STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455591	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Waxahachie	1413 W Main St Waxahachie, TX 75165

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 facility reviewed for environmental concerns. 1. The facility failed to repair a jagged lifted piece of metal with a pointed edge, which was present to the outside of the door, which opened to go out to the designated smoking area of the facility. 2. The facility failed to repair the magnet which was hanging out of the wall for the facility fire door which lead out of the dining room on the 400 hall. 3. The facility failed to repair or replace the door mechanism cover for the smoking door which lead from the sunroom resulting in exposed wiring and door mechanism at the top of the door. 4. The facility failed to repair or replace the loading dock door trim, which had a jagged piece of metal hanging from the door frame. 5. The facility failed to clean the mechanical lift body of the machine. 6. The facility failed to clean the facility handrails and inside the railing of the facility handrails. 7. The facility failed to clean the resident shower rooms after use. These deficient practices could place residents at risk of injuries and decreased quality of life. In an observation on 4/26/26 at 9:11 AM, of the dining room entrance from the 400 hall, revealed the fire door magnet mechanism hung out of the wall with wiring not connected from a hole approximately twice the size of the fire door magnet in the sheetrock. In an observation on 4/26/26 at 9:15 AM revealed the facility handrails and inside railing of the handrail leading from the dining room into the 400 hallway revealed trash, debris, a screw, popsicle stick, and what appeared to be melted and dried ice cream, pink and white in color. Further observation revealed a dried brown substance on the wall right above the handrail and dripped down into the inside railing. In an observation on 4/26/26 at 9:18 AM of facility loading dock door frame revealed a jagged metal door trim broke and pulled loose from door frame. In an observation on 4/26/26 at 9:37 AM revealed the door mechanism cover for the smoking door which lead from the sunroom was missing resulting in exposed wiring and door mechanism at the top of door. In an observation on 4/26/26 at 9:40 AM, of the facility mechanical lift in the hallway revealed the mechanical lift body of the machine was covered with dried dirt grime and debris on the arm mechanism of the lift, on the bottom legs of the lift, and on the lift's main body frame. In an observation on 4/26/26 at 9:43 AM, of facility shower room revealed the shower room floor was dirty with dried debris on floor, 3 dirty dry washcloths on floor, and a bucket with dried dirty washcloth hung out of the bucket. In an observation on 04/26/26 at 2:00 PM revealed the back of the facility door, which lead out to the designated smoking area, had a lifted jagged piece of metal with a pointed edge. In an observation on 4/28/26 at 8:28 AM, of the facility 600 hall handrails and handrail railing revealed a used q-tip in the railing and dried brown and red food like appearing substance. In an interview on 04/26/26 at 2:45 PM, CNA D stated she did not know the door in the facility that went out to the smoking area had a jagged piece of metal with a pointed edge on the outside part of the door just below the doorknob. She stated if a resident were to grab the door or rubbed their skin across the area where the jagged metal was, it could have caused a skin tear. In an interview on 04/27/26 at 11:34 AM, CNA E stated he stated she did not know the door in the facility that went out to the smoking area had a jagged piece of metal with a pointed edge on the outside part of the door just below the doorknob. She stated if a resident were to grab the door or (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	rubbed their skin across the area where the jagged metal was, it could have caused harm and they could have gotten hurt. She stated metal should not have been there because the residents used that door a lot and they could have gotten hurt. In an interview on 04/27/26 at 11:56 AM, LVN C stated she did not know the door in the facility that went out to the smoking area had a jagged piece of metal with a pointed edge on the outside part of the door just below the doorknob. She stated she believed they were waiting on a part to fix the door that allowed residents to use the push button to go in and out. She stated for now the residents had to open and close the door manually. She stated if a resident grabbed the door or rubbed their skin across the area where the jagged metal was, it could have caused a laceration or skin tear. In an interview on 04/27/26 at 12:25 PM, RN A saidshe did not know the door in the facility that went out to the smoking area had a jagged piece of metal with a pointed edge on the outside part of the door just below the doorknob. She stated if a resident grabbed the door or rubbed their skin across the area where the jagged metal was, it could have caused a resident to get an injury or skin tear and could have harmed the resident. In an interview on 04/27/26 at 1:10 PM, the ADM stated she did not know the door in the facility that went out to the smoking area had a jagged piece of metal with a pointed edge on the outside part of the door just below the doorknob. She stated if a resident were to have grabbed the door or rubbed their skin across the area where the jagged metal was, it could have caused a cut or resident injury. In an interview on 04/28/26 at 12:16 PM, the MTS stated he was not aware of the jagged piece of metal with a pointed edge that was bent up on the back of the smoking door. He stated the door had been automatic and they had some complications with the door so they had to fix it, so it had to be opened and closed manually. He stated they ordered a part for the door to fix it so it would open automatically again. He stated he was not aware of any incidents that had happened with the door or any injuries occurring. He stated if there was a lifted piece of jagged metal on the door and a resident rubbed their skin on it they could have gotten injured. In an interview on 04/28/26 at 12:32 PM, the DON stated she did not know the door in the facility that went out to the smoking area had a jagged piece of metal with a pointed edge on the outside part of the door just below the doorknob. She stated if a resident had grabbed the door or rubbed their skin across the area where the jagged metal was, it could have caused a resident to get a cut. In an interview on 4/28/26 at 12:57 PM with MTS stated it was the expectation to try to complete repair issues the day they were submitted unless parts were required that needed to be ordered. The MTS stated if parts needed to be ordered then repairs were completed once the needed parts came in. The MTS stated the facility staff put any maintenance requests or needs in the maintenance log that was at each of the nurse's station. The MTS stated he checked the logs daily if possible but at a minimum of several times a week. The MTS stated he was responsible for completing maintenance requests and building repairs. The MTS stated it could potentially negatively affect a resident if building repairs were not completed. The MTS stated when showed pictures of the back loading dock door, dining room fire door magnet, and door cover mechanism for the sunroom smoking door that he was unaware of these repairs needing to be made and none of these items had been logged into the maintenance log binder. MTS stated the facility staff who found the item needing repair are responsible for entering the repair request into the maintenance binder. In an interview on 4/28/26 at 1:24 PM, HK stated his expectation for facility cleanliness was the building be kept clean and to keep the residents' rooms cleaned. HK stated he received hands on training from his supervisor for the floor tech position and for the housekeeper position, he shadowed the lead housekeeper for several days before being assigned duties on his own. HK stated he was trained to clean the handrails and inside railing when he worked the position of the floor tech. HK stated there were floor techs scheduled for all 7 days of the week. HK stated sanitizer wipes were used to clean the handrails and inside the railing of the handrails. HK stated it was the responsibility of the floor tech to clean the handrails. HK stated it could negatively impact resident if the handrails were not cleaned because the residents could become sick from the spread of germs. HK stated it was the responsibility of housekeeping to clean the resident shower rooms weekly. HK stated the process was to pick up any (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	trash, mop the walls down with cleaner, and then to wipe the walls down with sanitizer wipes after they were cleaned from any soil. HK stated it could negatively affect residents if the shower rooms were not kept clean because of infection risks. HK stated that it was his first day back on shift at the facility since he only works PRN currently and he was unsure of who had recently been on shift or was responsible for ensuring the shower rooms and handrails had been cleaned. In an interview on 4/28/26 at 1:36 PM, HKS stated it was his expectation the facility be kept clean from top to bottom and all public areas and resident rooms. The HKS stated handrails and inside railings were cleaned once a week by housekeeping. The HKS stated it could negatively affect a resident if the handrails and inside of railing were not cleaned because of infection. The HKS stated the shower rooms were cleaned by housekeeping and by CNAs both. The HKS stated after the CNAs completed showers they picked up all linen used and any trash. The HKS stated housekeeping washed the walls with the chemical soap sanitizer and scrubbed the walls with a scrub brush then rinsed with water and wiped down with a dry towel weekly and typically this was completed on the weekends. The HKS stated yes, it could negatively affect a resident if shower rooms were not kept clean because of bacteria risk. In an interview on 4/28/26 at 2:38 PM, LVN H stated for any building repairs the requests were put into the maintenance log binder at the nurse station. LVN H stated the MTS checked the book and then completed the needed repairs. LVN H stated nurses and CNAs were responsible for cleaning the mechanical lift after each resident. LVN H stated sanitizer wipes were used to clean the mechanical lift. LVN H stated housekeeping was responsible for cleaning the facility which included the handrails and the inside of the railing. LVN H stated it could negatively affect a resident if the facility was not kept clean because of infection and bacteria. LVN H stated CNAs were responsible for cleaning the shower rooms after use with each resident. LVN H stated it could negatively affect the resident if the shower rooms were not cleaned because of bacteria. In an interview on 4/28/26 at 2:48 PM, CNA D stated that if the facility needed any repairs she would report it to the ADM. CNA D stated it was the responsibility of MTS to complete facility repairs. CNA D stated it was the responsibility of HK to keep the facility common areas and resident rooms clean. CNA D stated she was unsure who was responsible for cleaning the mechanical lift. CNA D stated if she needed to use the lift that she would clean it with sanitizer wipes prior to use if the lift appeared dirty. CNA D stated the shower rooms are cleaned by CNA staff and HK staff. CNA D stated that after each resident shower is completed that the CNA picks up any used towels and trash and does a general clean up between residents. CNA D stated that HK clean the showers weekly to sanitize. In an interview on 4/28/26 at 3:00 PM, ADM stated it was her expectation that any facility repair request be communicated via the maintenance log repair binder unless it was an emergency then to call the MTS or ADM. ADM stated repairs are completed the next day unless parts are needed to complete the repair then as soon as parts come in the repair is completed. ADM stated MTS is responsible for checking the maintenance log binder daily and completing facility repairs. ADM stated that it was her expectation that the facility be cleaned daily. ADM stated that it was HKS responsibility for ensuring the facility was kept clean. ADM stated that the handrails are cleaned daily. ADM stated that it was her expectation that the mechanical lift be cleaned when it was soiled and after each resident use. ADM stated she was unsure of the cleaning requirements for the mechanical lift, but it would be to look at the policy and the manufacture guidelines. ADM stated it was the responsibility of the nursing staff to clean the mechanical lift. ADM stated it was her expectation the resident shower rooms be cleaned after each resident by the nursing staff and daily by HK staff. ADM stated it could negatively affect the residents if the facility's appearance and cleanliness was not maintained because of possible injury or infection. In an interview on 4/28/26 at 3:30 PM, DON stated it was her expectation that any facility repairs be completed in a timely manner. DON stated that when repairs are needed the facility staff put the repair requests into the maintenance repair log binder. MTS then checks the binder and completes any requests and denotes them in the binder when the request was completed. DON stated MTS was responsible for completing facility repair requests and general facility maintenance. DON (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated it could negatively affect a resident if the facility is not kept in good repair because of the risk of injuries. DON stated it was her expectation that the facility be kept clean. DON stated she was unsure of how often the facility handrails are cleaned. DON stated HK are responsible for cleaning the facility handrails. DON stated it was her expectation that if the mechanical lift looks like it needs to be cleaned then it would be cleaned. DON stated she was unsure who was responsible for cleaning the mechanical lift or if there was a scheduled cleaning rotation. DON stated if the lift is soiled then the CNAs use sanitizer wipes to clean it. DON stated she did not believe if the mechanical lift was not cleaned that it could negatively affect the residents since the sling is the part of the lift that touches the resident and that each resident has their own slings that are laundered by facility staff. DON stated that it was her expectation regarding shower rooms that after each resident shower the CNA gathers all products used and picks up after themselves. [NAME] stated that housekeeping is responsible for cleaning the walls and floor of the shower rooms. DON stated she was unsure of the cleaning rotation with housekeeping. DON stated it could negatively affect residents if the shower rooms are not kept clean because of germs. Record review of maintenance log binder reflected the fire door magnet, the smoking door jagged metal piece, the loading dock door jagged metal trim, and the smoking door top door mechanism cover had not been recorded in the maintenance binder as items needing repair or replacement. Record review of facility's policy, dated 02/01/2017, titled Maintenance Service reflected Policy: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Procedure: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. f. Establishing priorities in providing repair service. 3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. The Maintenance Director is responsible for maintaining the following records/ reports. a. Inspection of building; Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed ensure the resident had a right to personal privacy and confidentiality of his or her personal and medical records for 15 of 20 residents (Residents #12, #54,#13, #10, #6, #49, #27,#47, #30, #33, #69, #20, #21, #45 and #29) reviewed for privacy and confidentiality. 1. The facility failed to ensure Residents #47, #30, #33, #69, #20, #21, #45 and #29 vital sign information was not exposed and left on top of MA F's medication cart unattended on 04/26/26. 2. The facility failed to ensure resident/responsible party education, for Out on Pass signed documents, which documented resident names and responsible party name and signatures were not exposed on the receptionist front window counter for Residents #13, #!2 and #54 on 4/26/26. 3. The facility failed to ensure resident personal information which included names and prescribed medications was not exposed on a counter next to the copy machine in public hallways for Residents #12, #6, #49, #27 and #10 on 4/26/26. 4. The facility failed to ensure ambulance transport certification documents, for Resident # 10, which documented the resident's personal information, was not exposed on the counter next to the copy machine in the public hallway on 4/26/26. These failures could place residents at risk of not having their personal privacy maintained during medication administration and their medical information exposed to unauthorized individuals.1. Record review of Resident #47's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with Parkinson's disease (a chronic degenerative disorder of the central nervous system that affects both the motor system and non-motor systems), diabetes (a group of diseases that result in too much sugar in the blood), chronic obstructive pulmonary disease (a lung disease characterized by chronic respiratory symptoms and airflow limitation), and bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs (mania or hypomania) and severe lows (depression). Record review of Resident #47's Quarterly MDS Assessment, dated 04/09/26, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. 2. Record review of Resident #30's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with multiple sclerosis (a chronic autoimmune disease where the immune system attacks the protective myelin sheath covering nerves in the brain and spinal cord), chronic kidney disease (long standing disease of the kidneys leading to renal failure), atherosclerotic heart disease of native coronary artery (coronary artery disease) (heart disease involving the reduction of blood flow to the cardiac muscle due to a buildup of atheromatous plaque in the arteries of the heart), and hyperlipidemia (abnormally high levels of any or all lipids or lipoproteins in the blood). Record review of Resident #30's Quarterly MDS Assessment, dated 04/10/26, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. 3. Record review of Resident #33's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with cerebrovascular disease (a general term for conditions that affect the blood vessels in the brain and spinal cord, which can lead to serious complication), chronic obstructive pulmonary disease (a lung disease characterized by chronic respiratory symptoms and airflow limitation), diabetes (a group of diseases that result in too much sugar in the blood), and benign prostatic hyperplasia (a common noncancerous enlargement of the prostate gland in men, typically occurring with aging, which causes lower urinary tract symptoms like weak stream, frequency, and nocturia). Record review of Resident #33's Quarterly MDS Assessment, dated 03/05/26, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. 4. Record review of Resident #69's admission Record, dated 04/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a lung disease characterized by chronic respiratory symptoms and airflow limitation), dementia (a general name for a (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decline in cognitive abilities that impacts a person's ability to perform everyday activities), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and psychosis (a disconnection from reality characterized by symptoms like hallucinations (seeing/hearing things) and delusions (false beliefs). Record review of Resident #69's Quarterly MDS Assessment, dated 02/20/26, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. 5. Record review of Resident #20's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and chronic pain syndrome (a long-term condition lasting 3-6+ months, extending beyond initial injury to include profound emotional, physical, and functional impairment, such as depression, anxiety, and fatigue). Record review of Resident #20's Quarterly MDS Assessment, dated 04/26/26, reflected the resident had a BIMS score of 12, which indicated the resident was moderately cognitively impaired. 6. Record review of Resident #21's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (COPD) (a lung disease characterized by chronic respiratory symptoms and airflow limitation), diabetes (a group of diseases that result in too much sugar in the blood), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), and dysphagia (difficulty in swallowing). Record review of Resident #21's Quarterly MDS Assessment, dated 04/14/26, reflected the resident had a BIMS score of 03, which indicated the resident was severely cognitively impaired. 7. Record review of Resident #45's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with atherosclerotic heart disease of native coronary artery (coronary artery disease) (heart disease involving the reduction of blood flow to the cardiac muscle due to a buildup of atheromatous plaque in the arteries of the heart), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs (mania or hypomania) and severe lows (depression), and insomnia (a common sleep disorder marked by persistent difficulty falling asleep, staying asleep, or getting quality rest, leading to daytime fatigue, irritability, poor concentration, and mood issues, and it can be short-term (acute, from stress) or long-term (chronic, lasting months). Record review of Resident #45's Quarterly MDS Assessment, dated 03/25/26, reflected the resident had a BIMS score of 03, which indicated the resident was severely cognitively impaired. 8. Record review of Resident #29's admission Record, dated 04/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs (mania or hypomania) and severe lows (depression), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and obsessive-compulsive disorder (a chronic mental health condition characterized by uncontrollable, recurring thoughts (obsessions) and/or repetitive behaviors ([compulsions]) that a person feels driven to perform to reduce anxiety). Record review of Resident #29's Quarterly MDS Assessment, dated 03/26/26, reflected the resident had a BIMS score of 12, which indicated the resident was moderately cognitively impaired. 9. Record review of Resident #13's admission Record, dated 04/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with a re-admission date of 2/1/23. The resident was diagnosed with seizures, mild cognitive impairment, localized edema (swelling), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), hypothyroidism (underactive thyroid gland), major depressive disorder (a (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), personality disorder (a mental health condition characterized by long-term, rigid, and unhealthy patterns of thinking, functioning, and behaving that differ significantly from cultural expectations), anxiety disorder (a condition marked by intense, excessive, and persistent worry and fear about everyday situations, heart failure, unspecified convulsions, hypokalemia (low blood potassium levels), acute kidney failure, lack of coordination, hypertension (high blood pressure), muscle weakness, morbid obesity, abnormalities of gait and mobility, cognitive communication deficit (a breakdown in communication caused by underlying cognitive impairment rather than a language or speech defect) and acute respiratory distress. Record review of Resident #13's Quarterly MDS Assessment, dated 4/3/26, reflected the resident had a BIMS score of 15, which indicated intact cognition. 10. Record review of Resident #12's admission Record, dated 4/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with a re-admission date of 2/23/26. The resident was diagnosed with type 2 diabetes (condition where the body resists insulin or fails to produce enough insulin causing high blood sugar levels), hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side (weakness or paralysis of right side following stroke), atherosclerotic heart disease (a condition where plaque builds up in the arteries hardening them), aphasia following cerebral infarction (a language disorder that impairs the ability to speak after a stroke), blindness in one eye low vision in other eye, peripheral vascular disease (circulation disorder involving narrowing or blockage of blood vessels outside the heart), chronic kidney disease stage 2, muscle wasting and atrophy, dementia (a progressive decline in cognitive function including memory, thinking , and reasoning severe enough to interfere with daily life), gangrene, osteomyelitis (a severe inflammation or infection of the bone and bone marrow), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), cognitive communication deficit (a breakdown in communication caused by underlying cognitive impairment rather than a language or speech defect), protein-calorie malnutrition, methicillin resistant staphylococcus aureus infection (a type of bacteria responsible for difficult to treat infections due to its resistance to common antibiotics), and amputation of right great toes and left toes. Record review of Resident #12's Quarterly MDS Assessment, dated 4/16/26, reflected the resident had a BIMS score of 9, which indicated moderate cognitive impairment. 11. Record review of Resident #54's admission Record, dated 4/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with a re-admission date of 11/3/25. The resident was diagnosed with congestive heart failure (a chronic progressive condition where the heart muscle is too weak or stiff to pump blood efficiently), type 2 diabetes (condition where the body resists insulin or fails to produce enough insulin causing high blood sugar levels), bipolar disorder (a chronic mental health condition characterized by extreme mood swings alternating between intense highs and severe lows), insomnia (a common sleep disorder characterized by persistent difficulty falling asleep or staying asleep), anxiety (intense, excessive, and persistent worry and fear about everyday situations), schizoaffective disorder bipolar type (a chronic mental health condition combining schizophrenia symptoms of hallucinations and delusions with manic episodes extreme highs and often depression), viral hepatitis C (a contagious liver disease caused by the hepatitis C virus), osteoporosis (bone weakness), chronic respiratory failure with hypoxia (a long-term gradual and progressive condition where the lungs cannot adequately transfer oxygen to the blood resulting in persistently low blood oxygen levels), Parkinson's disease (a progressive neurodegenerative movement disorder caused by loss of dopamine producing neurons in the brain), dementia (a progressive decline in cognitive function including memory, thinking , and reasoning severe enough to interfere with daily life), major depressive disorder (a serious mental health condition characterized by persistent intense sadness or a loss of interest in activities for a least 2 weeks), chronic obstructive pulmonary disease (a progressive ling disease that causes damaged inflamed airways making it hard to breath), morbid obesity, left leg above knee amputation, hypokalemia (low blood potassium levels), resistance to (continued on next page)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple antibiotics, and cognitive communication deficit (a breakdown in communication caused by underlying cognitive impairment rather than a language or speech defect). Record review of Resident #54's Quarterly MDS Assessment, dated 4/14/26, reflected the resident had a BIMS score of 15, which indicated intact cognition. 12. Record review of Resident #6's admission Record, dated 4/28/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with a re-admission on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a progressive ling disease that causes damaged inflamed airways making it hard to breath), schizophrenia (a serious brain disorder that disrupts how a person thinks, feels, and acts often causing difficulty distinguishing reality from imagination), anxiety disorder, hypertension (high blood pressure), gout (a common painful form of inflammatory arthritis characterized by sudden severe attacks of joint pain swelling and tenderness), insomnia (a common sleep disorder characterized by persistent difficulty falling asleep or staying asleep), anorexia (an eating disorder and serious mental health condition characterized by a person trying to keep their weight as low as possible through extreme exercise not eating and vomiting), depression, edema (swelling), osteoarthritis (a common form of arthritis a chronic degenerative joint disease), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), and muscle weakness. Record review of Resident #6's Comprehensive MDS Assessment, dated 4/2/26, reflected the resident had a BIMS score of 15, which indicated intact cognition. 13. Record review of Resident #49's admission Record, dated 4/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), schizoaffective disorder bipolar type (a chronic mental health condition combining schizophrenia symptoms of hallucinations and delusions with manic episodes extreme highs and often depression), anxiety disorder, insomnia (a common sleep disorder characterized by persistent difficulty falling asleep or staying asleep), contracture of right and left hand, muscle weakness, lack of coordination, bipolar disorder (a chronic mental health condition characterized by extreme mood swings alternating between intense highs and severe lows), schizophrenia (a serious brain disorder that disrupts how a person thinks, feels, and acts often causing difficulty distinguishing reality from imagination), hypokalemia (low blood potassium levels), heart failure, major depressive disorder (a serious mental health condition characterized by persistent intense sadness or a loss of interest in activities for a least 2 weeks), unspecified psychosis, and gastroesophageal reflux disease (a chronic digestive condition where stomach acid frequently flows back into the esophagus). Record review of Resident #49's Quarterly MDS Assessment, dated 3/4/26, reflected the resident had a BIMS score of 3, which indicated severe cognitive impairment. 14. Record review of Resident #27's admission Record, dated 4/28/26, reflected a 66 -year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. The resident was diagnosed with schizoaffective disorder bipolar type (a chronic mental health condition combining schizophrenia symptoms of hallucinations and delusions with manic episodes extreme highs and often depression), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), muscle weakness, major depressive disorder (a serious mental health condition characterized by persistent intense sadness or a loss of interest in activities for a least 2 weeks), lack of coordination, acute kidney failure, anxiety disorder, cognitive communication deficit (a breakdown in communication caused by underlying cognitive impairment rather than a language or speech defect), hyperlipidemia (elevated fat particles in the blood), tachycardia (a heart rhythm disorder), and abnormalities of gait and mobility. Record review of Resident #27's Quarterly MDS Assessment, dated 4/17/26, reflected the resident had a BIMS score of 3, which indicated severe cognitive impairment. 15. Record review of Resident #10's admission Record, dated 4/28/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. The resident was diagnosed with persistent vegetative state (a chronic, severe disorder of consciousness where a patient with severe brain damage appears to be awake but lacks awareness of their surroundings and has no cognitive (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	function), chronic respiratory failure with hypoxia (a long-term gradual and progressive condition where the lungs cannot adequately transfer oxygen to the blood resulting in persistently low blood oxygen levels), congestive heart failure (a chronic progressive condition where the heart muscle is too weak or stiff to pump blood efficiently), tracheostomy status (an artificial surgical opening in the neck used for long-term breathing support), hypertension (high blood pressure), dysphagia (swallowing difficulty), aphasia (a language disorder that impairs the ability to speak), muscle wasting and atrophy, morbid obesity, atherosclerotic heart disease, unspecified convulsions, anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood), GERD (a chronic digestive condition where stomach acid frequently flows back into the esophagus), cardiomegaly, cataract, contractures to bilateral upper extremities. Record review of Resident #10's Quarterly MDS Assessment, dated 3/7/26, reflected the resident had a BIMS score that was not documented. In an observation on 04/26/26 at 9:36 AM, during a facility walk through, revealed on the receptionist front window counter 3 resident/responsible party education for Out on Pass signed documents which contained resident names and resident responsible party names and signatures laid exposed on the front counter for anyone passing by to see. In an observation on 04/26/26 at 10:11 AM, during a facility walk through, revealed on the counter next to the copy machine in a public hallway a list of record of disposal for medications for 5 residents (Residents #12, #6, #49, #27 and #10 which contained resident names and resident medication names laying exposed on the counter in the public hallway for anyone passing by to see. In an observation on 04/26/26 at 10:15 AM, during a facility walk through, revealed on the counter next to the copy machine in a public hallway were ambulance transport certification documents for 1 resident (Resident #10) which contained the resident name, date of birth , sex, ethnicity, address, primary care provider, race, phone number, emergency contacts name and phone numbers, insurance provider information, hospital account number, advance directive status, and medical record number laid exposed on the counter next to the copy machine in the public hallway for anyone passing by to see. In an observation on 04/26/26 at 11:37 AM, during a medication administration observation, revealed a sheet of white paper which contained resident's #47, #30, #33, #69, #20, #21, #45, #29's names and vital sign information laid exposed for others to see on top of a medication cart. In an interview on 04/26/26 at 11:43 AM, RN F stated he meant to put the paper that included residents' name and vital signs in his pocket and he usually kept any information which contained resident information put away or in his pocket. He stated he was trained on HIPPA and if resident information was left out in the open and exposed, it could have violated the residents' rights and been an invasion of residents' privacy. In an interview on 04/26/26 at 2:45 PM, CNA D stated she was in-serviced on privacy and resident rights. She stated anything containing resident information should have been put away and should not have been out for anyone to see. She stated it was a HIPPA violation for resident information to be out in the open for the public to see. She stated if resident information was left exposed, it could have been an invasion of the residents' privacy, and it would have been against their resident rights. In an interview on 04/27/26 at 11:34 AM, CNA E stated was in-serviced regularly on privacy and resident rights. She stated anything containing resident information should have been put away and not been out for anyone to see. She stated it was a HIPPA violation for resident information to be left out in the open for the public to see. She stated if resident information was left exposed, it could have caused a HIPPA violation and would have caused the resident to have their privacy invaded. In an interview on 04/27/26 at 11:56 AM, LVN C stated she was in-serviced regularly on privacy and resident rights. She stated anything containing resident information should have been put away and not been left out for anyone to see. She stated it was a HIPPA violation for resident information to be left out in the open for the public to see. She stated if resident information was left exposed, it could have caused the resident to have anxiety, or it would have been an invasion of their privacy. In an interview on 04/27/26 at 12:25 PM, RN A stated she worked in the facility for about 2 years. She stated she was in-serviced regularly on privacy and resident rights. She stated anything containing resident information should have been put away and (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not been left out for anyone to see. She stated it was a HIPPA violation for resident information to be out in the open for the public to see. She stated if resident information was left exposed, it would be a HIPPA violation and would have been an invasion of their privacy and would be against the residents' rights. In an interview on 04/27/26 at 1:10 PM, the ADM stated staff were in-serviced on privacy and resident rights. She stated anything containing resident information should have been put away and not been left out for anyone to see. She stated it was a HIPPA violation for resident information to be left out in the open for the public to see. She stated if resident information was left exposed, it could have caused the resident financial issues and would have been an invasion of their privacy and resident rights. In an interview on 04/28/26 at 12:32 PM, the DON stated she had in-serviced staff regularly on privacy and resident rights. She stated anything containing resident information should have been put away and not been left out for anyone to see. She stated it was a HIPPA violation for resident information to be left out in the open for the public to see. She stated if staff were on a nursing cart and resident information was in front of the staff member while the staff was present that would be ok, but the staff member should not have walked away and left any information exposed. She stated if resident information was left exposed, it could have caused the resident an invasion of their privacy and been against their resident rights. Record review of the facility's policy, dated 2001 and revised October 2017, titled Confidentiality of Information and Personal Privacy reflected Policy Statement: Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation: The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her: b. medical treatment; c. written and telephone communications; d. personal care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety in the facility's kitchen reviewed for dietary services. The facility failed to ensure food was labeled and dated correctly in the refrigerator, freezer, and pantry on 04/26/26. This failure could place residents at risk of foodborne illnesses. Observation of the kitchen on 04/26/26 at 9:18 AM revealed the following:There were 2 opened packages of French fries in the freezer that did not have any dates on them.There was a container with Jello (a sweet gelatin-based dessert made from animal derived gelatin) that had a preparation date of 04/01/26 and a used by date of 04/02/26 in the refrigerator that had not been thrown away.There was an opened loaf of bread in the pantry that had a manufacturer's date of 06/24/26 on it but did not have a delivery date or an open date on it.There were six loaves of bread in the pantry with a manufacturer's date 06/24/26 on them, but they did not have a delivery date on them. Observation of the kitchen on 04/26/26 at 9:27 AM revealed the following verbiage was posted on the front of the refrigerator door: Any food that is 3 days past date on container must be thrown away. Interview with the DM on 04/26/26 at 10:02 AM revealed all kitchen staff were responsible for putting dates on food packages when they were delivered. The DM stated there should be a delivery date and an open date or prep (to prepare or cook food ahead of time) date on all food. She stated the manufacturer's expiration date was the disposal date for the food in the pantry and package foods in the refrigerator and freezer. The DM said the prepped food in the refrigerator had a prep date and a used by date and the food items were disposed of 3 days after the used by date. She advised the opened containers in the refrigerator of food that were not prepped had an open date and the manufacturer's date was the disposal date. The DM did not know why food items were not dated correctly as she stated staff knew what dates to use. The DM said she would review the food storage policy with the kitchen staff as soon as possible. Interview with CK G on 04/27/26 at 11:49 AM revealed she was unaware food items were not dated correctly. CK G said all kitchen staff were responsible for dating food when it was delivered to the facility. She stated the dates on the food depended on the food item. CK G stated there should be a delivery date and an open date or prep date on all food items. She stated the manufacturer's expiration date was the disposal date for the food in the pantry and for packaged food or food that came in a container in the refrigerator and freezer. CK G said the prepped food in the refrigerator had a prep date and a used by date. She stated they threw away food 3 days after the used by date. She said the opened containers in the refrigerator of food (that they did not have to prep) had an open date and the manufacturer's date was the throw away date. Telephone interview on 04/28/26 at 12:48 PM with the RD revealed all food items must have a delivery date on them. She stated dry food storage and freezer items should have a check-in date and they used the manufacturer's expiration date as the disposal date. She stated all refrigerator food items should have a delivery date, an open date, and a used by date for all prepped food. She stated prepped food must be thrown away 3 days after the used by date. The RD said food in the refrigerator that was not prepped was disposed by the manufacturer's date. She stated all kitchen staff were responsible for ensuring all food items were dated correctly to prevent foodborne illnesses. Interview with the ADM on 04/28/26 at 4:03 PM revealed she was unaware food was not dated and stored correctly. She said all kitchen staff were responsible for putting dates on food packages when they were delivered. The ADM advised the food storage policy was in place to prevent food-borne illnesses. The ADM concluded that a follow-up with kitchen staff to review the food storage policy would be completed as soon as possible. Record review on 04/27/26 of the food storage policy (effective date 01/2018 and revised 02/2026) revealed the following:Policy: Food should be stored in a safe and sanitary method to prevent contamination and food-borne illness. All food should be stored according to state, local, and federal regulations. ProcedureDry storage roomb. Bulk items that have (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been opened should be stored in covered containers or sealed bags and should be labeled and dated. 2. Refrigerators c. Refrigerated food should be dated, labeled, and sealed. d. Leftovers should be used within 3 days. Discard items after 3 days.3. Freezers d. Items should be sealed, labeled, and dated.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 of 6 residents (Resident #6) reviewed for PASARR assessments. The facility failed to ensure Resident #6 was referred to the mental health authority after receiving a new diagnosis of schizoaffective disorder. This failure could place residents at risk for a diminished quality of life and not receiving needed care and services in accordance with individually assessed needs.Findings include: Record review of Resident #6's admission Record, dated 04/28/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had diagnoses which included chronic obstructive pulmonary disease (a lung disease characterized by chronic respiratory symptoms and airflow limitation), anxiety (intense, excessive, and persistent worry and fear about everyday situations), schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking), and osteoarthritis - (a degenerative joint disease that causes the cartilage and bone in a joint to break down over time). Resident #6's admission record reflected Resident #6 had a diagnosis of schizophrenia with an onset date of 04/12/25. Record review of Resident #6's Significant Change MDS Assessment, dated 04/04/26, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Resident #6 required set up or clean up assistance for eating and substantial/maximal assistance with toileting, showering, and personal hygiene. Record review of Resident #6's care plan, dated 05/28/25, reflected Focus: [Resident #6] was on antipsychotic medication r/t: Schizophrenia. Goal: Resident will remain free from adverse reactions related to antipsychotic medication therapy. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/record occurrence of targeted behavior and document per protocol. In an interview on 04/28/26 at 12:23 PM, LVN B stated she was responsible for PASSAR's in the facility. She stated she had been in-serviced on PASSAR evaluations and completion and the PASARR process. She stated when a resident admitted , their PASARR should have already been completed. She stated if the PASSAR was not completed she would have immediately notified the sending facility and if she was not able to get a hold of them, she would have completed the PASSAR. She stated if a resident received a new psychological/IDD diagnosis after their PASSAR was completed, she would have filled out a 1012 form. She stated if the resident's primary diagnosis was dementia, she would have filled out the first form and stopped there, but if not, she would have went on to the next page and completed the PASSAR assessment. She stated then someone from the local authority would have come and done the residents PASSAR evaluation. She stated she was not aware Resident #6 received a new diagnosis of schizophrenia after she had a negative PASSAR completed. She stated a new PASSAR screening should have been completed when Resident #6 received the new diagnosis for schizophrenia. She stated if a residents PASSAR had not been done or the process had not been completed correctly, it could have caused a resident to miss their assessment to determine if they were eligible for additional benefits through PASSAR services. In an interview on 04/28/26 at 12:32 PM, the DON stated LVN B was responsible for PASSAR assessments in the facility, and she had been trained on the PASSAR process and completion. She stated the corporate office made the decisions on who all admitted to the facility. She stated if a resident received a new psychological/IDD diagnosis after their PASSAR was completed, LVN B would have needed to do a new PASSAR screening. She stated she was not aware Resident #6 received a new diagnosis of schizophrenia after her initial negative PASSAR was completed. She stated a new PASSAR screening should have been completed when Resident #6 received the diagnosis for schizophrenia. She stated if (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a resident's PASSAR was not done or the process was not completed correctly, it could have caused the resident to miss out on services that they could have benefited from. In an interview on 04/27/26 at 1:10 PM, the ADM stated LVN B was responsible for PASSAR assessments in the facility, and she had been trained on the PASSAR process and completion. She stated if a resident received a new psychological/IDD diagnosis after their PASSAR was completed, a form should have been completed to reassess residents PASSAR status. She stated she was not aware Resident #6 received a new diagnosis of schizophrenia after her initial negative PASSAR was completed. She stated a new PASSAR screening should have been completed when Resident #6 received the diagnosis for schizophrenia. She stated if a residents PASSAR assessment was not done or the process was not completed correctly, it could have caused the resident to have a lack of services that they could have been entitled to receive. Record review of the facility policy, dated 11/2023, and titled Resident Assessment reflected Policy: The purpose of this policy is to ensure PASRRs are being obtained and completed timely and accurately. PROCEDURE: 6. Follow Texas PASRR Policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASRR status. Record review of the Texas Health and Human Services' (PASRR) for Nursing Facilities online When a nursing facility (NF) resident with a negative PASRR (Level I) receives a new, confirmed diagnosis of an Intellectual or Developmental Disability (IDD), it is considered a significant change in condition requiring a Resident Review (RR). The facility must notify the Local Intellectual and Developmental Disability Authority (LIDDA) to conduct a new evaluation within seven calendar days.