

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/17/2025
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  2021 Shoaf Dr Irving, TX 75061	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to protect the residents' right to be free from abuse for two (Resident #2 and Resident #3) of 5 residents reviewed for abuse, in that: 1.) On 11/03/25 the facility failed to ensure that Resident #2 did not have coffee thrown on him by Resident #4 resulting in redness to the face and chest which faded quickly and resolved without need for treatment. The nursing assessment completed the same day revealed no injury and no redness or other changes in skin assessment from baseline.2.) On 12/03/25 the facility failed to ensure that Resident #3 was not hit on the left side of the face/jaw with a closed fist by Resident #4 resulting in no injury. These failures could result in resident abuse and injuries.Findings include: Resident #2 Review of Resident #2's Face Sheet reflected he was a [AGE] year-old male readmitted to the facility on [DATE].Review of Resident #2's Quarterly MDS dated [DATE] reflected in part diagnoses including dementia, cellulitis of left lower limb (a spreading skin infection) and generalized muscle weakness. The MDS did not reflect any mood or behavioral symptoms. A BIMS score of six indicated severe cognitive impairment.Review of Resident #2's active Care Plan with problem start date 1/15/25 reflected Resident #2 had a history of physically and verbally aggressive behaviors. The care plan included a total of 19 interventions for aggressive behavior with intervention revisions reflected by start dates ranging from 2/19/25 to 10/29/25 and included interventions such as obtain a psych consult/psychosocial therapy, provide realistic hope to Resident #2, encourage Resident #2 to verbal feelings and fears, clarify misconceptions, etc.Review of Resident #2's Skilled Daily Nurses Note Observation completed 11/3/25 reflected the nursing assessment did not identify any injuries or changes in his skin assessment. Resident #3Review of Resident #3's Face Sheet reflected he was a [AGE] year-old male readmitted to the facility on [DATE]. Review of Resident #3's Quarterly MDS dated [DATE] reflected in part diagnoses including traumatic subdural hemorrhage (bleeding near the brain that can happen after an injury), dementia, and unsteadiness on feet. The MDS reflected mood symptoms including little interest or pleasure in doing things, and being short-tempered, easily annoyed. The MDS reflected no behavioral symptoms with the exception of wandering. A BIMS score was not conducted with Resident #3 reflected as rarely/never understood.Review of Resident #3's active Care Plan dated 10-27-25 with problem start date 10/12/25 reflected Resident #3 had a problem with the behavioral symptom of wandering. The care plan identified 12 interventions for wandering including interventions such as Resident #3 will be assessed for placement in a specially designed secure unit, Resident #3 has proper fitting and appropriate foot attire, avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents), etc.Review of Resident #3's progress note dated 12/03/25 reflected the nurse assessed no injuries following the incident with Resident #4. Resident #4Review of Resident #4's Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE].Review of Resident #4's Quarterly MDS dated [DATE] reflected in part diagnoses including dementia, bipolar disorder (mental health condition causing extreme mood swings), anxiety disorder, depression, and hypertension (elevated blood pressure). The MDS reflected the mood symptom of little interest or pleasure in doing things. The MDS reflected physical behavioral symptoms directed towards others (e.g., hitting, kicking pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others). A BIMS score of 10 indicated moderate cognitive impairment.Review of Resident #4's Care Plan dated 9/18/25 with problem start date 7/13/25 reflected Resident #4 was independent with transfers, ambulation, bed mobility, dressing, and toileting. Care Plan with problem start date of 6/14/25 reflected Resident #4 had behavioral symptoms with multiple episodes of agitation and aggression towards other residents between June 2025 and December 2025. The following behavior related care plan interventions and revisions were noted: Nutritional Status: Get impatient and agitated when waiting for meals:09/18/25 Resident #4 will get his tray first and brought to his room as it comes out to avoid any agitation09/18/25 Resident #4 is to be served his coffee and tray first at each meal09/18/25 Offer alternative meal if patient dislikes the meal given Mood State: Blocks the door to his room due to he doesn't want to be bothered at night:08/08/25 Resident #4 likes to sleep throughout the night being undisturbed, his rights will be respected Impaired Decision-Making r/t Alzheimer's:7/13/25 Determine if decisions made by Resident #4 endanger him or others. Intervene if necessary7/13/25 Encourage to verbalize feelings, concerns, and fears. Clarify misconceptions7/13/25 Give objective feedback when inappropriate decisions are made. Discuss future</p>		