

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Dayton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 15 Residents (Resident #15) who were reviewed for pain management. The facility failed to ensure the WCN assessed for pain and medicated Resident #15 with PRN pain medication prior to wound care and then failed to stop wound care when Resident #15 yelled out in pain multiple times. This failure could place residents who received wound care, who had chronic pain conditions, who received as needed pain medication, or who received routine pain medications at risk for not having their pain addressed causing undue suffering. The findings included: Record review of a face sheet dated 09/17/25 indicated Resident #15 was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, osteoporosis (disease that weakens bones) with current pathological fracture and diabetes (too much sugar in the blood). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #15 had a BIMS score of 99 and was unable to complete the BIMS. Resident #15 had memory problems with short term and long term memories. The MDS indicated the number of unstageable pressure ulcers due to coverage of wound bed by slough (yellow or white tissue with dead cells) and/or eschar (black dead tissue) was 1 and indicated no other pressure ulcers. Record review of the care plan dated 09/12/25 indicated Resident #15 had an actual wound measuring 1.4 cm x 1.1cm x 0.1cm. Medical device pressure stage 4 wound to the left lateral malleolus (ankle) 1.3 cm x 1.4 cm x 0.2 also and the left great toe plantar side (under side of the toe) 2.1 cm x 2.1cm x UTD area is not open as of 09/11/25. Interventions included Treat as ordered by wound doctor, daily dressing change by nursing, and weekly skin checks. Record review of the physician's orders dated September 2025 indicated Resident #15 had treatments of Wound left lateral malleolus: clean with wound cleaner or NS apply medical honey to wound bed, cover with alginate, paint peri-wound with betadine and cover with dry dressing daily with start date 09/04/25. Wound plantar side left great toe -- clean area with wound cleaner or NS paint with betadine apply betadine-soaked gauze to wound bed and cover with dry dressing daily with start date 09/04/25. Left heel: paint with betadine and leave open to air daily with start date 09/02/25. Resident #15 had orders which included acetaminophen-codeine tablet; 300-30 mg, 1 tablet at bedtime and as needed every 8 hours for pain. Record review of the progress notes in the electronic medical record dated 08/28/25 indicated Resident #15 had 2 new unstageable wounds that were covered by the cast. The wound doctor identified these medical device pressure ulcers and are unstageable at this time. Wound #1 left lateral malleolus 4cm x 4cm x <0.1cm wound bed has 50% slough (yellow or white tissue consisted of dead cells), 50% granulation (new tissue), mild serous exudate (drainage) noted, peri-wound (around the wound) intact. Notified wound doctor received new orders clean with wound cleaner or normal saline, paint peri-wound with betadine, cover wound bed with medical - honey, apply calcium alginate and cover with dry dressing daily and PRN. Wound #2 -- Left great toe plantar side clean with wound cleaner or normal saline, paint with betadine daily cover with dry dressing monitor for area opening. The wound measured 2.0cm x1.5cm area is not open at this time (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 0697 Level of Harm - Actual harm Residents Affected - Few	and was unstageable with eschar (dead skin). During an observation and interview on 09/16/25 at 10:15 a.m., observed WCN was preparing to perform wound care to Resident #15. She donned gown and gloves and said Resident #15 was in EBP. She went into the room and prepared the resident for wound care providing privacy, and she spoke Spanish to Resident #15. #1 The WCN performed wound care for the area on coccyx (at the end of the spine). She cleaned the coccyx wound with wound cleanser and painted around the wound with betadine and applied collagen to the wound bed, covered with dry dressing. She performed as needed glove change and hand sanitization for Resident #15 wound on her coccyx. The WCN was removing the boot (a medical device to prevent pressure ulcer and prevent the ankle from moving) and Resident #15 hollered out Oh and Wound Care nurse was still trying to remove the boot. The WCN said she never cries out like this. Resident #15 was grimacing and moaned out, Surveyor asked the ADON to ask her if she was in pain and the resident said her pain was so, so. The WCN removed the boot off. #2. Resident #15 relaxed while the WCN removed her gloves and cleaned her hands with sanitizer and applied new gloves and removed the dressing to the ankle wound and removed gloves, hand sanitizer then donned new gloves. She cleaned the wound from inside out with the wound cleanser. She removed her gloves and donned new gloves without hand sanitizer, applied medical honey to wound bed, covered with alginate, painted peri-wound with betadine and covered with dry dressing. #3 The WCN changed gloves with no hand hygiene performed and applied new gloves. Then she went to remove the dressing on the left great toe, and Resident #15 began to holler out again. The WCN said Resident #15 does not normally have pain like this. The WCN said the pain is new, and she kept performing wound care. When the WCN removed Resident #15 dressing to left toe, Resident #15 quit crying out and relaxed., WCN changed her gloves with no hand hygiene and donned new gloves, cleaned the wound with wound cleanser and applied betadine-soaked gauze and covered with dry dressing the underside of the left great toe. Resident #15 yelled out again when new dressing was applied to great left toe. During an interview on 9/16/25 at 10:40 a.m., the WCN said she should have stopped and medicated the resident for pain. The WCN said she just got nervous and her yelling out was very different. She said normally the resident just doesn't like to be turned. During an interview on 9/17/25 at 8:33 a.m., the DON said WCN should have stopped the treatment and medicated Resident #15 to prevent pain. Record review of the facility's policy Pain - Clinical Protocol' indicated . 5. The nursing staff will identify any situation or interventions where an increase in the resident's pain may be anticipated, for example, wound care .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary psychotropic medications (is a medication used: without adequate indication for its use) for 2 of 8 residents (Residents #1 and #37) reviewed for unnecessary medications.* The facility did not have appropriate diagnoses for Resident #1's Risperdal (antipsychotic) and bupropion (antidepressant) and #37. * The facility did not have appropriate diagnoses for Resident #37's duloxetine (antidepressant). This failure could place residents at risk for unintended, harmful events attributed to the use of a medication without the appropriate indication. Findings included: 1. Record review of a face sheet dated 09/15/25 indicated Resident #1 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), chronic obstructive pulmonary disease ((COPD) a lung disease that blocks airflow making it difficult to breathe), depression (mental illness that negatively affects how you feel, the way you think and how you act), anxiety disorder (persistent and excessive worry that interferes with daily activities), malaise, and herpes viral infection (a viral infection caused by the herpes simplex virus). Record review of September 2025 physician orders indicated Resident #1 had the following medications with no indications for use:* Risperdal (risperidone) 1 mg daily at bedtime; and* bupropion 100mg daily. 2. Record review of physician orders for September 2025 indicated Resident #37 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), atherosclerotic heart disease of native coronary artery (a condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), atrial fibrillation (a type of irregular heartbeat), fracture of head of left femur (broken bone of the left upper leg), chronic kidney disease stage 3 (a disease or condition impairs kidney function, causing kidney damage), intestinal obstruction (a blockage that prevents food or liquid from passing through the small or large intestine), chronic pain, hypertension (a condition in which the force of the blood against the artery walls is too high), anxiety disorder (persistent and excessive worry that interferes with daily activities), and osteomyelitis (an infection in a bone). Record review of September 2025 physician orders indicated Resident #5 had duloxetine 30 mg daily with no indications for use. During a record review and interview on 09/17/25 at 04:00 p.m. LVN C acknowledged the orders were missing diagnoses for the medications on Residents #1 and # 37's orders. She said it was the CN responsibility to put the diagnoses with the psychotropic medications. During an interview on 09/17/25 at 04:10 p.m. the DON and the Administrator said they expected the diagnoses to be placed on the orders when they are written. A policy regarding indication for use for medications was requested on 09/17/25 at 04:15 p.m. from the Administrator but was not provided before exit.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 each resident's drug regimen was free from unnecessary medications (is a medication used: without adequate indication for its use) for 4 of 8 residents (Residents #1, # 3, #5, and #37) reviewed for unnecessary medications. * The facility did not have appropriate diagnoses for medication for Residents #1, #3, #5, and #37. This failure could place residents at risk for unintended, harmful events attributed to the use of a medication without the appropriate indication. Findings included: 1. Record review of a face sheet dated 09/15/25 indicated Resident #1 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), chronic obstructive pulmonary disease ((COPD) a lung disease that blocks airflow making it difficult to breathe), depression (mental illness that negatively affects how you feel, the way you think and how you act), anxiety disorder (persistent and excessive worry that interferes with daily activities), malaise, and herpes viral infection (a viral infection caused by the herpes simplex virus). Record review of September 2025 physician orders indicated Resident #1 had the following medications with no indications for use:* Anoro Ellipta 62.5-25 mcg/actuation daily at bed time;* lidocaine adhesive patch 4% to right knee twice daily;* Mucinex 600mg twice daily;* omeprazole 40mg daily;* potassium 10 mEq daily;* allopurinol 200 mg daily; and* montelukast 10 mg daily. 2. Record review of a face sheet dated 09/16/25 indicated Resident #3 was a [AGE] year-old male admitted on [DATE]. His diagnoses included osteomyelitis (an infection in a bone) of the right ankle and foot, peripheral vascular disease (blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), atrial fibrillation (a type of irregular heartbeat), systolic congestive heart failure (a condition in which the heart's main pumping chamber (left ventricle) is weak), cirrhosis of liver (a condition in which healthy tissue is replaced with scar tissue), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Record review of September 2025 physician orders indicated Resident #3 had the following medications with no indications for use:* Docusate sodium 100 mg twice daily;* Tradjenta 5 mg daily;* amiodarone 200 mg twice daily;* melatonin 15 mg daily at bed time;* hydrocodone-acetaminophen 5-325 mg every 6 hours;* methocarbamol 500 mg three times daily;* Eliquis 5 mg twice daily;* furosemide 40 mg daily;* levothyroxine 175 mcg daily;* meloxicam 15 mg daily;* metoprolol succinate 100 mg daily;* Miralax 17 gm daily; and* omeprazole 20 mg daily. 3. Record review of physician orders for September 2025 indicated Resident #5 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own), centrilobular emphysema (progressive lung disease primarily caused by smoking, affecting the upper lobes of the lungs and leading to breathing difficulties), peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), seasonal allergic rhinitis (reaction that causes sneezing, congestion, itchy nose and watery eyes), and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Record review of September 2025 physician orders indicated Resident #5 had the following medications with no indications for use for acidophilus (lactobacillus acidophilus) daily; and loratadine 10mg daily. 4. Record review of physician orders for September 2025 indicated Resident #37 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), atherosclerotic heart disease of native coronary artery (a condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), atrial fibrillation (a type of irregular heartbeat), fracture of head of left femur (broken bone of the left upper (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leg), chronic kidney disease stage 3 (a disease or condition impairs kidney function, causing kidney damage), intestinal obstruction (a blockage that prevents food or liquid from passing through the small or large intestine), chronic pain, hypertension (a condition in which the force of the blood against the artery walls is too high), anxiety disorder (persistent and excessive worry that interferes with daily activities), and osteomyelitis (an infection in a bone). Record review of September 2025 physician orders indicated Resident #5 had the following medications with no indications for use:* Admelog Units-100 insulin lispro with meals;* Adult low dose aspirin 81 mg daily;* gabapentin 100 mg every 8 hours;* methocarbamol 500 mg four times daily;* metoprolol succinate 50 mg daily;* atorvastatin 40 mg daily at bed time;* losartan 50 mg daily;* meloxicam 7.5 mg daily; and* omeprazole 20 mg daily. During a record review and interview on 09/17/25 at 04:00 p.m. LVN C acknowledged the orders were missing diagnoses for the medications on Residents #1, #3, #5, and #37's orders. She said it was the CN responsibility to put the diagnoses with the medications. During an interview on 09/17/25 at 04:10 p.m. the DON and the Administrator said they expected the diagnoses to be placed on the orders when they are written.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure each resident was provided and received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 kitchen and 6 of 18 residents (#3 #5, #8, and 3 de-identified residents) reviewed for palatable food. The facility failed to provide meal services in a manner to ensure food served was appetizing to residents for 1 of 2 meals observed for palatability and for Residents #3 #5, #8, and 3 de-identified residents. These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life. Findings include: During an interview on 09/15/25 at 9:00 a.m., Resident #8 said the food at the facility was not good. He said he preferred not to eat at the facility. He said he kept snacks in his room so he could get enough to eat. He said the meat was always over cooked, dry and tough. Record review of the facility's Weekly Menu dated Spring/ Summer 2025, indicated . [NAME] Sugar Glazed Ham, Butter Beans, Spinach with cheese, corn bread and marshmallow brownie. During an observation and interview on 09/15/25 at 12:30 p.m., revealed Residents #3 and Resident #5 were sitting at a table in the dining room. Resident #5 backed away from the table, leaving his tray which included a whole piece of ham. Resident #5 said the ham was not good and he could not eat it. He said, none of it was good and he left the dining room. His tray still had a serving of spinach with cheese, a serving of butter beans and a whole slice of ham. Resident #3 picked up her ham with her hands. Her tray had untouched portions of the spinach with cheese and the serving of butter beans. Resident #3 put the slice of ham up to her mouth and attempted to bite on it. She did not bite it and placed it back on her tray. She said none of the food was good and the ham was too tough to bite it. She placed her napkin on the tray and backed away. She said she did not want anything else to eat and sat at the table. During observations of the lunch meal on 09/15/25 at 12:45 p.m., 6 unnamed residents did not eat the ham on the tray, and the ham appeared to be dry and over cooked. During the confidential interview with 3 anonymous residents on 09/16/25, they said the ham served at lunch on 09/15/25 was dry, hard, overcooked, very hard to chew, and almost inedible. They said most of the meats served at the facility were overcooked and hard to chew, and they did not eat them. During an interview on 09/16/25 at 2:00 p.m., the DM said no one complained to her on Monday (09/15/25) about the meat being tough. She said the facility had been trying to adjust the menu to the residents' likes and dislikes. She said she observed the cook preparing the ham and he covered it with aluminum foil to preserve the moisture in the meat. She said the facility had been thinking of changing food providers. During an interview on 09/16/25 at 3:16 p.m., the Administrator said the DM had started on Monday (09/15/25). She said the facility had been thinking of developing a resident council team just to work on the food. Record review of the Food and Nutritional Services dated October 2017 indicated Each resident is provided with a nourishing, palatable, well - balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and interviews, the facility failed to ensure residents received food prepared in a form designed to meet individual needs for 1 of 2 meals, reviewed for nutrition services. The facility failed to ensure the lunch meal served on 09/16/25 had the appropriate consistency for the meat and au gratin potatoes serving for the pureed textured diet. This deficient practice could affect residents who received pureed meals from the kitchen by contributing to choking, poor intake, and/or weight loss. The findings included: During an observation on 09/16/25 at 12:00 p.m. revealed [NAME] D prepared the pureed pot roast turkey for the residents. [NAME] D pureed the au gratin potatoes and said there were 4 residents on a pureed diet. During an observation and interview on 09/16/25 at 12:40 p.m., revealed the test tray for the pureed diet consisted of pot roast turkey, au gratin potatoes and a vegetable melody. The pot roast turkey had small bits and was not smooth. The au gratin potatoes had small size pieces of potatoes. [NAME] D said he should have let the meat and potatoes run longer in the food processor. He said the pureed diet should be smooth and a pudding consistency to prevent choking. During an interview on 09/16/25 at 12:43 p.m. the DM said the facility had 4 residents who received pureed diets. She said the pureed food should not have lumps and should be smooth. Record review of the facility's Therapeutic Diets dated October 2017 indicated Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care in accordance with his or her goals and preferences. Policy Interpretation and Implementation . 5. If a mechanically altered diet is ordered, the provider will specify the texture modification. Record review of a reference obtained on the internet at Microsoft Word - 4_Pureed_p2_Adults_food to AVOID page_consumer handout_30Jan2019.docx indicated . What is this food texture level? Level 4 - Pureed Foods: Are usually eaten with a spoon Do not require chewing. Have a smooth texture with no lumps.		

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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 ensure food was stored, prepared, and served under sanitary conditions for 1 of 1 kitchen, 1 of 2 refrigerator, 2 of 5 walls, and the dishwasher reviewed for food served under sanitary conditions. The facility failed to ensure sandwiches were dated and labeled in 1 of 2 refrigerators. The facility failed ensure the 2 of 5 walls were free of black streaks of an unknown substance. The facility failed to ensure the dishwasher was maintained with sanitizer level at 50ppm. These failures could place residents at risk for food contamination, food borne illness and a diminished quality of life. The findings included: During an observation on 09/15/25 at 8:00 a.m., revealed the dish machine was ran 3 times and reached a temperature of 120 degrees Fahrenheit by Dietary Aide B. The dishwasher was run for a fourth time and the Dietary Aide B put the test strip in the water and there was no color change. She tried again and still no color change. She said she had not been trained on what to do if the dish machine did not have sanitation chemicals. She looked at the manufacturer signage posted on the dish machine which indicated the sanitization chemical level should be 50 ppm. After the surveyor intervened asked for the DM. During the observations and interviews on 09/15/25 at 8:20 a.m., the refrigerator contained 3 sandwiches without labels or dates. Dietary Aide B said the 3 sandwiches had no date of when the sandwiches were placed in the refrigerator. During an observation and interview on 09/15/25 at 8:30 a.m., revealed the DM came in the dish machine room and had brought new test strips. She ran the dish machine and checked the sanitization level and again no color change. She attempted to manually get the chemicals to enter the machine with a prime switch on the side of the machine. She rechecked the chemicals and said the dietary will use the 3-compartment sink and paper goods until the repair company fixed the dish machine, and she said maintenance would fix the back left burner. During an observation and interview on 09/15/25 at 9:00 a.m., indicated under the 3-compartment sink on the wall were 3 streaks of a black substance approximately 4 inches by 5 inches; and under the drying area from the dish machine, there were 2 streaks of black substance approximately 3 inches by 4 inches. During an interview on 09/16/25 at 11:00 a.m., the DM said the areas should be clean and free of discolored areas. She said all items in the refrigerators should be labeled and dated to prevent food borne illness. She said the walls should be deep cleaned weekly in those areas. Record review of facility's Food Receiving and Storage dated November 2022 indicated . Food services, or other designated staff, maintain clean. 7. Refrigerated foods are labeled, dated and monitored so they are used by the use-by date, frozen or discarded.		

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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 3 of 15 residents reviewed for infection control. (Residents #3, #4, & #15) 1. The facility failed to ensure the WCN performed proper hand hygiene every time she changed gloves during wound care for Resident #3. 2. The facility failed to ensure the Wound Care Nurse performed proper hand hygiene and used a clean applicator for each separated area of the wound during wound care for Resident #4. 3. The facility failed to ensure the Wound Care Nurse performed proper hand hygiene every time she changed gloves during wound care for Resident #15. These failures could place residents at risk for cross contamination and the spread of infection. 1. Record review of a face sheet dated 09/16/25 indicated Resident #3 was a [AGE] year-old male admitted on [DATE]. His diagnoses included osteomyelitis (an infection in a bone) of the right ankle and foot, peripheral vascular disease (blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), atrial fibrillation (a type of irregular heartbeat), systolic congestive heart failure (a condition in which the heart's main pumping chamber (left ventricle) is weak), cirrhosis of liver (a condition in which healthy tissue is replaced with scar tissue), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS dated [DATE] indicated Resident #3 had minimal difficulty hearing, he had clear speech, and he was able to make himself understood and understood others. He had 2 arterial and venous ulcers. Record review of September 2025 physician's orders for Resident #3 indicated the following orders: * 08/18/2025 Wound --Left third toe--Clean with wound cleaner or NS, cover with silver alginate and dry dressing 3 times weekly M-W-F; * 08/18/2025 Wound--Left 2nd toe--Clean with wound cleaner or NS apply alginate with silver and cover with dry dressing 3 times weekly M-W-F; * 08/18/2025 Wound: Right third toe -- clean with wound cleaner or NS pat dry apply calcium alginate with silver and cover with band aid 3 times weekly M-W-F; * 09/03/2025 Wound -- Left distal (the distance of a body part from a reference point) lateral (the side of the body on which a body part is located) ankle - Clean with wound cleaner or NS, silver alginate to wound bed cover with absorbent pad wrap with [NAME] boot (a compression dressing made by wrapping layers of gauze around your leg and foot), stretch gauze and wrap with cohesive bandage 3 times weekly M-W-F; * 09/05/2025 Wound -- Traumatic left calf -- Clean with wound cleaner apply silver alginate, cover and secure with [NAME] boot, stretch gauze and cohesive bandage 3 times weekly M-W-F; * 09/15/2025 Wound--Right anterior (front or forward-facing part of the body) lower leg-- Clean with wound cleaner or NS, apply alginate with silver to wound bed, cover with absorbent pad, wrap with (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] boot, stretch gauze and cohesive dressing 3 times weekly M-W-F; and * 09/15/2025 Wound--right lateral lower leg -- clean with wound cleaner or NS, apply alginate with silver to wound bed, cover with absorbent pad, wrap with [NAME] boot, stretch gauze and cohesive dressing 3 times weekly M-W-F. Record review of a Care Plan initiated 01/26/23 and edited on 09/15/25 indicated Resident #3 was at risk for impaired skin integrity related to CHF, chronic venous hypertension, CAD, decreased mobility. Resident #3 has actual wounds--diabetic ulcer (wound that is a complication of diabetes) left toe 1.5cm x 1.0cm x 0.1cm, a vascular ulcer (wounds that develop because of problems with blood circulation) right lateral lower leg 3.1cm x 2.5cm x 0.2cm, a vascular ulcer right anterior lower leg 18cm x 9.5cm x 0.2cm ,a vascular ulcer lower left lateral ankle 0.5cm x 0.4cm x 0.1cm, a diabetic ulcer left second toe 0.3cm x 0.2cm x 0.1cm, and a diabetic ulcer right plantar (related to the sole of the foot) toe 0.3cm x 0.2cm x 0.2cm. During an observation and interview on 09/15/25 at 10:45 a.m., the WCN did not wash her hands when she entered the resident's room and did not sanitize her hands twice when changing gloves, after cleaning the wound and prior to putting the silver alginate on the wounds to the left leg. After she finished the treatment to the left leg she did not wash her hands before donning (putting on) clean gloves to perform wound care to the right leg. She did not sanitize her hands twice when changing gloves, after cleaning the wound and prior to putting the silver alginate on the wounds to the right leg. When the WCN was asked if there was anything she could have or should have done differently, she said she probably should have changed her gloves more often and sanitized her hands between some of the glove changes she missed. 2. Record review of a face sheet dated 09/17/25 indicated Resident #4 was a [AGE] year-old-female readmitted on [DATE] with a diagnoses of pressure ulcer (a localized area of skin damage that develops when prolonged pressure is applied to the body), history of malignant (cancerous) neoplasm (tumor) of colon, and skin changes due to chronic exposure to radiation (a cancer treatment that uses high-energy rays to damage and kill cancer cells). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #4 had a BIMS score of 15 indicating her cognition was intact, required substantial/maximal assistance with bed mobility, and had a stage 4 pressure ulcer. Record review of a physician's order for Resident #4 dated 08/15/25 indicated to clean the wound to the coccyx with wound cleanser, apply betadine to peri wound, apply wound gel to wound bed, apply collagen to wound bed, and cover with dry dressing daily and as needed. Record review of a care plan with last revised 09/05/25 indicated Resident #4 had a pressure ulcer related to impaired mobility, stage 4 (a severe form of pressure injury that involves full-thickness tissue loss, exposing bone, tendon, or muscle), to her coccyx. The long-term goal was that the resident's ulcer would not increase in size and not exhibit signs of infection. During an observation and interview on 09/15/25 at 9:20 a.m., Resident #4 was sitting in her bed knitting. She said she had a wound to her buttocks that started from radiation when she had anal cancer. She said she had a colostomy (a surgical procedure that creates and opening (stoma) in the abdominal wall to divert stool from the colon (large intestine) to an external pouch) and a suprapubic (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheter (a thin, flexible tube inserted through a small incision in the lower abdomen to drain urine from the bladder). During an observation and interview on 09/16/25 at 9:00 a.m., the Wound Care Nurse gowned outside the room and entered without gloves. She adjusted the privacy curtain and donned gloves without washing or sanitizing her hands. She assisted Resident #4 to roll to her left side. The Wound Care Nurse changed her gloves without performing hand hygiene. Resident #4 had 3 visible wounds which included a sacral wound approximately fist size had a pink wound bed, a wound to her right leg was approximately dime size with a pink wound bed at the right lower buttock crease and another wound to the right leg approximately nickel size with a pink wound bed. The Wound Care Nurse said all three wounds were part of the original coccyx wound, and the areas opened and closed frequently. Surrounding the wounds was redness extending to the left buttocks and down the right leg. The Wound Care Nurse cleansed each wound with a wound cleanser and patted them dry with gauze. The Wound Care Nurse then performed hand hygiene and changed gloves. She then applied wound gel to each wound using the same wooden spoon. She applied collagen to each wound. She covered each wound with a dry dressing. She then applied betadine to all reddened areas surrounding the wound and left resident on her left side with a fan on to dry the betadine. She said the betadine would sit for 30 minutes with the fan blowing the area. During an observation at 09/16/25 at 9:40 a.m., the Wound Care Nurse sanitized her hands, gowned and gloved and turned off the fan and repositioned the Resident #4 for comfort. During an interview on 09/17/25 at 4:20 p.m., the Wound Care Nurse said that during Resident #4's wound care she should not have used the same wooden spoon to apply wound gel to her 3 sperate open areas. She said she should have washed her hands or performed hand hygiene with glove changes. She said she had been the Wound Care Nurse at the facility for 1 year and had gotten her wound care certification 2 years ago. She said she also received additional training every week from the wound care doctor. She said the possible negative outcome for not performing hand hygiene and using the same wooden spoon to apply wound gel to all three separate areas of the wound could be cross contamination of the wounds and increased exposure to possible infection. During an interview on 09/17/25 at 4:20 p.m. the DON said he expected all nurses to follow facility policy and protocol regarding infection control. He said the Wound Care Nurse should perform hand hygiene with all glove changes and use a new utensil to apply wound gel to each wound. He said the possible result on not observing infection control protocol could be cross contamination of the wounds and increased risk of wound infections. 3. Record review of a face sheet dated 09/17/25 indicated Resident #15 was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, osteoporosis (disease that weakens bones) with current pathological fracture (fracture could be caused by disease process and diabetes (too much sugar in the blood)). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #15 had a BIMS score of 99 and was unable to complete the BIMS. Resident #15 had memory problems with short term and long-term memories. The MDS indicated the number of unstageable pressure ulcers due to coverage of wound bed by slough (yellow or white tissue contained dead cells) and/or eschar (black tissue dead cells) was 1 and indicated no other pressure ulcers. Record review of the care plan dated 09/12/25 indicated Resident #15 had an actual wound (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measuring 1.4 cm x 1.1cm x 0.1cm. caused by a medical device pressure stage 4 wound to the left lateral malleolus (ankle) 1.3 cm x 1.4 cm x 0.2 also and the left great toe plantar side (under side of the toe) 2.1 cm x 2. 1cm x UTD area is not open as of 09/11/25. Interventions included to treat as ordered by the wound doctor, daily dressing change by nursing, and weekly skin checks. Record review of the physician's orders September 2025 indicated Resident #15 had treatments for a wound to the left lateral malleolus (ankle): clean with wound cleaner or NS apply medical honey to wound bed, cover with alginate, paint peri-wound with betadine and cover with dry dressing daily with start date 09/04/25. A wound on the plantar side (underside) left great toe: clean area with wound cleaner or NS paint with betadine apply betadine-soaked gauze to wound bed and cover with dry dressing daily with start date 09/04/25. The left heel: paint with betadine and leave open to air daily with start date 09/02/25. Record review of the progress notes in the electronic medical record dated 08/28/25 indicated Resident #15 had 2 new unstageable wounds that were covered by the cast. The wound doctor identified these medical device pressure ulcers and were unstageable at this time. Wound #1: left lateral malleolus 4cm x 4cm x <0.1cm wound bed has 50% slough (yellow or white consists of dead cells), 50% granulation (new tissue), mild serous exudate (drainage) noted, peri-wound (around the wound) intact. The nurse notified the wound doctor and received new orders to clean with wound cleaner or normal saline, paint peri-wound with betadine, cover the wound bed with medical - honey, apply calcium alginate and cover with a dry dressing daily and PRN. Wound #2: the left great toe plantar side (the underside) , clean with wound cleaner or normal saline, paint with betadine daily and cover with dry dressing monitor for area opening. The wound measured 2.0cm x1.5cm area and was not open at this time. The wound was unstageable with eschar (dead skin). During an observation and interview on 09/16/25 at 10:15 a.m., the Wound Care Nurse was preparing to perform wound care for Resident #15. She donned a gown and gloves and said Resident #15 was on EBP. She went into the room and prepared the resident for wound care, providing privacy and she spoke Spanish to Resident #15. #1 The Wound Care Nurse cleaned Resident #15's coccyx with wound cleaner or NS paint peri-wound with betadine, applied collagen to the wound, and covered with a dry dressing. She performed the needed glove change and hand sanitization. #2. The wound Care Nurse removed her gloves and cleaned her hands with sanitizer and applied new gloves and removed the dressing to Resident #15's ankle wound and removed her gloves, sanitized her hands then donned gloves. She cleaned the wound from inside out with wound cleaner. She removed her gloves and donned new gloves without hand sanitizer. She applied medical honey to the wound bed, covered with alginate, painted the peri-wound with betadine and covered with dry dressing. #3 Then changed gloves no hand hygiene was performed applied new gloves. Then she went to remove the dressing on the left great toe When the Wound Care Nurse removed Resident #15's dressing to her left toe. The Wound care nurse changed her gloves did not perform hand hygiene and donned new gloves. The Wound Care Nurse cleaned the wound with wound cleanser and applied gauze soaked with betadine and covered with a dry dressing. Wound plantar side left great toe -- cleaned area with wound cleaner painted with betadine apply betadine-soaked gauze to wound bed and cover (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with dry dressing daily. Resident #15 yelled out again when new dressing was applied to great left toe. The Wound Care Nurse removed her gloves and washed her hands and said she had finished wound care. #4 The Wound Care Nurse donned new gloves and painted the back of the left heel with betadine and left open. She removed her gloves and washed her hands. During an interview Wound Care Nurse said she should have used hand sanitizer during each glove change. She said that was to prevent spread of germs and said she just got nervous and Resident #15 yelling out was very different. She said normally Resident #15 just did not liked to be turned. Record review of a facility policy titled, Wound Care revised October 2010 indicated .Steps in the Procedure 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. .4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. . 13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. 14. Be certain all clean items are on clean field. 15. Remove the disposable cloth next to the resident and discard into the designated container. 16. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. Record review of a facility policy titled, Handwashing/Hand Hygiene last revised August 2019, indicated, . The facility considers hand hygiene the primary means to prevent the spread of infections. Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity for 1 of 4 residents (Resident #3) reviewed for resident rights.* The ADON did not knock on Resident #3's room door prior to entering the room. This failure could place residents at risk for decreased quality of life. Findings included: Record review of a face sheet dated 09/16/25 indicated Resident #3 was a [AGE] year-old male admitted on [DATE]. His diagnoses included osteomyelitis (an infection in a bone) of the right ankle and foot, peripheral vascular disease (blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm), atrial fibrillation (a type of irregular heartbeat), systolic congestive heart failure (a condition in which the heart's main pumping chamber (left ventricle) is weak), cirrhosis of liver (a condition in which healthy tissue is replaced with scar tissue), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS dated [DATE] indicated Resident #3 had minimal difficulty hearing, he had clear speech, and he was able to make himself understood and understood others. During an observation on 09/15/25 at 10:45 a.m. the WCN was conducting wound care on Resident #3. The door to the room was closed. The ADON opened Resident #3's door and did not knock prior to opening the door. The WCN had to yell out Patient Care to stop the ADON from entering the room. During an interview on 09/16/25 at 04:35 p.m. the WCN said staff were normally good about knocking on the door prior to opening and entering the resident room. She said she did not know why the ADON did not knock on the door. During an interview on 09/16/25 at 04:45 p.m. the ADON said she thought Resident #3 was in the dining room for an activity. She said she did not realize he was in the room having wound care done. She said staff should always knock on a resident's door before opening and entering the room. She said if the person knocking on the door could not hear the person in the room they should just open the door enough to hear the person in the room. During an interview on 09/17/25 at 02:25 p.m. Resident #3 said staff would sometimes forget to knock on the door before they entered. He said it did not bother him all the time but sometimes it did. During an interview on 09/17/25 at 04:10 p.m. the DON and the Administrator said they expected all staff to knock on the resident door before they entered. A policy related to staff knocking on resident doors was requested on 09/17/25 at 04:15 p.m. from the Administrator but not provided before exit.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to formulate an advance directive was provided for 1 of 2 residents reviewed for resident rights. (Resident #5) * The facility did not have a valid Out of Hospital-Do Not Resuscitate (OOH-DNR) for Resident #5. This failure could place residents at risk of lifesaving procedures being performed against their wishes resulting in bruising, broken ribs, electrical shocking of the heart, having a tube placed in the throat and provided artificial breathing methods, and possibly being brought back to life in an unaware and unresponsive state. Findings included: Record review of physician orders for [DATE] indicated Resident #5 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own) and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). An order dated [DATE] indicated Resident #5 had an order for DNR. Record review of a quarterly MDS dated [DATE] indicated Resident #5 had minimal difficulty hearing, she had clear speech, she was able to make herself understood, she was able to understand others, and a BIMS of 4 out of 15 indicating she had severely impaired cognition. Record review of a Care Plan for Resident #5 indicated a care plan for Code Status: DNR with a problem start date of [DATE], a Long Term Goal Target date of [DATE], and edit date of [DATE]. One of the interventions with an Approach Start Date of [DATE] indicated advanced directives would be reviewed by care plan team quarterly and prn. Record review of the OOH-DNR form dated [DATE] for Resident #5 indicated Section A of the form was signed by Resident #5 and Section B of the form was signed by the RP. The bottom of the form indicated All persons who have signed above must sign below, acknowledging that this document has been properly completed. The bottom of the form was not signed by the resident or the RP. During an observation and interview on [DATE] at 10:28 a.m. Resident #5 was sitting up in her wheelchair in her room. She said she was doing fine. She said she did not want anyone doing CPR on her she just wanted to pass peacefully. During an interview on [DATE] at 04:10 p.m. the DON, LVN C, and the Administrator said an incomplete OOH-DNR would mean Resident #5 was a full code (staff would have to initiate CPR). The Administrator said hospice services obtained the DNR on Resident #5 and should have ensured it was complete but ultimately it was the facility's responsibility. The DON said the negative outcome would be the resident could have CPR preformed on them against their wishes. Record review of a Do Not Resuscitate Order policy revised [DATE] indicated: .2. A Do Not Resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and placed in the front of the resident's medical record.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consult with the resident's physician and notify the representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 15 residents (Resident #15) reviewed for quality of care. The facility failed to notify the WC physician or physician of Resident #15's increase of pain during wound care observed on 09/16/25. This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. Findings included: Record review of a face sheet dated 09/17/25 indicated Resident #15 was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnosis included Alzheimer's disease, osteoporosis (disease that weakens bones) with current pathological fracture and diabetes (too much sugar in the blood). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #15 had a BIMS score of 99 and was unable to complete the BIMS. Resident #15 had memory problems with short term and long-term memories. The MDS indicated the number of unstageable pressure ulcers due to coverage of wound bed by slough (dead or non-viable tissue) and/or eschar (dead tissue) was 1 and indicated no other pressure ulcers. Record review of the care plan dated 9/12/25 indicated Resident #15 had an actual wound measuring 1.4 cm x 1.1cm x 0.1cm. Medical device pressure stage 4 wound to the left lateral malleolus (ankle) 1.3 cm x 1.4 cm x 0.2 also and the left great toe plantar side (under side of the toe) 2.1 cm x 2. 1cm x UTD area is not open as of 09/11/25. Interventions included Treat as ordered by wound doctor, daily dressing change by nursing, and weekly skin checks. Record review of the physician's orders dated September 2025 indicated Resident #15 had treatments of Wound left lateral malleolus (ankle): clean with wound cleaner or NS apply medical honey to wound bed, cover with alginate, paint peri-wound with betadine and cover with dry dressing daily with start date 09/04/25. Wound plantar side left great toe -- clean area with wound cleaner or NS paint with betadine apply betadine-soaked gauze to wound bed and cover with dry dressing daily with start date 09/04/25. Left heel: paint with betadine and leave open to air daily with start date 09/02/25. The orders included acetaminophen-codeine tablet; 300-30 mg; 1; oral at bedtime; and acetaminophen-codeine tablet; 300-30 mg; 1; oral every 8 hours - as needed. Record review of the progress noted in the electronic medical record dated 08/28/25 indicated Resident #15 had 2 new unstageable wounds that were covered by the cast. The wound doctor identified these medical device pressure ulcers and are unstageable at this time. Wound #1 left lateral malleolus 4cm x 4cm x <0.1cm wound bed has 50% slough (yellow or white tissue consists of dead cells), 50% granulation (new tissue), mild serous exudate (drainage) noted, peri-wound (around the wound) intact. Notified wound doctor received new orders clean with wound cleaner or normal saline, paint peri-wound with betadine, cover wound bed with medical - honey, apply calcium alginate and cover with dry dressing daily and PRN.Wound #2 -- Left great toe plantar side clean with wound cleaner or normal saline, paint with betadine daily cover with dry dressing monitor for area opening. Wound measures 2.0cm x1.5cm area is not open at this time. Unstageable with eschar (dead skin). Record review of nurse notes for 9/16/25 to 9/17/25 reflected no indication of physician or WC physician being notified of increase with Resident #15 pain level. During an observation and interview on 9/16/25 at 10:15 a.m. the WCN was preparing to perform wound care to Resident #15. She donned gown and gloves and said Resident #15 was in EBP. She went into the room and prepared the resident for wound care providing privacy, and she spoke Spanish to Resident #15. #1 The WCN performed wound care for the area on coccyx (the end of the spine). She cleaned the coccyx wound with wound cleanser and painted around the wound with betadine and applied collagen to the wound bed, covered with dry dressing. She performed as needed glove change and hand sanitization for Resident #15 wound on her coccyx. The (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	WCN was removing the boot (a medical device that prevent pressure and prevents movement of the ankle) that covered her left foot and extended up her calf). Resident #15 hollered out Oh and Wound Care nurse was still trying to remove the boot. The WCN said she never cries out like this. Resident #15 was grimacing and moaned out, Surveyor asked the ADON to ask her if she was in pain and the resident said her pain was so, so. The WCN removed the boot off. #2 Resident #15 relaxed while the WCN removed her gloves and cleaned her hands with sanitizer and applied new gloves and removed the dressing to the ankle wound and removed gloves, hand sanitizer then donned new gloves. She cleaned the wound from inside out with the wound cleanser. She removed her gloves and donned new gloves without hand sanitizer,. applied medical honey to wound bed, covered with alginate, painted peri-wound with betadine and covered with dry dressing. #3 The WCN changed gloves with no hand hygiene performed and applied new gloves. Then she went to remove the dressing on the left great toe, and Resident #15 began to holler out again. The WCN said Resident #15 does not normally have pain like this. The WCN said the pain is new, and she kept performing wound care. When the WCN removed Resident #15 dressing to left toe, Resident #15 quit crying out and relaxed., WCN changed her gloves with no hand hygiene and donned new gloves, cleaned the wound with wound cleanser and applied betadine-soaked gauze and covered with dry dressing. Resident #15 yelled out again when new dressing was applied to great left toe. During an interview on 9/16/25 at 10:45 a.m., the WCN said her yelling out was very different. She said normally the resident just doesn't like to be turned. She said she will report changes to the nurse, and she does not call the physician or wound care physician. During an observation on 9/16/25 at 10:50 a.m., the WCN was walking to Resident #15 room and said the charge nurse was going to medicate her for the increased pain. During an interview on 9/17/25 at 7:55 a.m., the Administrator said she spoke to the nursing staff about not stopping the treatment and medicating the residents. The Administrator said the nurses just leave notes for the primary physician to see and when he makes rounds, he would see it. During an interview on 9/17/25 at 8:33 a.m., the DON said WCN had reported an increase in her pain with Resident #15. The DON said the nurses should have called the wound care physician. During an interview on 9/17/25 at 10:28 a.m., the WC physician said he had not been notified of the increase of pain for Resident #15. He said the facility would need to notify him or the primary physician if there was a change in pain level with the residents. He said it could indicate infection or changes in the wound.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the assessments accurately reflected the resident's status for 2 of 18 residents reviewed for accuracy of assessments. (Residents #13 & #15) 1. The facility failed to ensure Resident #13's most recent quarterly assessment captured the resident's daily Aspirin as an antiplatelet. 2. The facility failed to ensure Resident #15's most recent quarterly assessment captured the current number of unstageable pressure ulcer as 2 unstageable pressure ulcers. These failures could place the residents at risk of not receiving the appropriate care and services. Findings included: 1. Record review of a face sheet dated 09/17/25 indicated Resident #13 was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included a history of pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot) and dementia (a group of thinking and social symptoms that interfere with daily functioning). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #13 had a BIMS score of 4 indicating she had severely impaired cognition, she was dependent for most ADLs and was taking an anticoagulant medication. Record review of a care plan last revised 08/13/25 indicated Resident #13 was at risk for bleeding and bruising secondary to use of a blood thinning medication. The goal indicated Resident #13 would not have any open areas or uncontrolled bleeding secondary to use of blood thinning medications. Record review of a physician order dated September 2025 indicated Aspirin-enteric coated 81mg 1 tablet orally once a day for diagnosis of ischemic heart disease (damage or disease in the heart's major blood vessels). During an observation on 09/15/25 at 8:48 a.m., Resident #13 was lying in bed with her call light in reach. She was unable to answer questions. During a telephone interview on 09/17/25 at 2:06 p.m., the MDS Nurse said that she started completing MDS assessments for the facility on 08/28/25. She said she used the RAI manual for coding all MDS. She said she was never formally trained on completing MDS but received most of her training in 2013 over the phone with an MDS consultant. She said she did view webinars for updates and changes in MDS and RAI manual. She said she worked remotely and had never actually visited the facility or assessed a facility resident in person. She said she reviewed Resident #13's most recent quarterly assessment and her medications and the MDS was coded incorrectly for anticoagulant because Aspirin was not classified as an anticoagulant it was classified as an antiplatelet. She said the DON was responsible for reviewing her coding in all MDS and correcting before submission to CMS. She said the possible negative outcome of an incorrectly coded MDS could be an inaccurate care plan for the residents. During an interview on 09/17/25 at 4:25 p.m., the DON said the MDS Nurse for the facility was out of the country, so MDS assessments were currently being done remotely. He said he expected MDS to be coded as outlined in the RAI manual. He said he reviewed all MDS and had missed that Aspirin was coded as an anticoagulant when it should have been coded as an antiplatelet for Resident #13. He said he was responsible for reviewing all MDS and approving them. He said he needed to review all MDS more carefully. He said the possible negative outcome of an incorrectly coded MDS could be an (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inaccurate care plan. During an interview on 09/17/25 at 5:20 p.m., the Administrator said the MDS Nurse, and the DON were responsible for ensuring all MDS were coded correctly. She said the possible negative outcome of incorrect coding of the MDS could be residents not receiving the care they needed. 2. Record review of a face sheet dated 09/17/25 indicated Resident #15 was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, osteoporosis (disease that weakens bones) with current pathological fracture and diabetes (too much sugar in the blood). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #15 had a BIMS score of 99 and was unable to complete the BIMS. Resident #15 had memory problems with short term and long-term memories. The MDS indicated the number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar was 1 and indicated no other unstageable pressure ulcers. Record review of the care plan dated 09/12/25 indicated Resident #15 had an actual wound measuring 1.4 cm x 1.1cm x 0.1cm. Medical device pressure stage 4 wound to the left lateral malleolus (ankle) 1.3 cm x 1.4 cm x 0.2 also and the left great toe plantar side (under side of the toe) 2.1 cm x 2. 1cm x UTD area is not open as of 09/11/25. Interventions included Treat as ordered by wound doctor, daily dressing change by nursing, and weekly skin checks. Record review of the physician's orders dated September 2025 indicated Resident #15 had treatments of Wound left lateral malleolus: clean with wound cleaner or NS apply medical honey to wound bed, cover with alginate, paint peri-wound with betadine and cover with dry dressing daily with start date 09/04/25. Wound plantar side left great toe -- clean area with wound cleaner or NS paint with betadine apply betadine-soaked gauze to wound bed and cover with dry dressing daily with start date 09/04/25. Left heel: paint with betadine and leave open to air daily with start date 09/02/25. Record review of the progress noted in the electronic medical record dated 08/28/25 indicated Resident #15 had 2 new unstageable wounds that were covered by the cast. The wound doctor identified these medical device pressure ulcers and are unstageable at this time. Wound #1 left lateral malleolus 4cm x 4cm x <0.1cm wound bed has 50% slough (yellow or white tissue consists of dead cells), 50% granulation (new tissue), mild serous exudate (drainage) noted, peri-wound (around the wound)intact. Notified wound doctor received new orders clean with wound cleaner or normal saline, paint peri-wound with betadine, cover wound bed with medical - honey, apply calcium alginate and cover with dry dressing daily and PRN. Wound #2 -- Left great toe plantar side clean with wound cleaner or normal saline, paint with betadine daily cover with dry dressing monitor for area opening. The unstageable wound measures 2.0cm x1.5cm area is not open at this time. During an interview on 09/17/25 at 3:00 p.m., the MDS nurse said she completed the MDS dated [DATE] for Resident #15. She reviewed the medical record for Resident #15 and said she just miscoded, and the pressure wounds should have been 2 unstageable pressure ulcers. Record review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual last updated May 2025 indicated .Code all high-risk drug class medications according to their (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacological classification, not how they are being used. N041511. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken during the 7-day observation period (or since admission/entry or reentry if less than 7 days). N041512. Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). Record review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual last updated May 2025 indicated . SECTION M: SKIN CONDITIONS Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. Code all pressure ulcers since admission Stage 1, Stage 2, Stage 3, Stage 4 or unstageable.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for 1 of 3 residents (Resident #15) reviewed for pressure injuries. The facility did not ensure WCN performed all the treatments for Resident #15 on 09/16/25 without surveyor intervention for 1 of 4 wounds. This failure could place residents at risk of improper wound management, deterioration in existing pressure injuries, infection, and pain. Findings included: Record review of a face sheet dated 09/17/25 indicated Resident #15 was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, osteoporosis (disease that weakens bones) with current pathological fracture and diabetes (too much sugar in the blood). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #15 had a BIMS score of 99 and was unable to complete the BIMS. Resident #15 had memory problems with short term and long-term memories. The MDS indicated the number of unstageable pressure ulcers due to coverage of wound bed by slough (yellow or white tissue nonviable) and/or eschar (dark black tissue and dead tissue) was 1 and indicated no other pressure ulcers. Record review of the care plan dated 09/12/25 indicated Resident #15 had an actual wound measuring 1.4 cm x 1.1cm x 0.1cm. Medical device pressure stage 4 wound to the left lateral malleolus (ankle) 1.3 cm x 1.4 cm x 0.2 also and the left great toe plantar side (under side of the toe) 2.1 cm x 2.1 cm x UTD area is not open as of 09/11/25. Interventions included Treat as ordered by wound doctor, daily dressing change by nursing, and weekly skin checks. Record review of the physician's orders dated September 2025 indicated Resident #15 had treatments of Wound left lateral malleolus: clean with wound cleaner or NS apply medical honey to wound bed, cover with alginate, paint peri-wound with betadine and cover with dry dressing daily with start date 09/04/25. Wound plantar side left great toe -- clean area with wound cleaner or NS paint with betadine apply betadine-soaked gauze to wound bed and cover with dry dressing daily with start date 09/04/25. Left heel: paint with betadine and leave open to air daily with start date 09/02/25. Clean with wound cleaner or normal saline wound on the coccyx wound paint peri-wound with betadine apply collagen to bed, cover with dry dressing daily. Record review of the progress notes in the electronic medical record dated 08/28/25 indicated Resident #15 had 2 new unstageable wounds that were covered by the cast. The wound doctor identified these medical device pressure ulcers and are unstageable at this time. Wound #1- left lateral malleolus 4cm x 4cm x <0.1cm wound bed has 50% slough (yellow or white tissue consists of dead cells), 50% granulation (new tissue), with mild serous exudate (drainage), peri-wound (around the wound) intact. Notified wound doctor received new orders clean with wound cleaner or normal saline, paint peri-wound with betadine, cover wound bed with medical - honey, apply calcium alginate and cover with dry dressing daily and PRN.Wound #2 -- Left great toe plantar side clean with wound cleaner or normal saline, paint with betadine daily cover with dry dressing monitor for area opening. Wound measures 2.0cm x1.5cm area is not open at this time unstageable with eschar (dead skin). During an observation and interview on 09/16/25 at 10:15 a.m. the WCN was preparing to perform wound care to Resident #15. She donned gown and gloves and said Resident #15 was in EBP. She went into the room and prepared the resident for wound care providing privacy and she spoke Spanish to Resident #15. #1 The WCN performed wound care for the area on coccyx (end of the spine). She cleaned the coccyx wound with wound cleanser and painted around the wound with betadine and applied collagen to the wound bed, covered with dry dressing. She performed as needed glove change and hand sanitization for Resident #15 wound on her coccyx. #2 Resident #15 relaxed while the WCN removed her gloves and cleaned her hands with sanitizer and applied new gloves and removed the dressing to the ankle wound and removed gloves, hand sanitizer then donned new gloves. She cleaned the wound from inside out with the wound cleanser. She (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed her gloves and donned new gloves without hand sanitizer, applied medical honey to wound bed, covered with alginate, painted peri-wound with betadine and covered with dry dressing. #3 The WCN changed gloves with no hand hygiene was performed before she applied the new gloves. Then she removed the dressing on the left great toe removed her gloves and with no hand hygiene donned new gloves, cleaned the wound with wound cleanser and applied betadine-soaked gauze and covered with dry dressing. Then the WCN removed her gloves and washed her hands and said she had finished wound care for Resident #15. The surveyor intervened and asked if Resident had any more areas and the WCN said no. Then when surveyor asked about the area to the upper part of the heel the WCN said yes, Resident #15 does have an open area there and said it just opened a few days ago and had treatment for that area. She said she had just gotten nervous and forgot.#4 So then she donned new gloves and painted the back of the left heel with betadine and left open. She removed her gloves and washed her hands. Record Review of the Wound Care policy dated October 2010 indicated . The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify the physician's orders .		

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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. Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 residents (Resident #12) for pharmacy services.* The facility did not clarify Resident #12's physician order for Flonase when the order was unclear. MA D administered Resident #12's Flonase nasal spray (used to treat allergies) 1 spray to each nostril during medication pass. The physician order indicated 1 spray nasal. This failure could place residents at risk of not receiving the therapeutic dosage of their medications. Findings included: During an observation on 09/17/2025 09:25 a.m. during medication pass, MA D administered Flonase nasal spray 1 spray to each nostril to Resident #12. Record review of physician orders for September 2025 indicated Resident #12 had an order dated 01/31/25 for Flonase Allergy Relief (fluticasone propionate) spray, suspension; 50 mcg/actuation; amt: 1 spray; nasal once a day; 09:00 a.m. There was no indication as to which nostril to administer the spray. Record review of September 2025 MAR indicated Resident #12 received Flonase Allergy Relief (fluticasone propionate) spray, suspension; 50 mcg/actuation; amount to administer: 1 spray; nasal once a day. There was no indication as to which nostril to administer the spray. During a record review and interview on 09/17/25 at 04:00 p.m. MA D reviewed Resident #12's order for Flonase and said the order did not indicate if the spray was to be administered in 1 nostril and which nostril or that it was to be administered into each nostril. MA D pulled the Flonase box to review the prescription label and it indicated 1 spray to each nostril daily. During a record review and interview on 09/17/25 at 04:10 p.m. the DON, LVN C, and the Administrator acknowledged the unclarity of Resident #12's Flonase order. LVN C said she would get a clarification on the order. LVN C and the DON said the medication would not be administered correctly the way the order read. The DON and Administrator said they expected medications to be administered correctly, or residents would not get the medications the way they were supposed to get them. Record review of an Administering Medications policy revised April 2019 indicated .Policy Interpretation and Implementation:.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all essential equipment in safe operating condition, for 1 of 1 stove in the kitchen reviewed for food service. The facility did not ensure the gas stove was in working order on 09/15/25. One of six gas stove burners (left back) did not light automatically, when the knob was turned to the on position on 09/15/25. This failure could place residents who eat out of the kitchen at risk for injury and under-cooked food and risk of food borne illnesses. Findings include: During an observation and interview on 09/15/25 at 7:55 a.m., revealed the gas stove had six burners total and One burner located in the left back, would not light automatically. The DM said they had to light it with matches sometimes. During an interview on 09/17/25 at 7:55 a.m., the Administrator said she expected staff to notify her of issues with equipment. She said she just trained all the dietary staff on the dish machine last week. She said food borne illness was a potential hazard for the dishwasher not working properly. She said the burner was fixed immediately. Record review of facility policy titled Sanitization dated revised November 2022 indicated . Dishwashing machines are operated according to manufacturer's instructions. b. Low - Temperature Dishwasher (Chemical Sanitization). (1) Wash temperature (120 Fahrenheit); (2) Final rinse with 50 parts per million (ppm) on dish surface in the final rinse; and (3) The chemical solution is maintained.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (A Hall) of 3 hallways reviewed for environment. An empty unlocked resident room was being used as a storage room on A Hall and contained potentially unsafe items. This failure could result in residents coming into contact with potentially unsafe items. The findings were: During an observation on 09/15/2025 at 9:35 a.m., during the initial tour on hall A revealed an empty room with the door shut and unlocked. There was a container of pesticide powder that was half full on a dresser in the unlocked room. The container had a label which indicated to keep out of reach of children and animals. Personal safety Warnings indicated to avoid contact: Do not get dust on skin, in eyes, or on clothing. There was no staff in sight. During an interview on 09/15/25 at 9:45 am. the Maintenance Supervisor walked down the hall and met the surveyor at the unlocked room. He said he forgot to lock the door, and he knew better because they had residents who were confused and wandered about the facility. He said all chemicals should be in sight or locked up. During an interview with the Administrator on 09/16/25 at 1:30 p.m., the Administrator said the maintenance supervisor locked the door after he had forgotten. She said he replaced the lock with a self-locking door after surveyor intervention.		