STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455642	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dayton Nursing and Rehabilitation	310 E Lawrence St Dayton, TX 77535

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to Health and Human Services Commission (HHSC) for 4 of 4 residents (Residents #1, #2, #3 and Resident #4) reviewed for abuse and neglect. 1. The facility did not report allegation of abuse involving Resident #1 and Resident #2 until 19 hours after they were aware of the incident. 2. The facility did not report an allegation of abuse involving Resident #3 until almost 22 hours after they were aware of the incident. 3. The facility did not report an allegation of abuse involving Resident #4 until almost 9 hours after they were aware of the incident. This failure could place residents at risk for further abuse, humiliation, intimidation, fear, shame, agitation, and a decreased quality of life.Findings included: 1. Record review of a face sheet dated 05/28/26 indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), generalized anxiety disorder (persistent and excessive worry that interferes with daily activities), and post-traumatic stress disorder (a mental health condition triggered by a terrifying event-either experiencing it or witnessing it). The face sheet indicated Resident #1 discharged to an out-of-town psychiatric hospital on [DATE]. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS of 6 out of 15 indicating severely impaired cognition; had no behaviors; supervision or touching assistance for transfers and independent with propelling self in a wheelchair; active diagnoses of Alzheimer's disease, anxiety disorder, and post-traumatic stress disorder; and received an antidepressant medication. Record review of a face sheet dated 05/28/26 indicated Resident #2 was a [AGE] year-old male admitted on [DATE]. His diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), mood disorder (mental disorders that primarily affect a person's emotional state), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and generalized anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #2 had a BIMS of 15 out of 15 indicating intact cognition; had no behaviors; required partial/moderate assistance with transfers; had active diagnoses of Alzheimer's disease, bipolar disorder, mood disorder, major depressive disorder, and generalized anxiety disorder; and received antipsychotic medication, antianxiety medication, and antidepressant medication. During an observation and interview on 05/28/26 at 10:38 a.m. Resident #2 was in bed. He was clean, neat, and had no odors. He said he was doing good. He said he liked the facility and had no issues with any staff. Resident #2 said he had an issue with a resident coming into his room several months ago, but he has had no other issues with any resident; he said he felt safe at the facility. Record review of the Provider Investigation Report dated 09/26/25 indicated the incident involving Resident #1 and Resident #2 occurred on 09/22/25 at 06:50 p.m., incident category was (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Abuse, and it was reported to HHSC on 09/23/25 at 02:00 p.m. Review of the HHSC TULIP Portal indicated the facility was aware of the incident involving Resident #1 and Resident #2 on 09/22/25 at 07:00 p.m.; it was categorized by the facility as Abuse; and it was received in the TULIP Portal on 09/23/25 at 02:41 p.m.-19 hours and 41 minutes after they were aware. 2. Record review of a face sheet dated 05/28/26 indicated Resident #3 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and generalized anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #3 had a BIMS of 7 out of 15 indicating severely impaired cognition; she had no behaviors; she required supervision or touching assistance with transfers; she had active diagnoses of bipolar disorder, major depressive disorder, and generalized anxiety disorder; and she received antipsychotic medication, antianxiety medication, and antidepressant medication. During an observation and interview on 05/28/26 at 11:00 a.m., Resident #3 was sitting on the side of her bed; she was clean, neat, and had no odors. Interactions with other residents and staff were appropriate. She said she was doing fine, she felt safe with the staff taking care of her, and had no issues. Record review of the Provider Investigation Report dated 01/20/26 indicated the incident involving Resident #3 occurred on 01/15/26 at 02:00 p.m., incident category was Abuse, and it was reported to HHSC on 01/16/26 at 11:50 a.m. Review of the HHSC TULIP Portal indicated the facility was aware of the incident involving Resident #3 on 01/15/26 at 02:00 p.m.; it was categorized by the facility as Abuse and Neglect; and it was received in the TULIP Portal on 01/16/26 at 11:56 a.m.-21 hours and 56 minutes after they were aware. 3. Record review of a face sheet dated 05/28/26 indicated Resident #4 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning). Record review of an admission MDS assessment dated [DATE] indicated Resident #4 had a BIMS of 11 out of 15 indicating moderately impaired cognition; she had no behaviors; she required substantial/maximal assistance with transfers; she had active diagnoses of non-Alzheimer's dementia; and she received antidepressant medication. During an observation and interview on 05/28/26 at 11:20 a.m. Resident #4 was up in her wheelchair propelling herself through the facility. She was clean, neat, and had no odors. Interactions with other residents and staff were appropriate. She said she was doing fine, she did not hate anyone. Resident #4 said she had an issue with a nurse recently but it was taken care of, she felt safe with the staff taking care of her, and had no issues. Record review of the Provider Investigation Report dated 05/06/26 indicated the incident involving Resident #4 occurred on 05/01/26 at 07:30 p.m., incident category was Abuse, and it was reported to HHSC on 05/01/26 with no time filled in. Review of the HHSC TULIP Portal indicated the facility was aware of the incident involving Resident #4 on 05/01/26 at 11:30 a.m.; it was categorized by the facility as Abuse and Neglect; and it was received in the TULIP Portal on 05/01/26 at 08:14 p.m.-8 hours and 44 minutes after they were aware. Record review of the Abuse, Neglect, and Exploitation Policy dated 2025 indicated: .VII. Reporting/ResponseA. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. During an interview on 05/28/26 at 03:20 p.m. the Administrator said she was the AC. She said she had received training on ANE. She said she thought if the Abuse did not cause serious bodily injury, then it was to be reported within 24 hours. She said she missed the part on the Provider Letter and the policy that Abuse was to be reported within 2 hours whether there was serious bodily injury or not.