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	03/25/2026

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 8 of 8 confidential residents, and 1 of 1 meal reviewed for palatability, attractiveness, and appetizing foods. The dietary staff failed to provide food that was palatable and at an appetizing temperature for residents. This failure could place residents at risk of a decreased food intake, hunger, and unwanted weight loss.Findings included: During an observation on 3/24/2026 at 11:50 PM revealed the last temperature was checked of the lunch meal on the warming table with warming plates to prepare to serve the assisted dining area first, main dining, north hall, west hall, and then South hall. The time betray line service began at 12:07 p.m. the test tray was made at 12:11 p.m. During an observation on 3/24/2026 at 12:20 p.m., the tray cart with the test tray left the kitchen preparation area. The tray cart was reviewed by nurses and left the dining room and went directly to the hall. The trays were passed starting from the dining room, the north hall ending when the test tray arrived in the work room at 12:42 p.m. During a confidential group interview at an undisclosed date at an undisclosed time revealed 11 of 11 residents said the food trays served on the halls were cold. During a test tray interview with the Dietary Manager and State Surveyors on 3/24/2026 at 12:45 p.m., the Dietary Manager stated the following regarding the regular food diet for lunch served on 3/24/2026: the turkey stew was good and warm; mixed vegetables were cold, roll was good but room temperature, and lemon pudding was room temperature not cold but flavor was good. Overall, the Dietary Manager stated the food was good but cold. The State Surveyors tasted each item on the test tray and the turkey stew was warm and had good flavor, the mixed vegetables were cold, the roll was good but room temperature, and the lemon pudding was good. Observation of the tray revealed unappealing food and hair on the plate. During an interview on 3/25/26 at 10:00 a.m. Dietary Aid S was unavailable to be interviewed, stated she would call back at a later time. During an interview on 3/25/26 at 10:10 a.m. [NAME] T was unavailable to be interviewed, stated she would call back at a later time. During an interview on 3/25/26 at 10:18 a.m. revealed the Dietary Manager was responsible for ensuring food was palatable and hot served to the residents to prevent weight loss. The Dietary manager unsure why there was hair on the plate. The Dietary Manager stated she requires all staff to wear hair nets in the kitchen. During an interview on 3/25/2026 at 2:21 p.m. [NAME] T revealed, on a phone call, she was responsible for ensuring the food tasted good and was hot when the resident got their tray. [NAME] T stated residents were at risk of weight loss and low quality of life. [NAME] T stated they do their best in the kitchen to prepare the tray and get them out as fast as possible. During a interview on 3/25/2026 at 2:32 p.m., the Registered Dietitian was called and left a voicemail with no return phone call. During an interview on 3/25/2026 at 2:33 p.m., Dietary Aid S stated her and the [NAME] were responsible for preparing and serving hot and good food to the residents. Dietary Aid S stated the resident had the right to good food to prevent weight loss. During an interview on 3/25/26 at 5:36 p.m. revealed the DON expected the dietary manager to ensure the food was delivered to the residents hot so the residents would eat and not lose weight. During an interview on 3/25/26 at 6:39 p.m. revealed the Administrator stated the dietary manager and the kitchen staff prepared the food in a timely manner so the residents received their food hot and food (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was good tasting. The administrator stated the residents were at-risk of clinical decline if they did not eat the food that was prepared. Record review of a Resident Council Meeting Form, dated 3/24/2026, indicated the group council voiced their food being cold. Record review of the food temperature log, dated 3/24/2026 , indicated the Regular meat's temperature at the time of serving was 188 degrees Fahrenheit, the cooked vegetables were 187, rolls was room temperature degrees, and the lemon pudding was 40 degrees Fahrenheit. Mechanical soft Turkey Stew was 186 degrees Fahrenheit the mechanical soft carrots was 174 degrees Fahrenheit the mechanical soft rolls were room temperature. Puree Turkey Stew was 185 degrees Fahrenheit. Carrots were 167 degrees Fahrenheit. Rolls were 135 degrees Fahrenheit and all residents were served the same dessert of lemon pudding which was 40 degrees Fahrenheit. Record review of Menus and Nutritional Adequacy policy, dated 7/22/2022, revealed pre-planned menu is provided to the facility, which has been planned or reviewed by a Registered Dietitian and includes meals that are adequate to meet the average residents nutritional needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's 1 of 1 kitchen reviewed for food safety requirements. The facility failed to ensure there was not dust on the air vent above the preparation area.The facility failed to ensure there was no dust and bugs inside the light fixture above the stove. The facility failed to ensure floors did not have a sticky substance.The facility failed to ensure the skillet did not have a carbon buildup around the edge.The facility failed to ensure the baking sheet did not have a carbon buildup around the edge.The facility failed to ensure there was no trash laying on the ground, spilled out of trash bag, in the outdoor garbage dumpster.The facility failed to ensure there was a trash can liner for the hand hygiene trash can. These failures could place residents at risk of foodborne illness, and food contamination.Findings included:During initial tour on 3/23/2026 at 9:40 a.m., the following were identified: the kitchen air vent above the preparation area was dusty, the light fixture above the preparation area was filled with brown dirt and bugs, the floors were sticky, the skillet used to cook a grilled cheese had brown buildup around the entire edge of the pan approximately half an inch, baking sheets had brown residue on the top and bottom, there was trash laying outside of the garbage receptacle on the ground, and there was no trash can liner in the hand hygiene trash can. During an observation on 3/24/2026 at 10:30 AM revealed the kitchen air vent above the preparation area was dusty, the light fixture above the preparation area was filled with brown dirt and bugs, the floors were sticky, the skillet used to cook a grilled cheese had brown buildup around the entire edge of the pan approximately half an inch, baking sheets had brown residue on the top and bottom, and there was no trash can liner in the hand hygiene trash can. German interview on 3/25/2026 at 10:18 AM the Dietary Manager revealed it was the Maintenance Director for cleaning light fixture and the air vent and reported it had not been done in two months although the kitchen was one of his daily rounds. The Dietary Manager stated the last time the event and the light was cleaned was when they had to replace the light bulbs. The Dietary Manager stated she was aware of the dirty light and vent. The Dietary Manager stated there was a risk of dirt and dust getting in the food. The Dietary Manager stated they clean the floors by mopping daily multiple times a day but have been unable to get them clean. The Dietary manager stated after survey or observation of particles built up on the skillet she determined it needed to be thrown away and she cleaned the baking pans. The dietary Manager stated the residents were at risk of foodborne illness and cross contamination due to the dirty equipment, kitchen floor, vent, light, trash on the ground outside, and no trash can liner. The Dietary Manager stated the staff cleaned the hand hygiene trash can but could not provide documentation. During an interview on 3/25/2026 at 11:04 a.m., the Maintenance Director revealed he was responsible for cleaning the lights and the air vent which he had done two months ago when he replaced the light bulbs. The Maintenance Director stated daily stand-up was when he was notified of issues to be addressed and he was unaware of there being any problems at this time. During an interview on 3/25/2026 at 2:21 p.m., [NAME] T revealed the air vents and lights did not get cleaned very often and she was unaware of the last time it was cleaned. [NAME] T stated it was the maintenance director's responsibility for cleaning the light fixture and the air vent. [NAME] T stated the floor was sticky from spilled tea a few weeks ago. [NAME] T stated they routinely cleaned the floors by mopping them but had not been able to get the residue off the ground. [NAME] T stated the pans and skillet did not get used often and were cleaned in the dishwasher, but both the sheet pans and skillet were that way for as long as she could remember. [NAME] T stated it was a shared responsibility between all hand maintenance to maintain the cleanliness of the kitchen to prevent cross contamination and foodborne illnesses. [NAME] T Stated it was a shared responsibility between all kitchen staff and nursing to take trash to the dumpster and she was unaware of why there was trash on the ground outside of the garbage can. [NAME] T stated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	she did not no one there was not a trash can liner in the hand hygiene trash can and she stated the dietary manager stated they clean the hand hygiene trash can each day. [NAME] tea stated maintenance does daily rounds and believed he was aware of air vent and light being dirty. During a interview on 3/25/2026 at 2:32 p.m., the Registered Dietitian was called and left a voicemail with no return phone call. During an interview on 3/25/2026 at 2:33 p.m., Dietary Aid S revealed she and the cook were responsible for cleaning the kitchen daily after meal services to prevent cross contamination and foodborne illnesses. Dietary Aide S stated they kept a log of when each item in the kitchen was cleaned instead of the air vent and the light fixture above the preparation area had been dirty for months. Dietary aid S stated she took trash out after she was done serving each meal there were two trash cans in the kitchen and between her and the cook they both took one bag out each. The Dietary Aide S stated when she took trash out there was no trash on the ground outside. The dietary Aid S stated she was unaware why there was no trash can liner in the hand hygiene trash can. Dietary aid stated maintenance comes in daily but has not cleaned the vent and light. Dietary aid stated she did not know she needed to report to the maintenance. During an interview on 3/25/2026 at 6:39 p.m., the DON stated she expected the kitchen to be cleaned and the dietary staff were responsible for cleaning and maintaining the area to prevent cross contamination and food borne illness. The maintenance director was responsible for making sure the vent was cleaned, the lights were cleaned and the kitchen was in good repair. The DON stated the Maintenance Director is in daily morning standup which he can be notified at that time of any needs. During an interview on 3/25/2026 at 6:43 p.m., the Administrator revealed it was the Maintenance Directors responsibility for ensuring the air vent and the light fixtures were cleaned routinely. The administrator stated dietary management was responsible for ensuring the kitchen was cleaned daily and after each meal service to prevent cross contamination. Record review of the daily schedule, dated week of 3/22/2026, revealed who was responsible for each equipment area daily which was signed off for all listed areas which indicated the kitchen areas and equipment were cleaned. Record review of the Food safety and Sanitation Plan, revision date 10/24/2022, revealed it is the policy of this facility to follow an effective, proactive food safety program that is based on preventing food safety hazards before they occur. The Hazard Analysis Critical Control Point (HACCP) Plan is an example of such a program. Record review of https://www.fda.gov/media/164194/download?attachment accessed on 3/31/2026 indicated:Chapter 4. Equipment, Utensils, and Linens Multiuse 4-101.11Characteristics. Multiuse equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. Certain materials allow harmful chemicals to be transferred to the food being prepared which could lead to foodborne illness. In addition, some materials can affect the taste of the food being prepared. Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens. Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment, so that food prepared on or in the equipment becomes contaminated. Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food. Studies regarding the rigor required to remove biofilms from smooth surfaces highlight the need for materials of optimal quality in multiuse equipment.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 facility reviewed for pest control. The facility failed have an effective pest control program to eradicate the cockroaches in the facility. This facility failure could place residents at risk for diarrhea, dysentery (infectious diarrhea), salmonella (an infection that can lead to diarrhea, fever, and stomach cramps), and other serious health concerns.Findings included:During an observation on 3/23/26 at 10:40 a.m. revealed 2 alive water bugs in the secure dining area crawling on the floor. During an observation on 3/23/26 at 11:09 a.m. revealed dead water bugs in the light fixture in the kitchen and on the ground of the dry storage room. During an observation on 3/24/26 at 10:05 a.m. revealed dead water bugs and dark brown particles in the light fixtures in the kitchen above the food preparation area. During an observation on 3/25/26 at 2:30 p.m., revealed large brown bugs in the hall were by the front entrance. During an interview on 3/25/26 at 4:45 p.m., revealed the Maintenance Director was responsible for cleaning the bugs out of the light fixture. During an interview on 3/25/26 at 6:50 p.m. revealed the Maintenance Director had contacted pest control due to the increased amount of alive bugs crawling noted by the staff and in resident rooms. The Maintenance Director reported he had documents from the previous visit from pest control to address the bug issue. The Maintenance Director stated he was responsible for ensuring the pest control program. The Maintenance Director stated the pest control company was coming monthly but not completing their required duties when the facility noticed an increase in alive bugs but could not recall an exact date, he contacted the pest control company supervisor who came to the facility and performed a full inspection and revealed the problem with water bugs. The Pest Control company increased their visits to every 2 weeks due to the increase in bugs. During an interview on 3/25/26 at 5:45 p.m. it was revealed the DON was aware of pest control coming every 2 weeks but did not report any issues with bugs. The DON stated that resident rooms were being treated buy was unaware of which residents. During an interview on 3/25/26 at 6:55 p.m. it was revealed the administrator had a binder of all documented visits by pest control. The Administrator stated the Maintenance Director was responsible for communicating and ensuring the pest control was taking place. The Administrator stated it was important to keep bugs out of the residents home to prevent illness. Record reviews of the only pest control service inspection report provided by the facility, dated 3/23/2026, reflected the device inspection summary listed 0 of 1 insect light trap and 0 of 1 rodent bait stations were inspected. No other pest control logs were provided. Record review of the Pest Control policy, dated 1/1/20, reflected it was the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 24 residents (Resident #15, Resident #10, and Resident #4) reviewed for care plans. The facility failed to ensure Resident #15's care plan included her medication Eliquis (an anticoagulant) and interventions. The facility failed to ensure Resident #4's care plan included her medication Eliquis (an anticoagulant) and interventions. The facility failed to follow Resident #10's care plan for palm protectors. These failures could place residents at risk of not having their needs met. Findings included: 1.Record review of Resident #15's face sheet dated 03/25/26 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included chronic obstructive pulmonary disease (chronic disease of the lungs that causes difficulty breathing), ventricular tachycardia (life threatening heart arrhythmia defined by a fast heart rate more than 100 beats per minute), diabetes mellitus (chronic metabolic disorder characterized by high blood sugars), major depressive disorder (a serious mental health condition characterized by persistent low mood and loss of interest in things), and high blood pressure. Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated she was understood by others, and she was able to make herself understood. The MDS also indicated she had a BIMS score of 13 which indicated she was cognitively intact. The MDS also indicated she required maximal assistance from staff for bed mobility, transfers, toileting, and bathing and she required setup assistance from staff for eating. The MDS also indicated Resident #15 was taking an anticoagulant medication. Record review of Resident #15's comprehensive care plan revised 01/15/26 did not indicate Resident #15 was receiving Eliquis (anticoagulant medication-blood thinner). Record review of Resident #15's order summary report dated as of 03/25/26, indicated she had an order for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for chronic atrial fibrillation with a start date of 02/08/25 and no end date. The order summary report did not indicate Resident #15 was being monitored for any side effects regarding his anticoagulant medication. Record review of Resident #15's medication administration record for the month of March 2026, indicated Resident #15 had received Eliquis 5mg one tablet two times daily since 02/08/25. The medication administration record did not indicate Resident #15 was being monitored for any side effects regarding his anticoagulant medication. 2. Record review of a face sheet dated 3/25/2026 indicated Resident #4 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with a diagnoses of unspecified atrial fibrillation (irregular, often rapid heart rate), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), parkinsonism (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	movements), history of transient ischemic attach (temporary blockage of blood flow to the brain) and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). Record review of Resident #4's physician orders dated 3/25/2026 indicated Resident #4 was ordered Eliquis Oral Tablet 5 milligrams by mouth two times a day related to heart failure on 8/05/2025 and started on 8/05/2025. Eliquis is a prescription blood thinner used to reduce stroke risk in atrial fibrillation (AFib), Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated Resident #4 was sometimes understood and usually understands. Resident #4's BIMS score was three which indicated severe cognitive impairment. The MDS quarterly assessment indicated Resident #4 was taking an anticoagulant. Record review of the comprehensive care plan dated 3/25/2026 indicated no focus, goals, or interventions for Anticoagulant use or monitoring. During an interview on 03/25/26 at 6:07 PM the DON said the medication should have been included on Resident #15 and Resident #4's care plan. The DON said the MDS Nurse was responsible for ensuring the anticoagulant medications were included in the care plan. The DON said the failure placed risks for Resident #15 and Resident #4 not being monitored for bleeding and their blood clotting correctly. During an interview on 03/25/26 at 6:15 PM the MDS Nurse said she was responsible for ensuring the anticoagulant was on Resident #15 and Resident #4's care plan. The MDS Nurse said she wanted to look on her computer and when she went into her computer, the MDS Nurse said the anticoagulant was not included in the care plan, but she was unsure of why not. The MDS Nurse said the failure placed a risk for the staff not knowing the residents were at risk for bleeding. During an interview on 03/25/26 at 6:52 PM the Administrator said she expected the Eliquis to be in the care plan for Resident #15 and Resident #4 to ensure the staff were aware of the medication and interventions. The Administrator said the DON or designee were responsible for ensuring the medication was included in the care plan. The Administrator said the failure placed a risk for the residents having a negative clinical effect for bleeding. 3.) Record review of a Resident #10's face sheet, dated 03/26/26, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included dementia (loss memory), right hand contractors, muscle weakness, and depressive disorder (persistently depressed mood). Record review of Resident #10's quarterly MDS, dated [DATE], indicated Resident #10 sometimes made herself understood and rarely understood others. Resident #10 had difficulty with recall, and her BIMs score was 02, which indicated severe cognitive impairment. The MDS indicated Resident #10 required extensive assistance with bed mobility, dressing, personal hygiene, and bathing. Record review of Resident #10's physician order dated 11/17/25, indicated: right palm protecter to be worn during waking hours as tolerated. Record review of the comprehensive care plan, revised date of 02/20/26, revealed Resident #10 had an alteration in her musculoskeletal status related to a contracture to the right hand. The intervention (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was for staff to apply the palm protector to her right hand related to her contracture and notify the charge nurse if she refused to wear the device. During an observation on 03/24/26 at 9:38 a.m., Resident #10 was lying in bed without anything in her right hand. During an observation and interview on 03/24/26 at 4:14 p.m., Resident #10 was lying in her bed without anything in her right hand. CNA B was in the room and said she was not aware of a palm protector for Resident #10. She looked in Resident #10's drawers and throughout the room but did not locate a palm protector. She said she was aware Resident #10 had a contracture to her right hand, but she usually applied a washcloth to her hand. During an observation and interview on 03/25/26 at 11:09 a.m., RN C said she was Resident #10's charge nurse. RN C looked at Resident #10's right hand and saw she did not have on her palm protector. RN C reviewed Resident #10's orders and said she was supposed to wear a palm protector, but she was unaware she had an order for the palm protector or where the palm protector was located. During an interview on 03/25/26 at 11:24 a.m., the Rehab Director said Resident #10 should have a palm protector in her right hand. He looked and saw Resident #10 did not have a palm protector in her right hand. He went and got a new palm protector and placed it in Resident #10's right hand. Resident #10 allowed the palm protector and thanked him for doing it. During an interview on 03/25/26 at 6:36 p.m., the DON said she was aware Resident #10 had orders and was care planned for a palm protector to her right hand. She said she was not aware why staff said they did not know she wore them because when she saw her out of bed in the dining room, she had them on. She said the CNAs were supposed to place the palm protector and the nurses were supposed to ensure the palm protector was on Resident #10's right hand. She said if Resident #10 did not have her palm protector on her right-hand it could make the contracture worse. During an interview on 03/25/26 at 7:00 p.m., the Administrator said she expected Resident #10 to have on her right palm protector if she was care planned and had an order for it. She said the CNAs were supposed to place the palm protector and the DON or designee was supposed to ensure the palm protector was on. She said failure to wear or have on the palm protector could cause her contractures to worsen. Record review of the facility's policy titled, Care Plans and CAAs (Care Area Assessments), dated 05/06/2021, indicated, Purpose: The purpose of this guide is to ensure that an interdisciplinary (IDT) approach is utilized in addressing the Care Area Triggers (CATs) that were generated by the completion of the Minimum Data Set in order to effectively address the Care Area Assessments and ultimately achieve the completion of an effective comprehensive plan of care for each resident. Care Plan Updates: The IDT will review the care plans annually, quarterly, and as needed to ensure all goals and approaches are appropriate. Acute Care Plans: As acute problems or changes to intervention or goals are identified, an appropriate care plan will be developed or modified by a Nursing staff member. Record review of the facility's policy titled, Following Physician Orders, dated 09/28/2021, indicated, Policy: The policy provide guidance on receiving and following physician orders. Policy Explanation and Compliance Guidelines:3. C. Carry out and implement physician orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 of 5 residents (Resident #45, Resident #37, Resident #19) reviewed for pressure ulcers. The facility failed to change Resident #45, Resident #37, Resident #19's wound dressings according to the physician's orders. This failure could place residents at risk of not receiving wound care services appropriately, could contribute to a decline in a wound, infection and a decline in physical, mental and psychosocial well-being.Findings included:Record review of face sheet dated 3/25/26 revealed Resident #45 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of lymphedema (swelling in the legs fluid build up), obesity (excess body weight), and pressure ulcer stage 4. Record review of care plan dated 3/25/26 revealed Resident #45 was care planned for stage 4 pressure ulcer to the right lateral ankle. Interventions were listed as provide wound care per physician orders. Record review of Quarterly MDS dated [DATE] revealed Resident #45 was admitted to the facility with the stage 4 pressure ulcer. Resident #45 had a BIMS score of 15 indicating no cognitive impairment. Record review of order summary dated 3/25/26 revealed Resident #45 had an order for daily wound care to the right lateral ankle stage 4. Ordered to clean, dry, apply xeroform, and covered with rolled gauze active with a start date of 3/9/26. Record review of treatment administration record dated 3/25/26 revealed Resident #45 did not receive ordered wound care on 3/22/26. Record review of wound care evaluation and summary management dated 2/9/26 revealed Resident #45 had a stage 4 to the right lateral ankle with measurements of 1.2x1.0x0.1cm. No further documentation was provided. Record review of face sheet date 3/25/26 revealed Resident #37 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of cellulitis, pressure ulcer to the right heel, pressure ulcer to the left heel and pressure ulcer to the back. Record review of care plan revision date 3/17/26 revealed Resident #37 was care planned for a stage 4 pressure ulcer to the left lateral ankle and left lateral foot with intervention to provide wound care per physician orders. Record review of comprehensive MDS dated [DATE] revealed Resident #37 had 4 stage 4 pressure ulcers which were present on admission. Record review of order summary dated 3/25/26 revealed Resident #37's wound care orders for his left lateral ankle, left lateral foot, left upper back, and right heel. Orders for wound care daily for left upper back include clean, dry, apply calcium alginate and cover with gauze dressing with a start date of 2/13/26. Record review of administration record dated 3/25/26 revealed Resident #37's wound care to left upper back was not completed on 3/22/26 and 3/8/26. Record review of wound care evaluation and summary management dated 3/16/26 and 3/23/26 revealed Resident #37 had wounds to his left lateral foot; left lateral ankle; left heel; right heel; back; left upper back. Measurements listed for left lateral foot 1.4x7.3.0.1cm, measurements for left lateral ankle stage 4 1.3x0.9x0.2cm, measurements for left heel stage 3 1.5x1.7x0.1cm, measurements for right heel stage 3 0.7x0.5x0.1cm, and measurements for upper back unstageable 1.7x2.1.0.1cm. Record review of face sheet date 3/25/26 revealed Resident #19 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of osteomyelitis right ankle and foot and cellulitis of right lower limb. Record review of care plan revision date of 2/24/26 revealed Resident #19 was care planned for pressure ulcer and wound with interventions to provide wound care per physician orders. Record review comprehensive MDS dated [DATE] revealed Resident #19 was not coded for any pressure ulcers. Resident #19 had a surgical wound. Resident #19 BIMS score was 6 indicating severe cognitive impairment. Record review of order summary dated 3/24/26 revealed Resident #19 had orders for daily wound care to the right and left heel. Order indicated to clean, dry, apply hydrogel and cover with a border dressing started on 3/5/26. Record review of administration record dated 3/25/26 revealed Resident #19 did not receive wound care on 3/22/26 to the left and right heel. Record review of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound care evaluation and summary management dated 3/16/26 revealed Resident #19 was seen by the wound care provider for his stage 3 pressure ulcer to the left heel and unstable pressure to the right heel. Measurements of the left heel are 2.1x2.1x0.1cm and right heel 4.4x4.1x0.1cm. An observation and interview on 3/23/26 at 11:26 a.m. revealed Resident #45 without a dressing on his left lateral ankle. Resident #45 stated that the wound care nurse took the bandage off this morning to be seen by the provider and it had been left off for his bed bath. Resident #45 stated had received his bed bath and was waiting for it to be put back on. Resident #45 stated he had been given his bath before 8:00 a.m. on the day shift. An observation on 3/23/26 at 2:30 p.m. revealed Resident #45 without dressing to his left lateral ankle situated up on heel protectors with foot rest at the end of the bed. Swelling noted to the ankle. Resident had been in the same position, on his back, since 11:26 a.m. An observation on 3/23/26 at 4:45 p.m. revealed Resident #45 without dressing to his left lateral ankle with increased swelling, yellow drainage seeping from tops of shins on to sheet and blood to the center of the wound coming off on to the heel protectors. Resident #45 was still lying on his back. An observation and interview on 3/23/26 at 11:24 a.m. revealed Resident #37's wound dressing dated 3/20/26 to the left lateral ankle and left lateral foot. An observation on 3/23/26 at 2:33 p.m. revealed Resident #37 with shoes on both feet in the bed without heel protectors. An observation and interview on 3/23/26 at 11:52 a.m. revealed Resident #19's wound dressing dated 3/20/26 to both heels. An observation on 3/23/26 at 2:36 p.m. revealed Resident #19 with shoes on both feet in the bed without heel protectors. An interview on 3/23/26 at 4:55 p.m. revealed the ADON was responsible for wound care for the day shift however she had not completed Resident #45, Resident #37, Resident #19 wound care and it had not been done since 3/20/26. The dressings should have been changed daily. Daily changes helped with ensuring the wound improved, and if they were not changed daily as ordered, there could be a decline in the wound healing, increased risk of infection, or multiple things. During an interview on 3/25/26 at 5:36 p.m. revealed the DON was made aware the wound care had not been completed 3/25/26 after surveyor intervention. DON stated she expected wound care for pressure ulcers to be completed according to physician orders. DON stated that every Monday the ADON and the wound care physician round in the morning to observe all wounds in the building. DON reported that after she was made aware of the incomplete wound care a verbal in-service with all nursing staff was completed, a progress note was documented, and the responsible party was notified. During an interview on 3/25/26 at 6:39 p.m. the Administrator was made aware that wound care was not complete. Administrator stated that she expected wound care to be done according to physician orders and reported to the DON if it is incomplete by the treatment nurse or charge nurse. Administrator stated that the Resident was at risk for clinical decline. Record review of the Skin Prevention and Management Guidelines, revised 4/13/23, revealed the facility is committed to the promotion of healing of existing pressure injuries. Evidence based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. Compliance with interventions will be documented in the monthly wound note summary charting. Pressure ulcer healing is documented using descriptive characteristics of the wound (i.e., depth, width, presence of granulation tissue, exudate).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 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 2 of 7 residents (Residents #20, and #5) and 2 of 2 staff reviewed for infection control.1. The facility failed to ensure CNA B thoroughly cleaned the peri area, changed gloves, and used hand hygiene before going from dirty to clean while providing incontinent care to Resident #20. 2. The facility did not ensure EBP were put in place for Resident #5. 3. CNA Q failed to perform hand hygiene between resident to resident contact when passing meal trays. 4. CNA R failed to perform hand hygiene between resident to resident contact when passing meal trays. These failures could place residents at risk for cross contamination and the spread of infection. Findings include: 1. During an observation on 03/23/26 at 3:16 p.m., revealed CNA B provided incontinent care to Resident #20. CNA B performed hand hygiene and put on gloves. CNA B pulled Resident #20's foreskin and cleaned the pubic area, without cleaning both crease areas between his legs. CNA B then turned Resident #20 on his left side and proceeded to wipe Resident #20's buttocks without performing hand hygiene or applying new gloves. CNA B grabbed a clean brief, applied the resident's brief, touched his bed remote, adjusted his clothes, lowered his bed, pulled up his covers without performing hand hygiene or applying new gloves. CNA B gathered the trash, disposed of it and performed hand hygiene. During an interview on 03/23/25 at 3:25 p.m., CNA B stated she should have changed gloves and performed hand hygiene after she cleaned the crease areas, turned Resident #20 to his left side and after cleaning Resident #20's buttocks. CNA B stated she was nervous the state surveyor was present. CNA B stated this failure could potentially lead to cross contamination and put Resident #20 at risk for UTI. 2. Record review of Resident #5's face sheet, dated 03/25/26, reflected Resident #5 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included end stage renal disease (kidneys cease functioning on a permanent basis). Record review of Resident #5's quarterly MDS assessment, dated 03/05/26, reflected Resident #5 usually made himself understood and usually understood others. Resident #5 BIMS score of 10, which reflected his cognition was moderately impaired. Resident #5 received dialysis treatment. Record review of Resident #5's comprehensive care plan, revised 03/24/26, reflected Resident #5 received dialysis related to renal failure and was at risk for the potential complications of dialysis. The care plan interventions included: monitor for possible complications such as shortness of breath peripheral edema (swelling in the legs, ankles and feet), chest pain, elevated blood pressure, dry itchy skin, nausea/vomiting or bleeding at access site. Record review of Resident #5's order summary report, dated 03/25/26, reflected an active physician's order to remove dialysis dressing from the left upper arm in the evening for prophylaxis (any medication treatment, medication, or measures taken to prevent disease of health issues before they occur) with start date of 06/10/25. The physician order summary report did not address EBP. During an interview on 03/23/26 at 11:27 a.m., Resident #5 stated staff did not wear PPE when proving care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/26 at 10:12 a.m., CNA D stated PPE was not required when proving care to Resident #5. CNA D stated it was important to ensure infection control practices were followed to prevent the spread of infection. During a telephone interview on 03/25/26 at 10:17 a.m., RN C stated she accessed Resident #5's shunt by touching to feel the thrill (reflect good blood flow) and bruit (whooshing or blowing sound heard through a stethoscope that signaled turbulent blood flow in an artery). RN C stated PPE was not required when providing care to Resident #5. RN C stated it was important to ensure infection control practices were followed to prevent the spread of infection. During an interview on 03/25/26 at 11:41 a.m., the ADON stated she was the Infection Control Preventionist for the facility. The ADON stated she expected CNA B to change gloves after she cleaned the crease areas, performed hand hygiene, and reapply new gloves before turning Resident #20 to his left side. The ADON stated CNA B should have reapplied new gloves and perform hand hygiene after cleaning Resident #20's buttocks and touching his bed remote and rearranging Resident #20 in the bed. The ADON stated she monitored incontinent care by random spot checks, skill checks and in services. The ADON stated she never had issues with CNA B performing care. The ADON stated staff were not required to wear PPE when providing care to Resident #5 because his dialysis access was under the skin. The ADON stated the nurses did not do anything with access except removed the dressing the afternoon of dialysis. The ADON stated it was important to ensure infection control practices were followed to prevent the spread of infection. During an interview on 03/25/26 at 12:45 p.m., the ADON stated she reviewed the EBP policy on what was required for EBP and Resident #5 should be on EBP. The ADON stated she was told by the previous DON the area had to be opened for a resident to be on EBP. During an interview on 03/25/26 at 5:20 p.m., the DON stated she expected the groin to be cleaned, and gloves changed with hand hygiene performed with each glove change and touching other items and other areas of the resident's body. The DON stated she just learned today (03/25/26) by the ADON that Resident #20 was required to be on EBP. The DON stated initially when EBP rolled out she was told by the previous regional nurse consultant that dialysis residents with shunts did not require EBP. The DON stated ultimately the ADON was responsible for monitoring and overseeing infection control, but she also monitored by monthly hand hygiene check offs and random spot checks. The DON stated it was important to ensure infection control practices were followed to prevent the spread of infection and UTI. During an interview on 03/25/26 at 6:00 p.m., the Administrator stated she expected the entire peri area to be cleaned by resident requirement. The Administrator stated gloves should be changed, and hand hygiene performed before touching a clean brief, and any of Resident #20's items. The Administrator stated she was unaware Resident #5 required PPE when providing care for him. The Administrator stated the DON, or designee, was responsible for monitoring and overseeing infection control. The DON stated it was important to ensure infection control practices were followed to prevent the spread of infection, UTI and skin breakdown. 3. During an observation on 3/24/2026 at 12:30 p.m. revealed CNA Q served meal trays to 4 residences on the North Hall without performing hand hygiene. During an interview on 3/24/2026 at 12:33 p.m., CNA Q stated she had forgotten to use sanitizer before and after delivering food trays. CNA Q stated she had cross contaminated the trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 3/24/2026 at 12:30 p.m. revealed CNA R served meal trays to 4 residences on the North Hall without performing hand hygiene. During interview on 3/24/2026 at 12:35 p.m., CNA R stated she knew she had to perform hand hygiene in between passing the trays but forgot and was reminded by the other CNA R who had hand sanitizer. CNA R stated hand hygiene was to prevent cross contamination. During an interview on 3/25/2026 at 5:36 p.m., the DON revealed she expected the CNA's to perform hand hygiene in between passing each resident there tray to prevent cross contamination. During an interview on 3/25/2026 at 6:43 PM, the Administrator stated she expected the DON to ensure the CNAs were using hand sanitizer in between each tray pass to prevent cross contamination. The administrator stated the DON was responsible for the quarterly in services for all nursing staff for hand hygiene. Record review of the facility's Hand Hygiene policy, dated 11/12/2017, reflected staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is to be performed with either antimicrobial soap and water or alcohol-based hand rub between resident contacts. Record review of the facility's policy titled, Enhanced Barrier Precautions, dated 03/20/24, reflected . It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism.2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Record review of the perineal competency checkoff reflected CNA B had been checked off by LVN E for perineal care on 02/09/26.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers,. for 1 of 6 (Resident #1) residents reviewed for psychoactive medications. The facility did not ensure written consent was obtained from the legal authorized representative on HHSC Form 3713 to administer Abilify 10 mg also known as Aripiprazole (atypical antipsychotic medication used to treat schizophrenia, bipolar I disorder, depression, autism-related irritability, and Tourette's syndrome) for Resident #1.This failure could place residents at risk for receiving unnecessary antipsychotic medications without informed consent.Findings included:Record review of Resident #1's face sheet, dated 03/25/26 indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included Bipolar (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), depression (sadness), and anxiety (a feeling of fear, dread, and uneasiness).Record review of Resident #1's quarterly MDS assessment, dated 03/05/26, indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 14, which indicated she was cognitively intact. The MDS indicated Resident #1 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and supervision for eating. Resident #1 received antianxiety medication during the 7-day look-back period. Record review of the comprehensive care plan, dated 11/14/24 indicated Resident #1 used psychotropic medications related to bipolar disorder. The intervention of the care plan indicated staff would give medication as ordered and would monitor/document for side effects and effectiveness.Record review of Resident #1's physician's orders, dated 10/30/25, indicated the resident had an order for Abilify 10 mg, give one tablet by mouth every day for bipolar and depression disorder.Record review for Resident #1's medication administration record, dated 03/01/26 through 03/25/26, indicated she received Abilify 10 mg as ordered over the last 25 days.Record review for Resident #1's consent for use of psychotropic medication, Abilify 10 mg every day was not documented in her chart.During an interview on 03/25/26 at 12:16 p.m., Resident #1 said she was not aware of her meds, but knew she took a lot of them. She said she trusted what the nurses gave her.During an interview on 03/25/26 at 5:15 p.m., LVN H said she was the nurse for Resident #1. She said consent should be obtained for all psychotropic medication before being given to allow the resident/responsible party an opportunity to decline or accept and to be aware of all possible side effects from the medications. LVN H said Resident #1 was given Abilify for bipolar and depression. LVN H said she was not aware that if the medication strength changed, she needed to obtain a new psychotropic medications consent.During an interview on 03/25/26 at 6:36 p.m., the DON said consent should be signed before administering any psychoactive medication. The DON said one reason consent was obtained was to inform the residents/families about the risks and benefits before receiving medication. The DON said the charge nurse who received the order was responsible for obtaining consent, and she was the overseer. She said she missed Resident #10's Abilify order change in October 2025 and therefore HHSC Form 3713 was not updated to the correct medication dosage. The DON said failure to obtain the correct consent could cause the resident/ family not to have all the information about the medication or a choice about the resident's care. During an interview on 03/25/26 at 7:00 p.m., the Administrator said she expected the nurses to ensure the consent form was completed. She said she expected the DON or designee to ensure the HHSC Form 3713 was filled out correctly for psychotropic medications. The Administrator said consents should be done to inform residents/families of risks and/or benefits of medication or a choice to decline it. Record review of the facility's policy titled Psychotropic Medication Policy review date of 01/12/25, indicated It is the facility's policy that each resident's drug regimen is free from unnecessary drugs, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including unnecessary Psychotropic drugs.Procedure: 3. Informed consent for Psychotropic medication prior to administration.21. Consents will be obtained as per state guidelines.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, 1 of 24 (Resident #11) reviewed for abuse. The facility did not implement their policy on reporting abuse to the Abuse Coordinator when Resident #11 stated the word rape while been provided a shower by CNA L. This deficient practice could place residents at risk of unreported abuse, neglect, and a decreased quality of life. Findings included: Record review of the facility policy for Policy and Procedures: Abuse, Neglect and Exploitation dated 10/24/22, reflected. 2. The facility's abuse prevention coordinator is responsible for reporting allegations or suspected abuse, neglect . to the state survey agency and other official in accordance with state law.VII Reporting/Response . A. (2.) Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: 2(a). Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or result in serious bodily injury.Record review of Resident #11's face sheet, dated 03/25/26, reflected Resident #11 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions).Record review of Resident #11's quarterly MDS assessment, dated 03/06/26, reflected Resident #11 rarely/never made herself understood and rarely/never understood others. The assessment did not address Resident #11's BIMS score but reflected she had long term and short-term memory problems.Record review of Resident #11's comprehensive care plan, revised on 08/04/25, reflected Resident #11 had a history of trauma that may have a negative effect: sexual abuse. The care plan interventions included: identify resident's triggers that have the potential to re-traumatize which may include male hugging or providing care, identify items that lessen the effects of trauma and provide her comfort, and monitor for signs and symptoms of depression, anxiety, sleep disturbances and substance abuse issues. Record review of the PIR, dated 03/24/26, reflected an allegation of abuse incident on Resident #11. The PIR reflected the date of the incident was unknown but occurred during a shower that was given by CNA L when Resident #11 stated the word rape. The PIR reflected no staff witnessed the incident. The incident was reported to the state agency on 03/24/26 at 2:23 p.m.During an attempted interview on 03/23/26 at 2:06 p.m., with Resident #11, indicated she was non-interview able due to cognitive loss. During a telephone interview on 03/24/26 at 9:41 p.m., Resident #11's family members stated Resident #11 had a history of sexual abuse prior to being admitted to the facility. Resident #11's family member stated she told the facility she did not want a male hugging or providing care to Resident #11. During an interview on 03/24/26 at 2:45 p.m., the Administrator stated she had called in a reportable incident of an allegation of abuse regarding Resident #11 The Administrator stated she was notified by LVN H last night (03/23/26) that an allegation of possible abuse was reported on Resident #11. LVN H stated she did not remember the conversation with the nurse until 3/24/26 when CNA B asked for a follow-up and that was when she called LVN H to reiterate the allegation from the night before. The Administrator stated that was when she reported the incident earlier today (03/24/26). The Administrator stated this was the first time she had ever heard Resident #11 said the word rape. The Administrator stated she expected staff to notify her directly and immediately of any allegation of abuse being mentioned. During an interview on 03/24/26 at 4:38 p.m., CNA B stated she and CNA K were getting ready to give Resident #11 a shower and CNA K made a comment to LVN H and her about Resident #11 screaming and hollering the word rape two weeks ago when she gave her a shower. CNA B stated 03/23/26 was the first time she heard a staff member stating Resident #11 stated the word rape during a shower. CNA B stated she gave Resident #11 a shower on 03/23/26 and did not have any issues. CNA B stated Resident #11 had a history of sexual abuse from a previous facility and had never made any accusations towards her when she provided her with a shower. CNA B stated she (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regularly provided a calming environment using music during Resident #11's routine showers because of her previous history and her becoming tense when you start wiping the perineal area. CNA B stated she had only had to assist CNA L once with Resident #11's shower which had been a long time ago and she never stated the word rape. CNA B stated CNA L's voice was a little heavier and her body frame was masculine. During an interview on 03/24/26 at 4:50 p.m., LVN H stated she heard CNA K discussing with CNA G and CNA B about Resident #11 stating the word rape when they provide her a shower. LVN H stated she asked the aides how long this had been going on and CNA K stated she was not able to give an exact date when she heard her saying it. LVN H stated CNA K stated when they cleaned her private area that was when she hollered out rape. LVN H stated she went and reported the incident to the DON, and she instructed her to contact the Administrator. LVN H stated she called the Administrator between 8:30 p.m.-9:00 p.m. on 03/23/26 and told her what was going on and informed her she confronted the aides about not reporting the allegation before 03/23/26. LVN H stated the Administrator stated she would take care of it and will have the Social Worker speak to the aides tomorrow. LVN H stated she went and monitored CNA B and CNA K while providing Resident #11 a shower on 03/23/26 and Resident #11 never showed any aggressive behavior or fear towards the aides. LVN H stated she was told when Resident #11 was first admitted she had a history of sexual abuse but did not have a history of false accusations. During an interview on 03/24/26 at 5:20 p.m., CNA K stated she could not recall the exact date when the incident occurred, but she was doing her charting at the nursing station when CNA L came up the hall flustered, stating she needed help because Resident #11 was stating something that made her feel uncomfortable. CNA K stated she asked if she could come and be a second witness and assist her with showering Resident #11. CNA K stated she went in to clean the shower room because Resident #11 was the last resident that needed a shower. CNA K stated CNA L continued to provide a shower to Resident #11 and she heard Resident #11 state the word rape under her breath and that was when she asked Resident #11 if she was ok. CNA K stated Resident #11 looked at her and stated ok which was her normal response. CNA K stated CNA L placed a gown on her and walked Resident #11 to her room. CNA K stated CNA L told her after she took her to her room, she was going to report the allegation to her nurse LVN M. CNA K stated she did not report the incident because CNA L stated she was going to. CNA K stated she was her regular shower aide and had never heard Resident #11 make an allegation of sexual abuse. CNA K stated that anytime you tried and pulled her pants down or clean between her private area Resident #11 became tensed. CNA K stated CNA L normally did not work the North Hall but due to a call-in she had to that night. CNA K stated she had heard about Resident #11 being touched inappropriately but at a different facility. CNA K stated it was her first time hearing Resident #11 make an allegation of abuse. During a telephone interview om 03/25/26 at 5:39 p.m., CNA L stated she was put on the North Hall with CNA B when the incident with her and Resident #11 occurred. CNA L stated the incident occurred between 03/02/26-03/06/26, unable to give the exact date. CNA L stated she grabbed supplies and started performing showers. CNA L stated she was told by CNA B Resident #11 normally gets her showers between 8:00 p.m.-8:30 p.m. CNA L stated she took Resident #11 in the shower room, and she noticed that Resident #11 started to grab her shirt and pants like she was holding on for dear life. CNA L stated she explained to her it was time for a shower and that was when she started to ease up while she undressed her. CNA L stated she got Resident #11 to sit down in the shower chair and had the water warm enough for her. CNA L stated she put some soap on the washcloth and washed her back, hair, under her arms, chest, stomach, legs and feet. CNA L stated she told Resident #11 she was about to wash in between her private area and once she started washing under her belly fold, she stated, rape. CNA L stated she stopped immediately, rinsed her off, and got a towel to dry her off the best she could. CNA L stated she took Resident #11 back to her room and asked CNA G, CNA K and CNA B if Resident #11 had ever made a statement about rape when you washed her private area. CNA L stated they all stated yes she had stated that before. CNA L stated she told them she had stated the word while providing her with a shower and from now on if she had to give her a shower, she (continued on next page)

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	03/25/2026

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would like someone to assist her. CNA L stated she had never asked CNA K to come in and assist with providing care to Resident #11. CNA L stated she had provided a shower a couple of months back prior to the incident and did not have any problems, that was why it caught her by surprise when she stated it. CNA L stated she did not report the incident to LVN M or the Administrator because it slipped my mind, I was busy. CNA L stated this failure put Resident #11 at risk for abuse. During an interview on 03/25/26 at 9:16 a.m., CNA G stated she did not know anything about Resident #11 stating the word rape until 03/23/26 when she heard CNA B tell LVN H about Resident #11 stating the word rape when CNA L gave her a shower. CNA G stated she used to provide Resident #11 her showers when she worked the North Hall, and she never stated the word rape. CNA G stated Resident #11 would tense up her thighs when providing incontinent care or putting water on her private area, CNA G stated you had to inform her you were not going to hurt her and she would loosen up. CNA G stated Resident #11 had a history of being messed with at another facility. CNA G stated she did not report the incident because CNA B had already reported the incident to LVN H. An attempted telephone interview on 03/25/26 at 9:54 a.m. with LVN M, was unsuccessful, voicemail left. During an interview on 03/25/26 at 5:00 p.m., the DON stated prior to the incident that occurred on 03/23/26, she had no knowledge of sexual abuse allegations related to Resident #11 when provided a shower. The DON stated she was not aware that Resident #11 had a history of sexual abuse until Monday (03/23/26). The DON stated LVN H came to her on 03/23/26 and stated she was letting her know that CNA B had informed her she was told by CNA L that Resident #11 had made those allegations two weeks ago. The DON stated LVN H asked what she needed to do and she advised her to notify the Administrator immediately. The DON stated she was not aware Resident #11 became uncomfortable when providing care to the private areas. The DON stated she monitored abuse by speaking to the residents that were cognitive and able to voice any concerns and those that were not she watched their body language and paid attention to how they reacted to staff. The DON stated she has not seen any issues with abuse. The DON stated Resident #11's showers had been changed to 6a-2p instead of 2p-10p for closer monitoring. The DON stated CNA L was tall, masculine like, and wore her hair up most of the time. The DON stated it was very possible that it could have been a trigger for Resident #11.During an interview on 03/25/26 at 6:00 p.m., the Administrator stated she was the Abuse Coordinator for the facility. The Administrator stated she monitored abuse by constant education provided to staff/cognitive residents, QOL rounds every morning, and open conversation with residents/staff to ensure comfortability to report concerns to her. The Administrator stated she was the only one in the facility who could report abuse allegations to HHSC. The Administrator stated it was important to report an allegation of abuse and neglect for safety and protection of the residents and try to prevent other incidents of abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 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, to the administrator of the facility and to other officials including to the State Survey Agency for 1 of 24 (Resident #11) residents reviewed for abuse and neglect. The Abuse Coordinator failed to identify and report an allegation of abuse to HHSC within 2 hours when LVN H informed him on 03/23/26 that Resident #11 stated the word rape and appeared scared while been provided a shower by CNA L. This failure to report could place the residents at risk for abuse and emotional distress. Findings included:Record review of Resident #11's face sheet, dated 03/25/26, reflected Resident #11 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions).Record review of Resident #11's quarterly MDS assessment, dated 03/06/26, reflected Resident #11 rarely/never made herself understood and rarely/never understood others. The assessment did not address Resident #11's BIMS score but reflected she had long term and short-term memory problems.Record review of Resident #11's comprehensive care plan, revised on 08/04/25, reflected Resident #11 had a history of trauma that may have a negative effect: sexual abuse. The care plan interventions included: identify resident's triggers that have the potential to re-traumatize which may include male hugging or providing care, identify items that lessen the effects of trauma and provide her comfort, and monitor for signs and symptoms of depression, anxiety, sleep disturbances and substance abuse issues. Record review of the PIR, dated 03/24/26, reflected an allegation of abuse incident on Resident #11. The PIR reflected the date of the incident was unknown but occurred during a shower that was given by CNA L when Resident #11 stated the word rape. The PIR reflected no staff witnessed the incident. The incident was reported to the state agency on 03/24/26 at 2:23 p.m.During an attempted interview on 03/23/26 at 2:06 p.m., with Resident #11, indicated she was non-interview able due to cognitive loss. During a telephone interview on 03/24/26 at 9:41 p.m., Resident #11's family members stated Resident #11 had a history of sexual abuse prior to being admitted to the facility. Resident #11's family member stated she told the facility she did not want a male hugging or providing care to Resident #11. During an interview on 03/24/26 at 2:45 p.m., the Administrator stated she had called in a reportable incident of an allegation of abuse regarding Resident #11 The Administrator stated she was notified by LVN H last night (03/23/26) that an allegation of possible abuse was reported on Resident #11. LVN H stated she did not remember the conversation with the nurse until 3/24/26 when CNA B asked for a follow-up and that was when she called LVN H to reiterate the allegation from the night before. The Administrator stated that was when she reported the incident earlier today (03/24/26). The Administrator stated this was the first time she had ever heard Resident #11 said the word rape. The Administrator stated she expected staff to notify her directly and immediately of any allegation of abuse being mentioned. During an interview on 03/24/26 at 4:38 p.m., CNA B stated she and CNA K were getting ready to give Resident #11 a shower and CNA K made a comment to LVN H and her about Resident #11 screaming and hollering the word rape two weeks ago when she gave her a shower. CNA B stated 03/23/26 was the first time she heard a staff member stating Resident #11 stated the word rape during a shower. CNA B stated she gave Resident #11 a shower on 03/23/26 and did not have any issues. CNA B stated Resident #11 had a history of sexual abuse from a previous facility and had never made any accusations towards her when she provided her with a shower. CNA B stated she regularly provided a calming environment using music during Resident #11's routine showers because of her previous history and her becoming tense when you start wiping the perineal area. CNA B stated she had only had to assist CNA L once with Resident #11's shower which had (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been a long time ago and she never stated the word rape. CNA B stated CNA L's voice was a little heavier and her body frame was masculine. During an interview on 03/24/26 at 4:50 p.m., LVN H stated she heard CNA K discussing with CNA G and CNA B about Resident #11 stating the word rape when they provide her a shower. LVN H stated she asked the aides how long this had been going on and CNA K stated she was not able to give an exact date when she heard her saying it. LVN H stated CNA K stated when they cleaned her private area that was when she hollered out rape. LVN H stated she went and reported the incident to the DON, and she instructed her to contact the Administrator. LVN H stated she called the Administrator between 8:30 p.m.-9:00 p.m. on 03/23/26 and told her what was going on and informed her she confronted the aides about not reporting the allegation before 03/23/26. LVN H stated the Administrator stated she would take care of it and will have the Social Worker speak to the aides tomorrow. LVN H stated she went and monitored CNA B and CNA K while providing Resident #11 a shower on 03/23/26 and Resident #11 never showed any aggressive behavior or fear towards the aides. LVN H stated she was told when Resident #11 was first admitted she had a history of sexual abuse but did not have a history of false accusations. During an interview on 03/24/26 at 5:20 p.m., CNA K stated she could not recall the exact date when the incident occurred, but she was doing her charting at the nursing station when CNA L came up the hall flustered, stating she needed help because Resident #11 was stating something that made her feel uncomfortable. CNA K stated she asked if she could come and be a second witness and assist her with showering Resident #11. CNA K stated she went in to clean the shower room because Resident #11 was the last resident that needed a shower. CNA K stated CNA L continued to provide a shower to Resident #11 and she heard Resident #11 state the word rape under her breath and that was when she asked Resident #11 if she was ok. CNA K stated Resident #11 looked at her and stated ok which was her normal response. CNA K stated CNA L placed a gown on her and walked Resident #11 to her room. CNA K stated CNA L told her after she took her to her room, she was going to report the allegation to her nurse LVN M. CNA K stated she did not report the incident because CNA L stated she was going to. CNA K stated she was her regular shower aide and had never heard Resident #11 make an allegation of sexual abuse. CNA K stated that anytime you tried and pulled her pants down or clean between her private area Resident #11 became tensed. CNA K stated CNA L normally did not work the North Hall but due to a call-in she had to that night. CNA K stated she had heard about Resident #11 being touched inappropriately but at a different facility. CNA K stated it was her first time hearing Resident #11 make an allegation of abuse. During an interview on 03/25/26 at 9:27 a.m., the Social Worker stated on 03/24/26 midafternoon was the first time she was made aware of any abuse allegations related to Resident #11. The Social Worker stated she was asked by the Administrator to performed safe surveys on North Hall with cognitive females. The Social Worker stated she spoke with psych services to come in and evaluate Resident #11. The Social Worker stated she had not spoken to the CNAs that were involved in the incident. During a telephone interview om 03/25/26 at 5:39 p.m., CNA L stated she was put on the North Hall with CNA B when the incident with her and Resident #11 occurred. CNA L stated the incident occurred between 03/02/26-03/06/26, unable to give the exact date. CNA L stated she grabbed supplies and started performing showers. CNA L stated she was told by CNA B Resident #11 normally gets her showers between 8:00 p.m.-8:30 p.m. CNA L stated she took Resident #11 in the shower room, and she noticed that Resident #11 started to grab her shirt and pants like she was holding on for dear life. CNA L stated she explained to her it was time for a shower and that was when she started to ease up while she undressed her. CNA L stated she got Resident #11 to sit down in the shower chair and had the water warm enough for her. CNA L stated she put some soap on the washcloth and washed her back, hair, under her arms, chest, stomach, legs and feet. CNA L stated she told Resident #11 she was about to wash in between her private area and once she started washing under her belly fold, she stated, rape. CNA L stated she stopped immediately, rinsed her off, and got a towel to dry her off the best she could. CNA L stated she took Resident #11 back to her room and asked CNA G, CNA K and CNA B if Resident #11 had ever (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	made a statement about rape when you washed her private area. CNA L stated they all stated yes she had stated that before. CNA L stated she told them she had stated the word while providing her with a shower and from now on if she had to give her a shower, she would like someone to assist her. CNA L stated she had never asked CNA K to come in and assist with providing care to Resident #11. CNA L stated she had provided a shower a couple of months back prior to the incident and did not have any problems, that was why it caught her by surprise when she stated it. CNA L stated she did not report the incident to LVN M or the Administrator because it slipped my mind, I was busy. CNA L stated this failure put Resident #11 at risk for abuse. During an interview on 03/25/26 at 9:16 a.m., CNA G stated she did not know anything about Resident #11 stating the word rape until 03/23/26 when she heard CNA B tell LVN H about Resident #11 stating the word rape when CNA L gave her a shower. CNA G stated she used to provide Resident #11 her showers when she worked the North Hall, and she never stated the word rape. CNA G stated Resident #11 would tense up her thighs when providing incontinent care or putting water on her private area, CNA G stated you had to inform her you were not going to hurt her and she would loosen up. CNA G stated Resident #11 had a history of being messed with at another facility. CNA G stated she did not report the incident because CNA B had already reported the incident to LVN H. An attempted telephone interview on 03/25/26 at 9:54 a.m. with LVN M, was unsuccessful, voicemail left. During an interview on 03/25/26 at 5:00 p.m., the DON stated prior to the incident that occurred on 03/23/26, she had no knowledge of sexual abuse allegations related to Resident #11 when provided a shower. The DON stated she was not aware that Resident #11 had a history of sexual abuse until Monday (03/23/26). The DON stated LVN H came to her on 03/23/26 and stated she was letting her know that CNA B had informed her she was told by CNA L that Resident #11 had made those allegations two weeks ago. The DON stated LVN H asked what she needed to do and she advised her to notify the Administrator immediately. The DON stated she was not aware Resident #11 became uncomfortable when providing care to the private areas. The DON stated she monitored abuse by speaking to the residents that were cognitive and able to voice any concerns and those that were not she watched their body language and paid attention to how they reacted to staff. The DON stated she has not seen any issues with abuse. The DON stated Resident #11's showers had been changed to 6a-2p instead of 2p-10p for closer monitoring. The DON stated CNA L was tall, masculine like, and wore her hair up most of the time. The DON stated it was very possible that it could have been a trigger for Resident #11.During an interview on 03/25/26 at 6:00 p.m., the Administrator stated she was the Abuse Coordinator for the facility. The Administrator stated she monitored abuse by constant education provided to staff/cognitive residents, QOL rounds every morning, and open conversation with residents/staff to ensure comfortability to report concerns to her. The Administrator stated she was the only one in the facility who could report abuse allegations to HHSC. The Administrator stated it was important to report an allegation of abuse and neglect for safety and protection of the residents and try to prevent other incidents of abuse.Record review of the facility policy for Policy and Procedures: Abuse, Neglect and Exploitation dated 10/24/22, reflected.: 2(a). Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or result in serious bodily injury.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the services provided, as outlined by the comprehensive care plan, met professional standards of quality, for 1 of 2 residents (Resident #13) reviewed for services provided to meet professional standards. The facility did not ensure Resident #13's hospice POC reflected her medication regimen. This deficient practice could place residents at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings include: Record review of Resident #13's face sheet, dated 03/25/26, reflected Resident #13 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included CAD (occurred when plaque buildup in the arteries, restricting blood flow and oxygen to the heart muscle). Record review of Resident #13's quarterly MDS assessment, dated 03/05/26, reflected Resident #13 sometimes made herself understood and rarely/never understood others. Resident #13 BIMS score of 3, which reflected his cognition was severely impaired. Resident #13 had a life expectancy of less than 6 months and received hospice services. Record review of Resident #13's comprehensive care plan, revised on 07/30/25, reflected Resident #13 had a terminal illness and was receiving hospice or palliative care. The care plan interventions included: monitor for s/sx of increased pain, discomfort, give medications, treatments as ordered and monitor for relief. Record review of the order summary report, dated 02/27/26, reflected Resident #13 had an order to admit to hospice with an order date 06/19/25. Record review of Resident #13's hospice binder and EMR, accessed on 03/24/26 at 9:30 a.m. reflected the hospice administration record and the facility's physician orders did not match. The following orders were noted on the hospice medication record: Bisacodyl 10mg rectally twice a day as needed for constipation; Levsin 0.125 mg 1-2 tablets by mouth or sublingual every 4 hours as needed for secretions. The facility order summary report reflected: Bisacodyl 10mg rectally every 24 hours as needed for constipation; Levsin (generic name Hyoscyamine Sulfate) 1 tablet by mouth as needed for increased secretion. During a telephone interview on 03/25/26 at 2:59 p.m., the Hospice RN Case Manager stated Resident #13 was admitted to hospice on 06/19/25 for CAD. The Hospice RN Case Manager stated she should be reviewing the facility medication list monthly to ensure the medication list was correct and updated. The Hospice RN Case Manager stated she could not remember the last time the medications were reviewed. The Hospice RN Case Manager stated it was important to ensure the medication list was updated in the hospice binder so Resident #13 would receive the correct medication. During a telephone interview on 03/25/26 at 3:07 p.m., RN C stated she coordinated with hospice weekly. RN C stated she was unaware the medication list was not updated. RN C stated she did not review the medication list in the binder because everything she should document regarding those medications would be in PCC. RN C stated it was important to ensure that recent hospice documentation was in the facility to keep communication between the facility and hospice for continuation of care. During an interview on 03/25/26 at 5:00 p.m., the DON stated she was not made aware of the medication difference until today (03/25/26). The DON stated MA F was responsible for reviewing the medication orders monthly to ensure compliance. The DON stated the Administrator was responsible for monitoring and overseeing hospice. The DON stated it was important to ensure recent hospice documentation was in the facility to keep communication between the facility and hospice for continuation of care. During an interview on 03/25/26 at 5:48 p.m., MA F stated she was responsible for uploading the hospice documents. MA F stated she had never been told to reconcile the medications orders from the hospice compared to the facility orders to ensure accuracy. During an interview on 03/25/26 at 6:00 p.m., the Administrator stated she expected the medication lists from the hospice and facility to match. The Administrator stated the DON/designee was responsible for ensuring the information was updated. The Administrator stated it was important to ensure recent hospice documentation was in the facility for continuation of care. Record review of the facility's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy titled Coordination of Hospice Services, dated 04/21/21, reflected, . When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs.7. The facility will monitor for medications. to ensure they are provided by hospice and indicated in the plan of care for palliation and management of the terminal illness.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene were provided for 1 of 6 residents (Resident #10) reviewed for ADL care.The facility failed to ensure Resident #10's fingernails were free from a brown material substance.This failure could place residents at risk of not receiving care/services, and decreased quality of life impacting their loss of dignity. Findings included:Record review of a Resident #10's face sheet, dated 03/26/26, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included dementia (loss memory), muscle weakness, and depressive disorder (persistently depressed mood).Record review of Resident #10's quarterly MDS, dated [DATE], indicated Resident #10 sometimes made herself understood and rarely understood others. Resident #10 had difficulty with recall, and her BIMs score was 02, which indicated severe cognitive impairment. The MDS indicated Resident #10 required extensive assistance with personal hygiene and bathing. Resident #10 was always incontinent of bowel and bladder. Record review of the comprehensive care plan, dated 10/10/23, revealed Resident #10 had an activities of daily living self-care performance deficit and was at risk for not having her needs met in a timely manner related to her immobility, and cognitive loss. The interventions were for staff to provide showers, shave, oral care, hair care, and nail care per schedule and when needed.During an observation and interview on 03/24/26 at 9:38 a.m., Resident #10 was lying in bed. She had jagged fingernails, some type of brown substance underneath her third, fourth and fifth fingernails and scattered across her entire hand. Resident #10 was unable to say how long her hand or fingernails had been dirty or the last time her nails had been trimmed.During an observation and interview on 03/24/26 at 4:14 p.m., Resident #10 was lying in her bed. Resident #10 was noted with jagged fingernails and brown like substance scattered on her right hand and under her third, fourth and fifth fingernails. CNA B was in the room and said the brown substance looked like fecal material. CNA B said Resident #10 often placed her hands in her brief. She said Resident #10 had a partial bed bath yesterday (03/23/26). She said she did not have a complete bed bath because Resident #10 became resistant and she stopped. CNA B said she did not attempt to complete the bed bath later during her 2pm-10pm shift. CNA B said she would trim and clean Resident #10's right hand and fingernails.During an observation on 03/24/26 at 4:35 p.m., Resident #10 was in her bed, and her right hand and fingernails were trimmed and cleaned. During an interview on 03/25/26 at 4:10 p.m., LVN H said nurses and CNAs were responsible for nailcare. LVN H said the brown material underneath Resident #10's fingernails could be fecal material. LVN H said she expected Resident #10's nails to be trimmed and clean on Sundays as their routine cleaning day as well as during her bath days of Monday, Wednesday, and Friday and as needed. She said jagged and dirty nails could lead to injury and/or infection control issues.During an interview on 03/25/26 at 6:36 p.m., the DON said nail care was a part of Sunday cleaning schedule. She said the CNAs were supposed to clean/trim all residents' nails on Sunday and the nurses were supposed to ensure nail care was done. She said she did random spot checks of the residents' nails. She said if Resident #10 had a brown like substance under her nails or jagged nails it could place her at risk for injury and/or infection.During an interview on 03/25/26 at 7:00 p.m., the Administrator said she expected fingernails to be clean and free from brown matter. She said the CNAs were responsible for cleaning the nails and the DON or designee were the overseers. She said jagged and dirty nails could lead to infection issues. Record review of the facilities policy titled, Activities of Daily Living Care Guidelines' dated 1/23/2016, indicated, Anticipated Outcome: Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #43) reviewed for quality of care. The facility did not ensure that LVN A followed physician orders for wound care on Resident #43's right second toe on 03/21/26 and 03/22/26. This failure could place residents at risk for a decline in wounds, infection, pain and a decline in functional abilities. Findings include: Record review of Resident #43's face sheet, dated 0325/26, reflected Resident #43 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included hypotension (low blood pressure). Record review of Resident #43's quarterly MDS assessment, dated 02/06/26, reflected Resident #43 usually made himself understood and usually understood others. Resident #43 BIMS score of 8, which reflected his cognition was moderately impaired. Resident #43 had an application of nonsurgical dressing and ointment/medications to feet. Record review of Resident #43's comprehensive care plan, revised on 03/18/26, reflected Resident #43 had a non-pressure wound of the right second toe and was at risk for infection, pain, and a decline in functional abilities. The care plan interventions included provide wound care per physician's order, keep dressing clean, dry, and intact. Record review of Resident #43's order summary, dated 03/25/26, reflected Resident #43 had an order with a start date 02/19/26 to cleanse the right second toe with normal saline (solution of sodium chloride in water) or wound cleanser, dry with gauze, apply xerofoam gauze (wound dressing) and cover with a boarder dressing once daily and as needed for wound healing. Record review of Resident #43's TAR, dated 03/01/26-03/31/26, reflected Resident #43's wound care to his right second toe was to cleanse with normal saline (solution of sodium chloride in water) or wound cleanser, dry with gauze, apply xerofoam gauze (wound dressing) and cover with a boarder dressing once daily and as needed for wound healing. The TAR was not signed off by LVN A as completed on 03/21/26 and 03/22/26. During an interview and observation on 03/23/26 at 10:52 a.m., Resident #43 stated he had a wound to his right foot. The ADON showed the state surveyor the dressing to Resident #43 right foot. The dressing was dated 03/20/26. The ADON stated the wound should be changed daily. During a telephone interview on 03/24/26 at 4:25 p.m., LVN A stated she was the nurse for Resident #43 on 03/21/26 and 03/22/26 and was responsible for wound care. LVN A stated normally the facility has someone come in and do wound care, but she did not show up. LVN A stated she could not remember why wound care was not performed on 03/21/26 and 03/22/26 was chaotic and she forgot. LVN A stated it was important wound was done daily to prevent an infection. During an interview on 03/25/26 at 5:00 p.m., the DON stated she expected wound care orders to be followed including the weekends. The DON stated she was not aware wound care was not done until state surveyor intervention. The DON stated the ADON makes rounds on Monday to ensure the wound care was performed over the weekend. The DON stated this past weekend there was not someone here that was dedicated to doing wound care and the nurses got overwhelmed and did not perform wound care. The DON stated usually there is someone that came in and did the wound care but if not, the nurses were responsible. The DON stated it was important wound care was done to promote healing. During an interview on 03/25/26 at 6:00 p.m., the Administrator stated she expected all wound care treatment to be done as ordered. The Administrator stated the DON or designee were responsible for monitoring wound care. The Administrator stated it was important for wound care to be performed per the physician's order to ensure the continuation of care and prevent worsening of the wound. An attempted telephone interview on 03/25/26 at 6:42 p.m., with the Medical Director, was unsuccessful. Record review of the facility's policy titled, Skin Prevention and Management Guidelines, revised 04/13/23, reflected did not address following physician orders related to wound care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the environment was as free of accident hazards as is possible for 1 of 24 residents (Resident #51) reviewed for accidents and hazards. The facility failed to ensure CNA N locked the mechanical lift when transferring Resident #51 from his wheelchair to his bed. These failures could place residents at risk of accidents that could result in serious injury, harm, impairment, or death.Findings included: Record review of Resident #51's face sheet dated 03/25/26 indicated he was an [AGE] year-old male who re-admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (a group of conditions that affect blood vessels and blood flow in the brain), history of traumatic brain injury (disruption in normal brain function caused by a blow or bump to the head), cognitive communication deficit (when someone has trouble with one or more cognitive processes involved in communication), and glaucoma (a group of diseases that damage the optic nerve often due to high fluid pressure). Record review of Resident #51's annual MDS assessment dated [DATE] indicated he usually understood others and usually made himself understood. The MDS also indicated Resident #51 had a BIMS score of 6 which meant he had severe cognitive impairment. The MDS indicated he was dependent upon staff for transfers, bed mobility, and bathing, and required moderate staff assistance with eating. Record review of Resident #51's comprehensive care plan revised 12/10/19 indicated he had ADL self-care performance deficit and required a total of two staff assistance for transfers. During an observation and interview on 03/24/26 at 10:17 AM CNA N and CNA O transferred Resident #51 from his wheelchair to his bed using a mechanical lift. CNA N failed to lock the wheels of the mechanical lift prior to lifting Resident #51 from his wheelchair and prior to lowering Resident #51 to his bed. CNA N said she did not realize she did that, but she did see the mechanical lift move when she began to lift Resident #51 from his wheelchair. CNA N said the failure placed Resident #51 at risk for falling. During an interview on 03/25/26 at 7:20 PM the DON said she expected the CNAs to ensure the mechanical lift was used correctly. The DON said the CNAs should have locked the mechanical lift prior to lifting Resident #51 from his wheelchair and prior to lowering Resident #51 to the bed. The DON said CNA N just started at the facility and she had her checkoff sheet with her and the DON was not sure if CNA N had been checked off on the mechanical lift use. The DON said the failure placed a risk of injury to Resident #51. During an interview on 03/25/26 at 7:22 PM the Administrator said she expected the CNAs to use the mechanical lift correctly and the DON or designee were responsible for ensuring the CNAs were completing mechanical lift transfers safely. The Administrator said the failure placed a risk for Resident #51 to have injury. During an interview on 03/25/26 at 7:27 PM CNA N said she had her skills checklist at home but she did not recall being checked off on using the mechanical lift.During an interview on 03/25/26 at 6:00 PM the Administrator said the facility did not have a mechanical lift policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 of 7 resident (Residents #5 and #15) reviewed for pharmacy services. 1.The facility did not ensure LVN A administered Resident #5's Sevelamer Carbonate (a medication used to manage high blood phosphorus levels in adults with chronic kidney disease) 800 mg on [DATE]. 2. The facility failed to ensure Resident #15's Novolog insulin vial (medication used to administer to residents with high blood sugars) on the west nurse medication cart was not expired prior to placing the open date of [DATE] on the bottle. These failures could place residents at risk for weak bones, joint pain, severe itching, and fractures.Findings include: 1.Record review of Resident #5's face sheet, dated [DATE], reflected Resident #5 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included end stage renal disease (kidneys cease functioning on a permanent basis). Record review of Resident #5's quarterly MDS assessment, dated [DATE], reflected Resident #5 usually made himself understood and usually understood others. Resident #5 BIMS score of 10, which reflected his cognition was moderately impaired. Resident #5 received dialysis treatment. Record review of Resident #5's order summary report, dated [DATE], reflected an active physician's order for Sevelamer Carbonate 800 mg: 4 tablets by mouth with meals for vitamin deficiency with a start date [DATE]. Record review of Resident #5's comprehensive care plan, revised [DATE], reflected Resident #5 received dialysis related to renal failure and was at risk for the potential complications of dialysis. The care plan interventions included: monitor for possible complications such as shortness of breath peripheral edema (swelling in the legs, ankles and feet), chest pain, elevated blood pressure, dry itchy skin, nausea/vomiting or bleeding at access site. During an observation and interview on [DATE] at 12:19 p.m., revealed Resident #5 was served a chef salad for his lunch meal. Resident #5 ate his salad and left the dining room at 1:15 p.m. without being given (4) Sevelamer Carbonate with his meal. Resident #5 stated he received medication with his meals but not today with his lunch meal ([DATE]). Resident #5 did not have any adverse reaction to not being administered the medication. During a telephone interview on [DATE] at 4:25 p.m., LVN A stated she was responsible for administering Resident #5's Sevelamer Carbonate with his lunch meal. LVN A stated she was aware the medication must be given with meals, but she had a family emergency. LVN A stated she did not leave Resident #5's medication or let her charge nurse know he had medications to be given with meals. LVN A stated she did not know why it was important to give the medication with meals. During an interview on [DATE] at 5:00 p.m., the DON stated her expectations were for the medication to be given with Resident #5's meals. The DON stated she was not made aware of the nurse leaving until after the state surveyor intervention. The DON stated LVN A should have notified the charge nurse that the medication needed to be administered with Resident #5's lunch meal. The DON stated she monitored medication administration by random spot checks and reviewing the medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration record that reflected if the medication was given or administered late. The DON stated if there was a problem, she would in-service the nurse or MA immediately. The DON stated this was the first time for as she knew Resident #5's medication not been given with meals. The DON stated it was important Resident #5's medication was given with meals to prevent malnutrition and weight loss. During an interview on [DATE] at 6:00 p.m., the Administrator stated LVN A was responsible for administering Resident #5's medication timely. The Administrator stated she was not aware the medication was not given with his meals but expected LVN A to go to the charge nurse or the DON to inform of issue and to ensure timely delivery of medication. The Administrator stated the DON, or designee, was responsible for monitoring medication administration. The Administrator stated it was important Resident #5's medication was administered timely to ensure there was no adverse effect of the resident care. An attempted telephone interview on [DATE] at 6:42 p.m., with the Medical Director, was unsuccessful. 2. Record review of Resident #15's face sheet dated [DATE] indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included chronic obstructive pulmonary disease (chronic disease of the lungs that causes difficulty breathing), ventricular tachycardia (life threatening heart arrhythmia defined by a fast heart rate more than 100 beats per minute), diabetes mellitus (chronic metabolic disorder characterized by high blood sugars), major depressive disorder (a serious mental health condition characterized by persistent low mood and loss of interest in things), and high blood pressure. Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated she was understood by others, and she was able to make herself understood. The MDS also indicated she had a BIMS score of 13 which indicated she was cognitively intact. The MDS also indicated she required maximal assistance from staff for bed mobility, transfers, toileting, and bathing and she required setup assistance from staff for eating. The MDS also indicated Resident #15 was taking an anticoagulant medication. During an observation and interview on [DATE] at 11:17 AM of the west nursing cart revealed Resident #15's Novolog insulin vial had an expiration date of [DATE] and an open date of [DATE]. RN P said she did not notice the bottle expiration date. RN P said she only verified the open date. RN P said the nurse who placed the NovoLog insulin on the cart with the open date was responsible for ensuring the insulin was not out of date. RN P said the failure placed Resident #15 at risk for the insulin not being effective. During an interview on [DATE] at 7:07 PM, the DON said she expected the charge nurses to check insulin to ensure it was removed when it was expired. The DON said RN P failed to look at the actual expiration date on the bottle. The DON said RN P only looked at the opened date on the bottle, but she expected the charge nurses to complete both checks for expirations. The DON said the failure placed a risk for Resident #15's blood sugar not being regulated. During an interview on [DATE] at 6:56 PM, the Administrator said her expectation was for no medications to be given expired. The Administrator said the DON and designee were responsible for ensuring the insulin was removed from the medication cart. The Administrator said the failure placed a risk for negative clinical effects and medications may not work effectively. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Medication-Treatment Administration and Documentation Guidelines, revised [DATE], reflected To provide a process for accurate, timely administration and documentation of medication and treatments.4. Administer the medication according to the physician order. Record review of the facility's policy, dated [DATE], Medication Storage indicated: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. 8. Medication Carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are removed and destroyed in accordance with the facility policy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' drug regimen was adequately monitored and free from unnecessary drugs for 2 of 6 residents (Resident #15 and Resident #4) reviewed for pharmacy services. 1. The facility failed to monitor Resident #15 for side effects/adverse reactions for the use of Eliquis (an anticoagulant medication- blood thinner). 2. The facility failed to monitor Resident #4 for side effects/adverse reactions for the use of Eliquis (an anticoagulant medication- blood thinner).These failures could place residents at risk of swelling, bruising, and bleeding. Findings include: 1.Record review of Resident #15's face sheet dated 03/25/26 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included chronic obstructive pulmonary disease (chronic disease of the lungs that causes difficulty breathing), ventricular tachycardia (life threatening heart arrhythmia defined by a fast heart rate more than 100 beats per minute), diabetes mellitus (chronic metabolic disorder characterized by high blood sugars), major depressive disorder (a serious mental health condition characterized by persistent low mood and loss of interest in things), and high blood pressure. Record review of Resident #15's quarterly MDS assessment dated [DATE] indicated she was understood by others, and she was able to make herself understood. The MDS also indicated she had a BIMS score of 13 which indicated she was cognitively intact. The MDS also indicated she required maximal assistance from staff for bed mobility, transfers, toileting, and bathing and she required setup assistance from staff for eating. The MDS also indicated Resident #15 was taking an anticoagulant medication. Record review of Resident #15's comprehensive care plan revised 01/15/26 did not indicate Resident #15 was receiving Eliquis (anticoagulant medication-blood thinner).Record review of Resident #15's order summary report dated as of 03/25/26, indicated she had an order for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for chronic atrial fibrillation with a start date of 02/08/25 and no end date. The order summary report did not indicate Resident #15 was being monitored for any side effects regarding his anticoagulant medication.Record review of Resident #15's medication administration record for the month of March 2026, indicated Resident #15 had received Eliquis 5mg one tablet two times daily since 02/08/25. The medication administration record did not indicate Resident #15 was being monitored for any side effects regarding his anticoagulant medication. 2. Record review of a face sheet dated 3/25/2026 indicated Resident #4 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with a diagnoses of unspecified atrial fibrillation (irregular, often rapid heart rate), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), parkinsonism (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable movements), history of transient ischemic attach (temporary blockage of blood flow to the brain) and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). Record review of Resident #4's physician orders dated 3/25/2026 indicated Resident #4 was ordered Eliquis Oral Tablet 5 milligrams by mouth two times a day related to heart failure on 8/05/2025 and started on 8/05/2025. Eliquis is a prescription blood thinner used to reduce stroke risk in atrial fibrillation (AFib), Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated Resident #4 was sometimes understood and usually understands. Resident #4's BIMS score was three which indicated severe cognitive impairment. The MDS quarterly assessment indicated Resident #4 was taking an anticoagulant. Record review of the comprehensive care plan dated 3/25/2026 indicated no focus, goals, or interventions for Anticoagulant use or monitoring.During an interview on 03/25/26 at 5:31 PM the ADON said she expected monitoring for anticoagulants to be in the medication administration record. The ADON said any nurse could place the order in for monitoring. The ADON said the failure placed a risk for Resident #15 and Resident #4 to bleed out . During an interview on 03/25/26 at 6:07 PM the DON said the medication Eliquis should have been on (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15's and Resident #4's medication administration record for monitoring. The DON said she was responsible for ensuring the monitoring was in place. The DON said she expected the charge nurses to recognize and know what medications should need monitoring, but the DON was completing an audit to ensure all the monitoring was in place. The DON said the failure placed a risk for Resident #15 and Resident #4 having a fall or bruise, having a bleed, and adverse effects with her diagnosis of atrial fibrillation (heart rhythm disorder characterized by rapid heartbeats), and staff would not know if Resident #15 or Resident #4's blood was clotting correctly. During an interview on 03/25/26 at 6:52 PM the Administrator said she expected the anticoagulant monitoring to be in place for the nurses to check each shift for Resident #15 and Resident #4. The Administrator said the orders should have been input by the DON or designee. The Administrator said the failure placed a risk for Resident #15 and Resident #4 having a negative clinical effect of bleeding. Record review of the facility policy, reviewed 2/15/20, Physician Monitoring Orders did not indicate any monitoring for anticoagulant.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide or obtain laboratory services to meet the needs of its residents for 2 of 24 residents (Resident #6 and Resident #5) reviewed for laboratory services. 1. The facility failed to obtain Resident #6's CMP (lab test that provides an overall picture of your body's chemical balance and metabolism, and can help diagnose, screen for, or monitor health conditions or medication side effects), CBC (used to monitor and diagnose medical conditions, check the health of the immune system, and detect disorders including infections, anemia, and blood cancer), and HgA1c (lab test that provides a measurement of the average of the blood sugars in the last 2-3 months to manage diabetes) as ordered on 11/18/25 and every 3 months.2. The facility failed to obtain Resident #5's Magnesium lab (measures the amount of magnesium in the blood which can affect the heart, muscle, and nerve function) as ordered on 11/15/24 and every 12 months. These failures could place residents at risk of not receiving timely diagnoses, treatment, and services to meet their needs.Findings include:1. Record review of Resident #6's face sheet, dated 03/25/26, indicated a [AGE] year-old male who re-admitted to the facility on [DATE]. Resident #6 had diagnoses which included diabetes mellitus (a disease in which the body loses the ability to produce insulin and causes elevated blood sugars), bipolar disorder (chronic mental health condition characterized by intense mood swings from lows to highs, chronic respiratory failure (long-term condition in which the lungs cannot adequately exchange oxygen and carbon dioxide), and dementia (decline in mental ability that is severe enough to interfere with daily life). Record review of Resident #6's quarterly MDS assessment, dated 02/18/26, indicated he was usually understood by others and sometimes understood others. Resident #6 had a BIMs score of 10, which indicated he had moderate cognitive impairment. Record review of the Order Summary Report, dated as of 03/25/26, indicated Resident #6 had an order for a CMP, CBC, HgA1c in AM, then every 3 months. Diagnosis was diabetes with a date of 11/18/25.Record review of Resident #6's EMR on 03/25/26 indicated the CMP, CBC, and HgA1c labs were never drawn after being ordered on 11/18/25. Record review of Resident #6's care plan did not address obtaining labs.During an interview on 03/25/26 at 5:48 PM, the Resident #51's NP said she inputted the order, and she said she expected the lab to be drawn and followed up on, but she could not recall why it was not, because she had been off for a few months. The Resident #51's NP said a risk of not checking the resident's HgA1c was they wouldn't catch when Resident #51 needed his insulin titrated (the process of adjusting a medication dose to reach a target effect safely). During an interview on 03/25/26 at 6:05 PM, the DON said she expected the labs to be drawn when the physician ordered the labs. The DON said the failure placed a risk for issues with not knowing if his medications were effective or not and could have caused further problems like kidney failure. 2. Record review of Resident #5's face sheet, dated 03/25/26, indicated an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included end stage renal disease (permanent irreversible kidney failure where the kidneys can no longer filter waste), cirrhosis of the liver (late stage irreversible scarring of the liver caused by long-term liver disease and conditions such as alcoholism or hepatitis), heart disease, diabetes mellitus (a disease in which the body loses the ability to produce insulin and causes elevated blood sugars), and senile degeneration of the brain (progressive age related cognitive decline caused by brain cell death commonly from Alzheimer's). Record review of Resident #5's quarterly MDS assessment, dated 03/05/26, indicated he was usually understood by others and he usually understood others. Resident #5 had a BIMs score of 10, which indicated he had moderate cognitive impairment. Record review of Resident #5's comprehensive care plan, revised on 02/16/26, indicated he had a diagnosis which included diabetes and was at risk for unstable blood sugars and dependent on dialysis with an intervention to obtain, monitor, and report labs to the physician as ordered. Record review of Resident #5's order summary report, dated 03/25/26, indicated Resident #5 had an order for CBC, BMP (continued on next page)

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	03/25/2026

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	magnesium, vitamin D level now and every 12 months. DX: ESRD with a date of 11/15/24. During an interview on 03/25/26 at 2:40 PM, the DON said she expected labs to be drawn as ordered but she called the lab, and she did not know why it was missing. The DON said she was responsible for ensuring the labs were drawn. The DON said the failure placed a risk for issues with not knowing if his medications were effective or not.During an interview on 03/25/26 at 6:54 PM, the Administrator said she expected all labs to be completed as ordered and in a timely manner. The Administrator said the failure placed a risk for staff not knowing what was going on with the residents and had negative effects. Record review of the facility's policy, revised 1/30/26, lab tracking system indicated Process: The lab results are automatically uploaded into the electronic health record. As Lab orders are received, the nurse receiving the order completes the lab requisition and places the requisition slip in lab. The nurse manager will review the facility's Lab results daily and retroactive for seven (7) days to include any test that may take longer to complete.A 24-hour chart check is completed routinely to verify new orders for lab tests are transcribed on the laboratory tracking tool.