity for 1 of 2 residents (Resident #1) reviewed for resident rights. The facility failed to honor the request by Resident #1's to change his Medical Power of Attorney on 06/04/26 after his care plan meeting. This failure could place residents at risk of not having their preferred responsible party represent them in medical or care decisions. Findings included: Record review of Resident #1's face sheet, dated 06/23/26 indicated an [AGE] year-old male admitted to the facility on [DATE] and re-admitted [DATE] with diagnoses which included, dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities), stroke and high blood pressure. Record review of Resident #1's quarterly MDS assessment, dated 03/10/26, indicated Resident #1 is usually understood at times and was sometimes understood by others. Resident #1 had a BIMS score of 09 which indicated his cognition was moderately impaired. The MDS indicated Resident #1 required assistance with his ADLs. Record review of Resident #1's comprehensive care plan, dated 09/19/25, indicated, Resident #1 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to diagnosis of dementia. The interventions included staff to monitor/document/report to the physician any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status changes. Record review of Resident #1's Medical Power of Attorney dated 05/27/26 had Family Member A and Family Member B listed on his Medical Power of Attorney. Family Member A being the primary. During an interview on 06/22/26 at 11:50 a.m., Family Member C said they had a care plan meeting on a date unknown with Resident #1. Family Member C said Resident #1 indicated he wanted Family Member A and Family Member C to be his Medical [NAME] of Attorney with Family Member A being the primary. Family member C said the facility had not updated or given the family members a copy of his new medical power of attorney. During an attempted interview on 06/23/26 at 11:30 a.m., Resident #1 was in his bed but unable to answer any questions when asked about his Power of Attorney related to his decline in condition and cognition. During an interview on 06/24/26 at 9:55 a.m., Family Member D said they had a care plan meeting on an unknown date with Resident #1. Family Member D said Resident #1 indicated he wanted Family Member A and Family Member C to be his Medical [NAME] of Attorneys with Family Member A being the primary. During an interview on 06/24/26 at 2:42 p.m., the DON said they had a care plan meeting on 06/04/26 for Resident #1. She said Family Member C, Family Member D, the Administrator, and herself were in attendance when Resident #1 said he wanted Family Member A and Family Member C to be his Medical [NAME] of Attorney with Family Member A being the primary. The DON said Resident #1 answered promptly and without hesitation when asked who he wanted to be his Medical Power of Attorney. She said she did not feel the resident was coerced with his answers. The DON said the Social Worker was the person responsible for ensuring the Medical Power of Attorney papers were completed according to the resident wishes. She said she was not aware the paperwork had not been completed. She said failure to complete the paperwork was against the residents' wishes. During an (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 06/24/26 at 6:42 p.m., the Social Worker said she was responsible for helping residents and families with the Power of Attorney paperwork. She said she did not attend the care plan meeting for Resident #1 on 06/04/26 because she was on vacation. She said she was not aware she needed to complete a new Medical Power of Attorney for Resident #1. She said not filing out the medical power of attorney could be against the residents' rights and wishes. During an interview on 06/24/26 at 7:12 p.m., the Administrator said the Social Worker was responsible for the power of attorney paperwork. She said the facility had a care plan meeting for Resident #1 on 06/04/26. She said Family Member C, Family Member D, the DON, and herself were in attendance when Resident #1 said he wanted Family Member A and Family Member C to be his Medical [NAME] of Attorneys with Family Member A being the primary. She said she thought she and the Social Worker had discussed Resident #1's wishes for his power of attorney. She said failure to have paperwork completed and in his medical records was not honoring his wishes. During an interview on 06/24/26 at 7:50 p.m., the Administrator said they did not have a policy on Power of Attorney. Review of the facility's policy Resident Rights, revised on 02/20/21, indicated: Policy: The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Residents Rights: #1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. B. In the case of a resident who has not been adjudged incompetent by the State court, the resident has the right to designate a representative, in accordance with State law.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, it was determined that the facility failed to ensure residents have the right to receive visitors of his or her choice and at the time of his or her choosing for 1 (Resident #2) of 10 Residents reviewed for resident rights. The facility did not allow Resident #2 to visit or talk with her Family Members E and G when they called and or came to the facility when Resident #2 wanted to have visitors and calls. This failure could place residents at risk of isolation, decreased emotional wellbeing, and diminished quality of life. Findings included: Review of Resident #2's face sheet dated 06/23/26 reflected that Resident #2 was a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities), depression(sadness), and anxiety (mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Review of Resident #2's admission MDS dated [DATE] reflected she needed setup assistance with her ADL's and had severe cognitive impairment for daily decision making. Review of Resident #2's care plan revised on 06/11/26 reflected that Resident #2 had impaired cognition and was at risk for a further decline in cognitive and functional abilities related to her diagnosis of dementia with behaviors. Interventions included for staff to reduce any distractions, turn off television or radio, close doors etc., ensure the residents understand, use consistent, simple, direct sentences. Repeat information as needed. Explain all procedures with terms and gestures the resident can understand. Stop and return if the resident becomes agitated. Review of Resident #2's progress notes dated 05/29/26 through 06/23/26 did not include any information regarding visitation limitations or visitors/visitation. Review of Resident #2's psychological services progress note dated 06/11/26 completed by Licensed Professional Counselor (LPC), revealed Resident #2 reported feeling happy because it was her birthday and Family Member F was going to visit. Record review of Resident #2's progress notes dated 06/21/26 documented by LVN C revealed Resident #2's Family Member F wanted to talk to Resident #2 and LVN C told Family Member F she could not let her talk to Resident #2 without Family Member E's approval. During a phone interview on 06/22/26 at 11:24 a.m., Family Member F said the facility would not allow her to visit Resident #2 on unknown dates. She said she was not given a reason she could not visit Resident #2. She said she called the facility to talk with Resident #2 on yesterday (06/21/26) and was denied. She said she felt it was against Resident #2's wishes. During a phone interview on 06/22/26 at 11:45 a.m., Family Member G said the facility would not allow her to visit Resident #2 on an unknown date. She said she was not given a reason why she could not visit. She said she was at the facility when CNA A told her she could not visit Resident #2 without giving a reason why. Family Member G said she asked to speak with management, but no one came so she left the facility. During an interview on 06/23/26 at 12:46 p.m., LVN E said she was Resident #2's nurse. She said to her knowledge family members could visit at any time. She said she was not aware of any restrictions of family calls or visits for Residents #2. LVN E said Resident #2 had a lot of behaviors at the beginning of the month but had improved some with medication adjustments. She said Resident #2 had behaviors such as yelling, throwing things, kicking, or wondering throughout the secure unit and banging on doors, whether she had visitors or not. During a phone interview on 06/23/26 at 2:31 p.m., Family Member E said she did not want Resident #2 to have visits from Family Member G because she would stay too long during visits and tells Resident #2 things such as telling her she does not have to be here. She said Family Member E could visit but on a set schedule. She said she felt Family Members F and G's visits caused Resident #2 to act out and have behavior issues. Family Member E said she had Medical Power of Attorney over Resident #2. She said she had not heard Resident #2 say she did not want to see Family Member F or G. She said she and Resident #2's family members have had confrontations most of her life. She said they were going to have a meeting with the Ombudsman on 06/25/26 at 3:00 pm to talk about (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visitation for Resident #2. During an interview on 06/23/26 at 4:29 p.m., LVN C said Family Member F called on 06/21/26 and wanted to talk with Resident #2. LVN C said she told Family Member F that she could not talk to Resident #2. LVN C said she called Family Member E to clarify about Resident #2 talking on the phone and Family Member E said she does not want Family Member F to talk to Resident #2. LVN C said she did not hear Resident #2 say she does not want to talk to Family Members F. She said Resident #2 had dementia and she followed Family Member E's wishes because she had Power of Attorney. She said she felt she was doing what was best for Resident #2. During an interview on 06/24/26 at 1:20 p.m., Resident #2 said she wanted to see or talk to her family members and named them. Family Members F and G were included. During a phone interview on 06/24/26 at 2:40 p.m., the Ombudsman said she had been at the facility on 06/19/26 and visited with Resident#2 who said she wanted Family Members F and G to visit her. She said they had a family meeting scheduled for 06/25/26 at 3:00 pm. She said she felt Resident #2 could make her decisions on her visitors. During a phone interview on 06/24/26 at 4:04 p.m., CNA D said Family Member E said she did not want Resident #2 to have visits or phone calls from Family Members F and G unless she approved it. She said Family Member E said they upset Resident #2 and after they visit Resident #2 has behaviors. CNA D said Family Member G came to the facility, and she told Family Member G that she could not see Resident#2 because that was what Family Member E requested. She said she thought the nurses and the Administrator were aware. During an interview on 06/24/26 at 5:00 p.m., the facility's Medical Doctor said he was not aware of any family members not being able to see Resident #2. He said he had taken care of Resident #2 at her previous facility and now at this facility. He said she had dementia with behavior and would have outburst and behaviors at times, sometimes more than less. He said it was part of her diagnosis. During a phone interview on 06/24/26 at 5:00 p.m., LVN B said she worked a variety of shifts as needed. She said Family Member E called on the phone and said she did not want Resident #2 to talk on the phone or have visits from Family Members F or G. She said Family Member E did not say why she did not want Family Members F or G to talk or visit Resident #2 and she said she did not ask. During an interview on 06/24/26 at 6:33 p.m., CMA D said he worked with Resident #2 on his assigned shifts 2pm-10pm. He said Resident #2 had behavior issues most nights such as kicking doors, cursing, or wandering throughout the unit whether she had visitors or not. During an interview on 06/24/26 at 6:42 p.m., the Social Worker said she had never told any family members they could not visit or call any residents. She said there was a concern from Family Member E about visits and things being said when Family Member E and G came to visit, but she was not sure of all the details. She said she became aware on Monday (06/21/26) that Family Member F called the facility to talk with Resident #2 over the weekend but was not sure which date (06/19/26 or 06/20/26) and was denied. She said she had already talked with the Ombudsman Friday (06/19/26) in which Family Member F had already reached out to as well. The Social Worker said they scheduled a care plan for Thursday, 06/25/26 to discuss any issues or concerns. She said failure to allow visits or phone calls could place the residents at risk of isolation, social wellbeing, or increased depression. During an interview on 06/24/26 at 7:12 p.m., the DON said all residents have rights. She said Resident #2 was able to talk and could make decisions for herself. She said she was not aware of any family members who could not see Resident #2. She said all staff were responsible for ensuring resident rights were being honored. She said failure to allow Resident #2 to have visitors was against her choice and could cause isolation. During an interview on 06/24/26 at 7:24 p.m., the Administrator said all staff were responsible for ensuring resident rights were maintained. She said she was not aware Resident #2's family members were not being allowed to visit or talk with her. She said she was only aware of Family Member H who could not visit related to threats toward the administrator and law enforcement ordered a No Trespassing. She said even if Resident #2 had dementia she had rights. She said if a family member had Power of Attorney, it only became effective if the resident was unable to make decisions for themselves. She said failure to have visitors could cause depression and isolation. Review of the facility's policy Resident Rights, revised on 02/20/21, (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated: Residents Rights: #5. Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: d. The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner, which does not impose on the rights of another resident.