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 03/04/2026
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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement the facility's own written abuse and neglect prevention policy and procedure for one (Resident # 1) of thirteen residents reviewed for abuse and neglect. The facility did not immediately notify Resident #1's representative of an allegation of sexual abuse by The Maintenance Director on 02/19/26, causing the family to learn of the allegation when Resident #1 called to tell them that the police were at the facility, attempting to speak with her about the allegation on 02/20/26. This failure could place residents at risk of their responsible parties not having knowledge of allegations of abuse or neglect, thereby not having the emotional or logistical support of their responsible parties during an investigation.Findings included: Review of the policy Abuse Investigation and Reporting, revised July 2017, reflected: [.] Role of the Administrator: 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual. [.] 3. The administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. [.] 6. The administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. [.] 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies: [.] c. The Resident's Representative (Sponsor) of Record; [.] Review of Resident #1's face sheet, dated 02/26/26, reflected Resident #1 was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), Alzheimer's disease, pain disorder exclusively related to psychological factors, chronic pain, depression, and unspecified sequelae of cerebral infarction (lingering effects of a stroke, which could include problems with cognition (mental ability), mood, and physical weakness.) The document listed RP A as her emergency contact and responsible party. Review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1's preferred language was Spanish, and she would need an interpreter for communication with physicians and other healthcare staff. Resident #1 was able to understand others, and to be understood by others. She had a BIMS score of 3, indicating severe cognitive deficits. Resident #1 rejected care from four to six days of a seven-day lookback period, but had no other mood or behavioral issues during that time. She was able to ambulate using a walker. Resident #1 required partial or moderate assistance (helper does less than half the effort) for toileting, showering/bathing, dressing, and putting on/taking off footwear. She only required set-up and clean-up assistance with meals. She was able to move herself around in her bed, and sit on the side of the bed, but required partial or moderate assistance for transfers, and for walking 50 feet. Resident #1's primary reason for admission to the facility was her progressive neurological condition. Review of Resident #1's care plans reflected the following:- Mood state: PHQ-9 score of five, indicating mild depression, dated 02/26/26- Activities: preference to not join group activities, and to participate in in-room, self-led activities, including watching Spanish language media.- Cognitive loss/dementia related to age, dated 09/25/24- Behavioral: resident picks (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at skin, dated 04/01/24- Behavioral: refusals of incontinence care and showers Review of the HHSC Provider Investigation Form and attached documentation, dated 02/26/26, reflected the facility had investigated an allegation of abuse by Resident #1, who had informed another resident that the Maintenance Director had exposed himself to her, and the other resident informed a CNA, who reported it to the Social Worker, who reported it to the Administrator. During the investigation of this allegation, Resident #1 denied ever having said such a thing, and continued to do so throughout the investigation. The facility suspended the Maintenance Director, and the Administrator (who was married to the Maintenance Director), who both returned to work after the full investigation was done. During the investigation, camera footage was reviewed, and no instances of the Maintenance Director being in Resident #1's room by himself for more than a few seconds were found. No other residents or staff reported related concerns about the Maintenance Director when interviewed. An interview on 03/03/26 at 9:25 AM with the Administrator and the Executive Assistant revealed that the police questioned the Administrator on 02/20/26 and were asking her questions about things like when she was last in Resident #1's room. The Administrator thought maybe a staff member whose employment she had terminated on 02/18/26 had probably called the police with a complaint about her, in addition to the allegation made against the Maintenance Director, and the police would not tell her what the allegation about her was, if there was one. She had already suspended herself as soon as the allegation was made against the Maintenance Director, because of her close relationship with him. She said she handed the investigation for the allegation against the Maintenance Director over to the Executive Assistant. An interview on 03/03/26 at 1:03 PM with RP A and Resident #1 revealed Resident #1 refused to use a professional interpreter over the phone and wanted RP A to interpret for her. During the interview, Resident #1 initially refused to talk about the allegation against the Maintenance Director. RP A stated on 02/20/26 Resident #1 called her, and told her the police were at the facility, trying to speak with her about the allegation, and she did not want to talk to them. She said the Administrative staff had known about the allegation since 02/19/26, and while they called her every time Resident #1 did not want to shower, or did not want to do this or that, nobody bothered to call her about this. Resident #1 then told the surveyor that the Maintenance Director had entered her room, and exposed his genitals to her, and prior to that had brought her sodas and snacks, and kissed her. Resident #1 and RP A said they had not seen that staff member since Resident #1 made that allegation. Resident #1 was unable to say when the alleged incident occurred. An interview on 03/04/26 at 1:45 PM with the Executive Assistant revealed the police spoke with the Administrator and would not say what she had been accused of. She said the number one thing when an allegation was made, was that the residents be kept safe. She said the Maintenance Director had already left for the day on 02/19/26, but was put on suspension as soon as the allegation against him was made. She said after the Administrator was questioned by the police on 02/20/26, she also had to be suspended, but she had already gone home when the allegation against the Maintenance Director was made. She said when an allegation of abuse or neglect was made, they did not make a progress note or incident report in the EMR, and the self-report and investigation itself was their documentation of the allegation. She said Resident #1 denied anything happened to her multiple times during the investigation, to multiple people. She said she and the Social Worker interviewed residents and staff as part of the investigation, and Resident #1 continued to deny anything happened, and refused to be assessed. She said RP A called her on the morning of 02/20/26, asking why the police were interrogating Resident #1, and she did meet with RP A several times on that day, but she did not contact them on 02/19/26 about the allegation against the Maintenance Director. She said the notification to the family should happen on the same day, and it was important to inform them because they have a right to be aware of what is going on with their loved one, and it provided the resident opportunity to have their support during the investigation. She said she was new to the investigation process, and still learning. An interview on 03/04/26 at 2:41 PM with RN B revealed she had been working on 02/19/26, on the 2:00 PM-10:00 PM shift, and learned about the allegation of (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sexual abuse of Resident #1 later in the day, around bedtime. She said she attempted to assess Resident #1, but the resident refused to be assessed, denied anything had happened, and said she did not need anyone to look at her body. She said nobody told her to notify the family or told her if they had been notified. She said when she did notify families of problems with residents, it was done as soon as she knew about the problem, but she did not always document notifying them. She said if she had been the one receiving an allegation from a resident, she would do an event (incident) report in the EMR, and would notify the Administrator, even if the resident denied it after they said it, and she would notify the responsible party. An interview on 03/04/26 at 3:01 PM with the Executive Assistant revealed she was new at reporting to HHSC, because the Administrator usually did it, and had just learned more information about the notification part of the process. She said they had a very new DON, who was still in training, and was not present on 02/19/26, and there was not a nurse manager in the building at the time she took over the investigation. She said she thought they completed the skin assessment in the EMR, but she was incorrect in thinking that. She said they were supposed to open the Incident Progress Note template in the EMR, which would have then prompted the nurse to do the clinical part of the investigation, and to make all of the notifications necessary. She said she did put a note in about speaking to the family, but she did not know to select that template. She said normally the DON or Nurse Manager on duty would also instruct the nurse what to do, but neither of them were available in the initial steps of the investigation. An interview on 03/04/26 at 3:14 PM with the Administrator revealed she was already at home on [DATE] when the police called, because she had left the facility immediately when she learned about the allegation of sexual abuse by the Maintenance Director. She said she normally would work from home, but this time she handed the investigation and reporting off to the Executive Assistant. She said normally she notified the DON when an allegation was made, and the DON would take the nursing piece of the investigation, and she would take the rest, but DON was not there, and she did not follow up on the nursing piece of the investigation, so the staff did not realize they had to open the event template, and that caused the missed notification. Normally the family would be notified immediately as part of the process of filling out the form. It's their right to know, and important for them to know of any incidents involving the resident.