STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect the residents' right to be free from abuse for three (Resident #2, Resident #3, and Resident #4) of five residents reviewed for abuse, in that: 1.) On 03/01/26 the facility failed to ensure that Resident #2 did not have her hair pulled by Resident # 1, resulting in Resident #2 screaming loudly in what sounded to facility staff like pain.2.) On 03/05/26 the facility failed to ensure that Resident #3 was not scratched on the face by Resident #1 resulting in redness.3.) On 03/10/26 the facility failed to ensure that Resident #4 was not verbally threatened, grabbed by the throat and her hair pulled by Resident #1 with no resulting injury. These failures could result in resident abuse and injuries.Findings include: Resident #1Review of Resident #1's Face Sheet with report date of 03/10/26, reflected she was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses in part including dementia (loss of memory, language, problem-solving and other thinking abilities), malignant neoplasm (cancer) of left breast, generalized anxiety disorder (excessive, ongoing anxiety and worry), diabetes mellitus (condition of high blood sugar), and hyperlipidemia (high levels of fat in the blood).Review of Resident #1's admission MDS dated [DATE] did not reflect any mood or behavioral symptoms except for Resident #1 reported often feeling lonely or isolated from those around her. A BIMS score of zero indicated severe cognitive impairment.Review of Resident #1's active Care Plan (undated) reflected Resident #1 was identified with a problem of Behavioral Symptoms with a start date of 08/15/25 which included symptoms of verbal aggression, physical aggression, and calling 911. Goals and approaches (interventions) were identified for behavioral symptoms including some of the following:-I will be reminded that I don't have to call 911 when other people are not behaving correctly. Remind her that staff are here to help her (Start Date: 03/04/26)-Praise [Resident #1] when behavior is appropriate. Let her know it will be a good day (Start Date 02/27/26)-Remove [Resident #1] from group activities when behavior is unacceptable. Provide in room activities (Start Date 02/27/26)-When [Resident #1] becomes verbally abusive, move to a quiet, calm environment (Start Date 02/27/26)-Administer medications: as ordered. Monitor and record effectiveness. Report adverse side effects (02/26/26-Assess whether the behavior endangers herself and/or others. Intervene if necessary (Start date 2/2026)-Avoid power struggles with [Resident #1] (Start Date 02/20/26)-Obtain a psychiatric consult/psychosocial therapy (Start Date 12/20/25)-Avoid over-stimulation e.g., noise, crowding, other physically aggressive residents (Start Date 11/25/25)-When I'm upset and exhibiting behaviors, staff will offer calming interventions by playing or providing access to preferred music by the Brothers [NAME] (Start Date 08/19/25) Resident #2Review of Resident #2's Face Sheet with report date of 03/24/26, reflected she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses in part including Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), hypertension (high blood pressure), mood disorder (mental health condition of emotional disturbances), atherosclerotic heart disease (a buildup of plaque that restricts blood flow to the heart), and hyperlipidemia (high levels of fat in the blood).Review of Resident #2's Quarterly MDS dated [DATE] did not reflect any mood or behavioral symptoms except for wandering. A BIMS score (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0600 Level of Harm - Actual harm Residents Affected - Few	of zero indicated severe cognitive impairment.Review of Resident #2's active Care Plan (undated) reflected Resident #2 was identified with a problem of Behavioral Symptoms with a start date of 02/23/24 which included symptoms of physical aggression and sexually inappropriate behaviors, with the last behavior listed on 09/04/24. The care plan identified a goal and approaches (interventions) for behavioral symptoms. Resident #3Review of Resident #3's Face Sheet (with report date of 3/24/26) reflected she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses in part including dementia (loss of memory, language, problem-solving and other thinking abilities), bipolar disorder (mental health condition causing extreme mood swings), muscle weakness, and generalized anxiety disorder (excessive, ongoing anxiety and worry).Review of Resident #3's Quarterly MDS dated [DATE] reflected Resident #3 had no behavioral or mood symptoms except for wandering and rejection of care. A BIMS score of zero reflected severe cognitive impairment.Review of Resident #3's active Care Plan (undated) reflected Resident #3 had behavioral symptoms including a history of aggression, with the last incident listed dated 10/24/25. The Care Plan identified a goal and approaches (interventions) for behavioral symptoms. Resident #4Review of Resident #4's Face Sheet (undated) reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses in part including Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), epilepsy (brain condition of recurrent seizures), mood disorder (mental health condition involving emotional disturbances), and hypothyroidism (thyroid gland does not make enough thyroid hormone).Review of Resident #4's admission MDS dated [DATE] reflected no mood or behavioral symptoms. A BIMS score of 99 reflected Resident #4 was unable to complete the interview.Review of Resident #4's Care Plan (undated) reflected the behavioral symptom of wandering. No verbal aggression, physical aggression or other behavioral symptoms were identified. Record Review of Resident #1's progress note written by RN A and dated 03/01/26 at 03:30 p.m., reflected that RN A had responded to the dining room to find that a CNA/Medication Aide (unnamed) had separated Resident #4 from Resident #2. The CNA/Medication Aide notified RN A that Resident #2 was walking in front of Resident #1 when Resident #1 suddenly stood up, ran toward Resident #2 and pulled her hair. A head-to-toe assessment was completed on both residents and there were no injuries. Resident #1 received as needed medication for anxiety. The physician, administrator, and resident representative were notified.Record review of Resident #1's progress note written by LVN B and dated 03/05/26 at 01:03 p.m., reflected that Resident #1 was observed yelling at another resident (Resident #3) and that before LVN B could get to the altercation, LVN B witnessed Resident #1 scratch Resident #3 on the face. The physician, Director of Nurses, and power of attorney were notified.Record review of Resident #1's progress note written by LVN B and dated 03/05/26 at 01:05 p.m., reflected new physician orders were received for labs and urinalysis.Record review of Resident #1's interdisciplinarian progress note dated 03/05/26 at 03:33 p.m. by RN C, reflected Resident#1's aggressive behavior of pulling another resident's hair and that a 30-day discharge notice was issued for aggression towards other residents.Record review of Resident #1's progress note written by SW D on 03/09/26 at 09:43 a.m. and 01:38 reflected the social worker sent out referrals to four behavioral health hospitals. Resident #1 was declined by three of the facilities and the fourth did not respond.Record review of Resident #1's progress note dated 03/10/26 at 04:04 a.m. by LVN E, reflected Resident #1 remained on Q15 minute observations.Record review of Resident #1's progress note dated 03/10/26 at 09:22 pm by RN F, reflected that Resident #1 had a psychiatric recommendation and received a new physician order for an anxiety medication.Record review of Resident #1's progress note written by RN B on 03/10/26 (time unknown) reflected that without provocation Resident #1 grabbed Resident #4 by the throat and pulled her hair and made the statement, stop looking at me b**** I'll cut your f***** throat. The residents were separated and the physician, the administrator, and family were notified. No injuries were reflected. During an observation and interview on 03/24/26 at 12:10 p.m., Resident #2 was observed sitting calmly and quietly in the dining area. She had no obvious signs of abuse or neglect. She could not remember or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0600 Level of Harm - Actual harm Residents Affected - Few	provide meaningful responses to questions about the incident. She had no bruises, scratches, or obvious signs of injury.In an interview with Resident #2's family on 04/06/26 at 11:10 a.m., they reported that Resident #2 did not experience any injury from having her hair pulled and that she did not exhibit any trauma associated signs or symptoms. They stated she was her typical self following the incident. Resident #2's family stated that the facility is very good at dealing with and separating aggressive residents when they become upset. She denied any concerns about her family member's care.During an observation and interview on 03/24/26 at 12:15 p.m., Resident #3 was observed ambulating in the dining room using her walker. She answered interview questions in an off-topic and disorganized manner. She was dressed, clean with no signs of obvious abuse or neglect. She had no bruises, scratches, or obvious signs of injury.During an interview attempt with Resident #3's family on 04/06/26, multiple calls were not answered and there was no ability to leave a voice mail.During an observation and interview on 03/24/26 at 12:20 p.m., Resident #1 was observed ambulating using a rolling walker in the hallway of the locked female unit. She stated she was hungry, and she was headed to the dining room. She could not remember or provide any details of prior aggressive behaviors. She stated, I'm fine and walked off. She was not observed demonstrating any aggressive behaviors.During an observation and interview on 03/24/26 at 12:25 p.m., Resident #4 was observed on the female locked unit. She did not respond to questions. She was observed as dressed, clean, and sitting in a wheelchair. She had no bruises, scratches, or obvious signs of injury. No obvious signs of abuse or neglect were observed.During an interview on 04/06/26 at 11:00 a.m., Resident #4's family member reported she had visited Resident #4 around the time of the incident. She stated she noted no injuries and that Resident #4 acted like her normal self. She denied witnessing any signs of trauma or distress or other changes in behavior.During an interview on 03/24/26 at 12:05 p.m., LVN B reported that she has had training on resident-to-resident abuse and dealing with difficult behaviors at this facility. She was able to describe the signs of escalation and how to intervene during altercations between residents. She stated that Resident #1's behavior had not significantly improved since the incidents of aggression on 03/05/26 and 03/10/26. She stated that Resident #1 was again seen by psychiatric services on 03/23/26 and she was ordered both an increase on one medication and a new medication for her mood. She stated that Residents are placed on Q15 minute observations following any aggressive events and that they remain on that observation for at least 72 hours. She stated that Resident #1 was placed on Q15 minute checks following the aggressive behaviors on both 03/05/26 and 03/10/26. She stated that Resident #1's behavior is random and unpredictable and that she would have benefited from having a sitter.LVN B stated that on 03/05/26 she observed Resident #1 yelling at Resident #3 and that she began running towards the altercation but that she witnessed Resident #1 scratch Resident #3's face with her fingernails before she got to them. She stated the residents were separated and that she noted that Resident #3 had red marks without any break in the skin to her face. She stated this redness remained on Resident #3's face for about 24 hours. She stated Resident #3 did not require intervention but that she was angry and agitated for about forty minutes following the incident. She stated that she notified the physician and Resident #1 was placed on Q15 minute monitoring. She stated that on 03/10/26 she witnessed Resident #1 suddenly without provocation grab Resident #4 by the throat and pull her hair. She stated that she responded immediately, redirected the residents, and Resident #4's breathing was not restricted. She stated she believes Resident #1 thinks people are looking at her and that she had yelled at Resident #4 to stop looking at her. She stated that she assessed Resident #4 and she did not have any injuries. She stated that Resident #1 was placed on Q15 minute checks. In an interview on 03/24/26 at 03:07 p.m., the DON stated that she has been the DON at this facility for two days. She stated Resident #1 was on psychiatric services and her medications were being monitored frequently and staff often had Resident #1 near the nurse's station with them. She stated that she was going to schedule a care plan meeting with her physician and psychiatric services so that medication adjustments could be reviewed comprehensively. She stated she had seen where Resident #1 had her monitoring increased (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0600 Level of Harm - Actual harm Residents Affected - Few	to Q15 minutes when she pulled Resident #2's hair on 03/01/26. She stated she had not been aware that Resident #1 had scratched Resident #3's face on 03/05/26. She stated that she was definitely going to be making her (Resident #1) safer around everyone else in this building. She stated that the comprehensive care plan is updated by herself and the assistant directors of nurses for any acute incidents. The DON stated she intended to further update Resident #1's care plan for aggression. She stated that failing to update interventions in Resident #1's care plan would be a risk to the resident because, putting the proper care plans in place is important and the care plan is a way to communicate that plan to anyone who is providing care.In an interview on 03/24/26 at 04:00 p.m., RN A stated that on 03/01/26 she heard Resident #2 screaming loudly and she ran to the dining room where staff had separated Resident #1 from Resident #2. She stated the Medication Aide (name unknown) informed her that Resident #2 had been watching Resident #1 and that Resident #1 became angry saying she was staring at her and suddenly grabbed Resident #2 by her hair. She stated the staff were able to immediately intervene and separate the residents without incident. She stated she assessed Resident #2 and she had no bruise or signs of injuries but that she believed when she heard her scream, she was screaming in pain due to having her hair pulled. She stated Resident #2 did not require pain medication or treatment. RN A stated that she has had abuse and neglect training at this facility and would report abuse to the administrator. She stated that she has received training on dealing with difficult behaviors and resident-to-resident aggression. She stated that she notified the physician and administrator and Resident #1 was placed on Q15 minute monitoring.Record review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2001 reflected, Residents have the right to be free from abuse and it included the objective to, Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to:.other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans.The facility failed to develop or revise care plan interventions for Resident #1 following three episodes of aggression towards other residents on 03/01/26, 03/05/26, and 03/10/26. This failure could have placed residents at risk of not having their needs identified and met.Findings include:Review of records noted that on: 1.) On 03/01/26 Resident #2 had her hair pulled by Resident # 1, resulting in Resident #2 screaming loudly in what sounded to facility staff like pain.2.) On 03/05/26 Resident #3 was scratched on the face by Resident #1 resulting in redness.3.) On 03/10/26 Resident #4 was verbally threatened, grabbed by the throat and her hair pulled by Resident #1 with no resulting injury. Resident #1Review of Resident #1's Face Sheet with report date of 03/10/26, reflected she was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses in part including dementia (loss of memory, language, problem-solving and other thinking abilities), malignant neoplasm (cancer) of left breast, generalized anxiety disorder (excessive, ongoing anxiety and worry), diabetes mellitus (condition of high blood sugar), and hyperlipidemia (high levels of fat in the blood).Review of Resident #1's admission MDS dated [DATE] did not reflect any mood or behavioral symptoms except for Resident #1 reported often feeling lonely or isolated from those around her. A BIMS score of zero indicated severe cognitive impairment.Review of Resident #1's active Care Plan (undated) reflected Resident #1 was identified with a problem of Behavioral Symptoms with a start date of 08/15/25 which included symptoms of verbal aggression, physical aggression, and calling 911. Goals and approaches (interventions) were identified for behavioral symptoms including some of the following:-I will be reminded that I don't have to call 911 when other people are not behaving correctly. Remind her that staff are here to help her (Start Date: 03/04/26)-Praise [Resident #1] when behavior is appropriate. Let her know it will be a good day (Start Date 02/27/26)-Remove [Resident #1] from group activities when behavior is unacceptable. Provide in room activities (Start Date 02/27/26)-When [Resident #1] becomes verbally abusive, move to a quiet, calm environment (Start Date 02/27/26)-Administer medications: as ordered. Monitor and record effectiveness. Report adverse side effects (02/26/26-Assess whether the behavior endangers herself and/or others. Intervene if necessary (Start date 2/2026)-Avoid power struggles with [Resident #1] (Start Date 02/20/26)-Obtain a psychiatric consult/psychosocial therapy (Start Date 12/20/25)-Avoid over-stimulation e.g., noise, crowding, other physically aggressive residents (Start Date 11/25/25)-When I'm upset and exhibiting behaviors, staff will offer calming interventions by playing or providing access to preferred music by the Brothers [NAME] (Start Date 08/19/25) The Review of Resident #1's active Care Plan (undated) reflected the care plan contained no up updates or revisions to Behavioral Symptoms or other pertinent areas following the episodes of aggression which occurred on 03/01/26, 03/05/26, and 03/10/26.Resident #2Review of Resident #2's Face Sheet with report date of 03/24/26, reflected she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses in part including Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), hypertension (high blood pressure), mood disorder (mental health condition of emotional disturbances), atherosclerotic heart disease (a buildup of plaque that restricts blood flow to the heart), and hyperlipidemia (high levels of fat in the blood).Review of Resident #2's Quarterly MDS dated [DATE] did not reflect any mood or behavioral symptoms except for wandering. A BIMS score of zero indicated severe cognitive impairment.Review of Resident #2's active Care Plan (undated) reflected Resident #2 was identified with a problem of Behavioral Symptoms with a start date of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/23/24 which included symptoms of physical aggression and sexually inappropriate behaviors, with the last behavior listed on 09/04/24. The care plan identified a goal and approaches (interventions) for behavioral symptoms. Resident #3Review of Resident #3's Face Sheet (with report date of 3/24/26) reflected she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses in part including dementia (loss of memory, language, problem-solving and other thinking abilities), bipolar disorder (mental health condition causing extreme mood swings), muscle weakness, and generalized anxiety disorder (excessive, ongoing anxiety and worry).Review of Resident #3's Quarterly MDS dated [DATE] reflected Resident #3 had no behavioral or mood symptoms except for wandering and rejection of care. A BIMS score of zero reflected severe cognitive impairment.Review of Resident #3's active Care Plan (undated) reflected Resident #3 had behavioral symptoms including a history of aggression, with the last incident listed dated 10/24/25. The Care Plan identified a goal and approaches (interventions) for behavioral symptoms. Resident #4Review of Resident #4's Face Sheet (undated) reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses in part including Alzheimer's disease (type of dementia that affects memory, thinking, and behavior), epilepsy (brain condition of recurrent seizures), mood disorder (mental health condition involving emotional disturbances), and hypothyroidism (thyroid gland does not make enough thyroid hormone).Review of Resident #4's admission MDS dated [DATE] reflected no mood or behavioral symptoms. A BIMS score of 99 reflected Resident #4 was unable to complete the interview.Review of Resident #4's Care Plan (undated) reflected the behavioral symptom of wandering. No verbal aggression, physical aggression or other behavioral symptoms were identified. Record Review of Resident #1's progress note written by RN A and dated 03/01/26 at 03:30 p.m., reflected that RN A had responded to the dining room to find that a CNA/Medication Aide (unnamed) had separated Resident #4 from Resident #2. The CNA/Medication Aide notified RN A that Resident #2 was walking in front of Resident #1 when Resident #1 suddenly stood up, ran toward Resident #2 and pulled her hair. A head-to-toe assessment was completed on both residents and there were no injuries. Resident #1 received as needed medication for anxiety. The physician, administrator, and resident representative were notified.Record review of Resident #1's progress note written by LVN B and dated 03/05/26 at 01:03 p.m., reflected that Resident #1 was observed yelling at another resident (Resident #3) and that before LVN B could get to the altercation, LVN B witnessed Resident #1 scratch Resident #3 on the face. The physician, Director of Nurses, and power of attorney were notified.Record review of Resident #1's progress note written by LVN B and dated 03/05/26 at 01:05 p.m., reflected new physician orders were received for labs and urinalysis.Record review of Resident #1's interdisciplinarian progress note dated 03/05/26 at 03:33 p.m. by RN C, reflected Resident#1's aggressive behavior of pulling another resident's hair and that a 30-day discharge notice was issued for aggression towards other residents.Record review of Resident #1's progress note written by SW D on 03/09/26 at 09:43 a.m. and 01:38 reflected the social worker sent out referrals to four behavioral health hospitals. Resident #1 was declined by three of the facilities and the fourth did not respond.Record review of Resident #1's progress note dated 03/10/26 at 04:04 a.m. by LVN E, reflected Resident #1 remained on Q15 minute observations.Record review of Resident #1's progress note dated 03/10/26 at 09:22 pm by RN F, reflected that Resident #1 had a psychiatric recommendation and received a new physician order for an anxiety medication.Record review of Resident #1's progress note written by RN B on 03/10/26 (time unknown) reflected that without provocation Resident #1 grabbed Resident #4 by the throat and pulled her hair and made the statement, stop looking at me b**** I'll cut your f***** throat. The residents were separated and the physician, the administrator, and family were notified. No injuries were reflected. During an observation and interview on 03/24/26 at 12:10 p.m., Resident #2 was observed sitting calmly and quietly in the dining area. She had no obvious signs of abuse or neglect. She could not remember or provide meaningful responses to questions about the incident. She had no bruises, scratches, or obvious signs of injury.During an interview with Resident #2's family on 04/06/26 at 11:10 a.m., they (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported that Resident #2 did not experience any injury from having her hair pulled and that she did not exhibit any trauma associated signs or symptoms. They stated she was her typical self following the incident. Resident #2's family stated that the facility is very good at dealing with and separating aggressive residents when they become upset. She denied any concerns about her family member's care.During an observation and interview on 03/24/26 at 12:15 p.m., Resident #3 was observed ambulating in the dining room using her walker. She answered interview questions in an off-topic and disorganized manner. She was dressed, clean with no signs of obvious abuse or neglect. She had no bruises, scratches, or obvious signs of injury.During an interview attempt with Resident #3's family on 04/06/26, multiple calls were not answered and there was no ability to leave a voice mail.During an observation and interview on 03/24/26 at 12:20 p.m., Resident #1 was observed ambulating using a rolling walker in the hallway of the locked female unit. She stated she was hungry, and she was headed to the dining room. She could not remember or provide any details of prior aggressive behaviors. She stated, I'm fine and walked off. She was not observed demonstrating any aggressive behaviors.During an observation and interview on 03/24/26 at 12:25 p.m., Resident #4 was observed on the female locked unit. She did not respond to questions. She was observed as dressed, clean, and sitting in a wheelchair. She had no bruises, scratches, or obvious signs of injury. No obvious signs of abuse or neglect were observed.During an interview on 04/06/26 at 11:00 a.m., Resident #4's family member reported she had visited Resident #4 around the time of the incident. She stated she noted no injuries and that Resident #4 acted like her normal self. She denied witnessing any signs of trauma or distress or other changes in behavior. During an interview on 03/24/26 at 12:05 p.m., LVN B reported that she has had training on resident-to-resident abuse and dealing with difficult behaviors at this facility. She was able to describe the signs of escalation and how to intervene during altercations between residents. She stated that Resident #1's behavior had not significantly improved since the incidents of aggression on 03/05/26 and 03/10/26. She stated that Resident #1 was again seen by psychiatric services on 03/23/26 and she was ordered both an increase on one medication and a new medication for her mood. She stated that Residents are placed on Q15 minute observations following any aggressive events and that they remain on that observation for at least 72 hours. She stated that Resident #1 was placed on Q15 minute checks following the aggressive behaviors on both 03/05/26 and 03/10/26. She stated that Resident #1's behavior is random and unpredictable and that she would have benefited from having a sitter.LVN B stated that on 03/05/26 she observed Resident #1 yelling at Resident #3 and that she began running towards the altercation but that she witnessed Resident #1 scratch Resident #3's face with her fingernails before she got to them. She stated the residents were separated and that she noted that Resident #3 had red marks without any break in the skin to her face. She stated this redness remained on Resident #3's face for about 24 hours. She stated Resident #3 did not require intervention but that she was angry and agitated for about forty minutes following the incident. She stated that she notified the physician and Resident #1 was placed on Q15 minute monitoring. She stated that on 03/10/26 she witnessed Resident #1 suddenly without provocation grab Resident #4 by the throat and pull her hair. She stated that she responded immediately, redirected the residents, and Resident #4's breathing was not restricted. She stated she believes Resident #1 thinks people are looking at her and that she had yelled at Resident #4 to stop looking at her. She stated that she assessed Resident #4 and she did not have any injuries. She stated that Resident #1 was placed on Q15 minute checks.In an interview on 03/24/26 at 03:07 p.m., the DON stated that she has been the DON at this facility for two days. She stated Resident #1 was on psychiatric services and her medications were being monitored frequently and staff often had Resident #1 near the nurse's station with them. She stated that she was going to schedule a care plan meeting with her physician and psychiatric services so that medication adjustments could be reviewed comprehensively. She stated she had seen where Resident #1 had her monitoring increased to Q15 minutes when she pulled Resident #2's hair on 03/01/26. She stated she had not been aware that Resident #1 had scratched Resident #3's face on 03/05/26. She stated that she was definitely (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	going to be making her (Resident #1) safer around everyone else in this building. She stated that the comprehensive care plan is updated by herself and the assistant directors of nurses for any acute incidents. The DON stated she intended to further update Resident #1's care plan for aggression. She stated that failing to update interventions in Resident #1's care plan would be a risk to the resident because, putting the proper care plans in place is important and the care plan is a way to communicate that plan to anyone who is providing care.In an interview on 03/24/26 at 04:00 p.m., RN A stated that on 03/01/26 she heard Resident #2 screaming loudly and she ran to the dining room where staff had separated Resident #1 from Resident #2. She stated the Medication Aide (name unknown) informed her that Resident #2 had been watching Resident #1 and that Resident #1 became angry saying she was staring at her and suddenly grabbed Resident #2 by her hair. She stated the staff were able to immediately intervene and separate the residents without incident. She stated she assessed Resident #2 and she had no bruise or signs of injuries but that she believed when she heard her scream, she was screaming in pain due to having her hair pulled. She stated Resident #2 did not require pain medication or treatment. RN A stated that she has had abuse and neglect training at this facility and would report abuse to the administrator. She stated that she has received training on dealing with difficult behaviors and resident-to-resident aggression. She stated that she notified the physician and administrator and Resident #1 was placed on Q15 minute monitoring.