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	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	2021 Shoaf Dr Irving, TX 75061

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure the resident's environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one of one maintenance room reviewed for accidents and hazards. The facility failed to ensure the door to the maintenance room located outside by the smoking area, which contained plugged power tools, harmful chemicals, and sharp tools, was secured. This failure placed residents at risk for injuries due to having access to an unsecured maintenance room.Findings include: In an observation on 4-7-2026 at 9:00 AM, the maintenance room door was left propped open and unattended by staff. The maintenance room was in a small building within 25 feet of the unlocked unalarmed dining room exit door and within 30 feet of the open smoking area. There were no barriers to block off access to the maintenance room door. There was an electric grinder, with the blade facing upward, plugged into an electrical outlet. The grinder was observed to turn on, sitting on top of sheetrock, close to the entry door. There was also a key making machine plugged into an electrical outlet with an exposed cutting blade. The maintenance room had various 5-gallon paint cans, spray paint cans with lids off, paint stripper cans, a pickaxe, and flat head axe. No residents were observed in the immediate area. Observation on 4-7-2026 at 11:00 AM, revealed the maintenance room door was still propped opened and unattended. At this time, the Director of Environmental Services was notified by the state surveyor the maintenance room door was propped open, unattended, and was a potential hazard to residents. The Director of Environmental Services radioed a staff member to secure the maintenance room door. Observation on 4-7-2026 at 11:15 AM, revealed the maintenance room door was opened about 6 inches, unattended by staff, and not secured. The door was observed to be easily accessible to residents. Observation on 4-8-2026 at 4:45 PM, the maintenance room door was closed but unlocked. The door to the maintenance room was unattended by staff and easily accessible to residents. Interview on 4-8-2026 at 4:50 PM, with the Director of Environmental Services revealed the reason the door to the maintenance room was left unlocked and unattended by staff on 4-7-2026, was because a maintenance assistant was using the electrical grinder to cut sheetrock and was called away to move something in the facility. When the Director of Environmental Services was informed the door to the maintenance room was still not secured on 4-8-2026, he had no answer for why it was not secured. The Director of Environmental Services said he was going to purchase a one-way door lock and install it on the maintenance room door. The Director of Environmental Services said he was responsible for ensuring the maintenance room door remained secured so it would not be a risk to residents. The Director of Environmental Services said the risk to residents for not securing the maintenance room door was it could potentially allow access to residents thereby exposing them to harm. The Director of Environmental Services said his expectations were to purchase and install a door lock on the maintenance room door, so the door would stay closed and always locked. Interview on 4-9-2026 at 4:45 PM, with the CEO/President Interim Administrator revealed the maintenance staff were responsible for ensuring the maintenance room door remained secured so residents did not have access to it. The CEO/President Interim Administrator said the risk to residents having access to the (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintenance room was they could be harmed. The CEO/President Interim Administrator said his expectation was for the maintenance room door to remain locked when staff were not in the room. Record review of an in-service training signed by the Director of Environmental Services, dated 4-8-2026 at 9:00 AM, stated: The Maintenance is responsible for ensuring that all hazardous areas within the facility remain properly secured at all times. This includes rooms such as maintenance shops, chemical storage areas, utility closets, and any space containing potentially dangerous equipment or substances. It is essential that all locking mechanisms are functional, routinely inspected, and promptly repaired if found to be defective. The Maintenance Director must also ensure that access is limited to authorized personnel only and that keys or access codes are controlled and monitored. Any identified issues, including broken locks, unsecured doors, or access concerns, must be addressed immediately to prevent risk of injury, exposure, or regulatory noncompliance. Maintaining secure hazardous areas is critical component of environmental safety and directly supports the protection of residents, staff, and visitors. Record review of the facility's policy, dated 7-2017, titled Hazardous Areas, Devices, and Equipment stated: Policy StatementAll hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Policy Interpretation and ImplementationAs part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the safety committee. Identification of HazardsA hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following:Equipment and devices that are left unattended or are malfunctioning;Devices and equipment that are improperly used or poorly maintained;Sharp objects that are accessible to vulnerable residents;Open areas or items that should be locked when not in use; .Access to toxic chemicals . Assessment and Analysis of Hazards1. Assessment and analysis of hazardous areas and equipment will include resident-specific information including identification of vulnerable residents.2. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous

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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 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 store, prepare, and serve food in accordance with professional standards for food service safety in the facility's one of one kitchen, reviewed for food and nutrition services. 1. The facility failed to ensure food items, placed in the dry storage areas, were sealed and kept off the floor. 2. The facility failed to ensure food items placed in the refrigerator and/or freezer were dated, sealed and labeled appropriately. 3. The facility failed to ensure garbage receptacles in the kitchen had lids on them, when trash was in the containers, not being used. These failures could place residents at risk for food-borne illnesses.Findings include: In an observation on 4-7-2026 at 9:00 AM, revealed the facility's dry storage area had a few loose potato chips on the floor, 1 cart of approximately 20 bags of potato chips on the floor, one cheese puff, 14 boxes delivered with various food items sitting on the floor, and items that had fallen on the floor behind a large food shelf, were one six-pack of V-8 juice, one 13 oz can of Rykoff Sexton anchovies, one 30oz container of ground cinnamon, two 8 oz thickening dairy beverages, one 10 oz can of Rotel tomatoes, and one 4 oz container of prune juice. The facility's only walk in refrigerator, revealed there was a multi-level rolling tray with approximately 50 beverages that were unlabeled and undated. The facility's only freezer contained a tray of 25 slices of unsealed, undated, and unlabeled cheesecake. In a second storage room containing the kitchen's plasticware and storage containers, there was a used pair of latex gloves on the floor, a bag of plastic containers used to store leftovers unsealed within a few feet of a mouse trap. There were no signs of rodents or rodent droppings.In an observation on 4-7-2026 at 9:10 AM, revealed the facility's only kitchen had two large trash cans, not in use, with liners, containing trash without lids. One of the trash cans was in the dishwashing area and the other trash can was located by the back door.In an interview on 4-7-2026 at 9:15 AM, the Dietary Manager revealed a mouse had recently been caught in the room housing the plasticware and plastic containers.In an interview on 4-8-2026 at 11:30 AM, the [NAME] said she did not put the lid back on the trash can by the back door on 4-7-2026 because she was busy doing another task and forgot to. The [NAME] said it was important to keep lids on trashcans in the kitchen area because it could attract insects and might get in resident's food.In an interview on 4-8-2026 at 2:00 PM, the Dietary Manager said she had worked at the facility as a Dietary Manager for 6 years. The Dietary Manager said the reason the boxes of food were on the floor, in the dry storage area, was because the facility had food delivery, and the kitchen staff had not stocked the items yet. The Dietary Manager said she believed the reason the food items were on the floor, behind the food shelf in the dry storage area, was because someone had moved the shelf causing the food items to fall and did not pick them up. The Dietary Manager said the reason the beverages were not dated and labeled was because they were going to be used the same day. When asked, the Dietary Manager could not identify what the beverages were. The Dietary Manager said she believed the reason the cheesecake, in the freezer was not sealed, labeled, or dated, was because the cake was used the previous night and the kitchen staff did not think to seal, date, or label it. The Dietary Manager said she believed the plastic containers were not sealed due to carelessness and the latex gloves were on the floor due to a staff member overstuffing a trash bag and the gloves fell out on the floor. The Dietary Manager said the reason food items in the refrigerator, freezer, and dry storage areas should be dated, labeled, and sealed was to prevent insects or rodents from getting into them. The Dietary Manager said she was primarily responsible to ensure proper food storage was implemented and then the Dietary Aides. The Dietary Manager said her expectations were for food in the refrigerator and freezer to be sealed, dated, and labeled. Her expectations for her staff was for the food in the dry storage areas were to be kept off the floor, sealed, dated, and labeled. The Dietary Manager said the lid was not on the trash can in the dishwashing area because the Dietary Aide was putting away a mop and was not using the trash can at the time. The Dietary Manager said the reason the trash can (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the back door did not have a lid on it was because the cook stopped throwing away trash and started other duties. The Dietary Manager said it was the responsibility of the dietary aide in the dishwashing area and the cook by the back door to ensure trash can lids stayed on trash cans when not in use. The Dietary Manager said it was also the Dietary Manager's responsibility to ensure that lids were kept on trash cans in the kitchen area. The Dietary Manager said if trash can lids were not kept on trash cans it could attract insects and rodents which could cause residents' food to be infected and make them sick. The Dietary Manager said it was her expectation that trash can lids stay on the trash cans when not in use. In an interview on 4-9-2026 at 4:45 PM, the CEO/Interim Administrator said the Dietary Manager was responsible to ensure proper food storage regulations were followed in the facility's only kitchen. The CEO/Interim Administrator said his expectations were for food to be kept off floors, sealed, dated, and labeled in the dry storage area, refrigerators, and freezers. The CEO/Interim Administrator said if the proper rules regarding food storage were not followed it could cause contamination and get into resident's food. He stated his expectations were for trash can lids to be kept on kitchen trash cans whenever they were not in use. The CEO/Interim Administrator said the risk of not keeping lids on trash cans was insects and rodents could get into resident's food causing illness. The CEO/Interim Administrator said the people working in the kitchen were responsible for ensuring lids were kept on kitchen trash cans. The CEO/Interim Administrator said the facility did not have a policy on trash disposal. Record review of the facility's policy, dated November 2022, and titled Food Receiving and Storage stated: Policy StatementFoods shall be received and stored in a manner that complies with safe food handling practices. Dry Food StorageNon-refrigerated foods, disposable dishware and napkins are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in - first out system.Food in designated dry storage areas are kept at least six (6) inches off the floor (unless packaged for case lot handling, for example, dollies, pallets, racks and skids) and clear of sprinkler heads, sewage/waste disposal pipes and vents. 5. Food in designated dry storage areas are kept at least six (6) inches off the floor (unless packaged for case lot handling, for example, dollies, pallets, racks and skids) and clear of sprinkler heads, sewage/waste disposal pipes and vents. Refrigerated/Frozen StorageAll foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.8. Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. Foods and Snacks Kept on Nursing Units 4. Beverages are dated when opened and discarded after twenty-four (24) hours.5. Other opened containers are dated and sealed or covered during storage. Record review of the U.S. Public Health Services Food Code, dated 2022 reflected: 3-305 Preventing contamination from the premises 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:(1) In a clean, dry location;(2) Where it is not exposed to splash, dust, or other contamination; and(3) At least 15 cm (6 inches) above the floor. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.Review of the U.S. Public Health Service Food Code, dated 2022, reflected: 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.

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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 interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 7 residents (Resident #3 and Resident #4) reviewed for resident assessments.The facility failed to accurately assess Resident #3's anticoagulant medication status.The facility failed to accurately assess Resident #4's anticoagulant medication status.These failures could place residents at risk of having an inaccurate care plans and inappropriate identification of care needs. Findings include:Record review of Resident #3's quarterly MDS, dated [DATE], revealed an [AGE] year-old female, who was readmitted to the facility on [DATE]. Resident #3 had a primary diagnosis which included sepsis (body has extreme response to infection). Other pertinent diagnoses included dementia (brain disease that alters brain function and causes a cognitive decline), cognitive communication deficit (impaired communication), atrial fibrillation (his is a heart condition that causes an irregular, often rapid heart rate that can cause poor blood flow), and hypertensive heart disease with heart failure (heart unable to pump enough blood to meet body's need for blood and oxygen). Section N - Medications revealed under N0415. High-Risk Drug Classes: Use and Indication, Resident #3 was documented as she had taken an anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Resident #3's active and discontinued orders, from 01/01/2026 - 04/09/2026, revealed Resident #3 was not prescribed an anticoagulant. Resident #3 was prescribed Aspirin 81 mg chewable one tab PO daily, the start date was 04/16/2023 and the end date was 02/03/2026. Record review of Resident #3's care plan, dated 02/24/2026 revealed there was not a care plan for an anticoagulant medication. Attempted interview with Resident #3 on 04/07/2026 at 12:18 p.m., was unsuccessful, Resident #3 smiled at the state surveyor and did not respond to any questions. No concerns with Resident #3's appearance or well-being. Record review of Resident #4's quarterly MDS, dated [DATE], revealed a [AGE] year-old female, who was readmitted to the facility on [DATE]. Resident #4 had a primary diagnosis of chronic obstructive pulmonary disease (COPD; a lung disease that blocks airflow and makes it difficult to breathe). Other pertinent diagnoses included non-Alzheimer's dementia (brain damage that is caused by something like a stroke that causes memory loss), acute and chronic respiratory failure (do not have enough oxygen in blood, can develop suddenly or overtime), and metabolic encephalopathy (brain disorder that occurs when a chemical imbalance of the blood affects the brain). Section N - Medications revealed under N0415. High-Risk Drug Classes: Use and Indication, Resident #3 was documented as she had taken an anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Resident #4's active and discontinued orders, from 10/05/20265- 04/09/2026, revealed she was not ordered an anticoagulant. Record review of Resident #4's care plan, dated 04/01/2026 revealed there was not a care plan for an anticoagulant medication. During an interview on 04/08/2026 at 11:28 a.m. with Resident #4, she said she was not receiving an anticoagulant. She said she was not aware of any history of taking blood thinners or an anticoagulant. Resident #4 denied any history of having a stoke, atrial fibrillation, or blood clots. During an interview on 04/09/2026 at 1:30 p.m. with the MDS coordinators, LVN D and RN E, LVN D said when completing the medication review for the quarterly MDS assessment, he looked at the resident's medication they were given in the last 7 days. He said Resident #3 was in the hospital recently and was probably given an anticoagulant in the hospital. He reviewed Resident #3's hospital records; he said she was in the hospital from [DATE]-[DATE] and said she got heparin in the hospital, which indicated that was why Resident #3 was shown to have anticoagulant use selected on her MDS. LVN D said section N stated medication the resident had taken in the last 7 days but was unsure if hospital medication applied. LVN D said aspirin would not be considered an anticoagulant under the MDS assessment because it was an NSAID. RN E said even if a resident was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the hospital during the time period of the last 7 days and was given a medication while in the hospital, the facility could claim that medication on the MDS assessment. She gave the example if Resident #3 fell in the time period for the assessment, they could put that into the MDS. RN E said section N said medications within the last 7 days and the assessment did not state medication taken within the last 7 days in the facility. During an interview on 04/09/2026 at 4:50 p.m. with the CEO/Interim Administrator of the facility, he said the facility utilized the RAI manual for guidance when completing the MDS assessment. He said accurate MDS assessments were important because the facility wanted accurate assessments on their residents. He said if an MDS assessment was not correct, the facility would go back and update and modify the MDS assessments and make sure they were correct. Record review of the facility's Resident Assessment dated 10/2023, reflected: Policy StatementA comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. Data from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required.Policy Interpretation and Implementation1. OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include.b. Quarterly Assessment.2. PPS Assessments are conducted (in addition to the OBRA required assessments) for residents for whom the facility receives Medicare Part A SNF benefits. PPS assessments provide information about the clinical condition of and SNF-level care provided for beneficiaries.4. Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status . Non-comprehensive assessments include Quarterly assessments .12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.13. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2025, reflected: SECTION N: MEDICATIONS Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. In addition, two medication sections have been added. The first is an Antipsychotic Medication Review. The second is a series of data elements addressing Drug Regimen Review. These data elements document whether a drug regimen review was conducted upon the start of a SNF PPS stay through the end of the SNF PPS stay and whether any clinically significant medication issues identified were addressed in a timely manner.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review 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 7 residents (Resident #11) reviewed for comprehensive person-centered care plans. The facility failed to develop a care plan to address Resident #11's nicotine dependence. This failure could place residents at risk of not receiving services to maintain their highest practicable physical, mental, and psychosocial well-being.Findings include:Record review of Resident #11's face sheet revealed a [AGE] year-old female. Resident #11 had a primary diagnosis which included attention and concentration deficit following cerebral infarction (cognitive impairment following a stroke). Other pertinent diagnoses included cognitive communication deficit (impaired communication), need for assistance with personal care, contracture right hand (shortening or hardening of muscle, restrict join mobility), muscle weakness, and nicotine dependence. Record review of Resident #11's admission MDS, dated [DATE], revealed Resident #11 had a BIMs score of 15, which indicated cognitive ability was intact. Resident #11 was a current tobacco user. Record review of Resident #11's smoking assessment, dated 02/28/2026, revealed Resident #11 was a smoker and used a vape and was determined a safe smoker. Record review of Resident #11's care plan, dated 04/07/2026, revealed there was no care plan for her nicotine dependence or smoking status. During an observation on 04/07/2026 at 1:30 p.m. of a smoke break revealed Resident #11 used an electronic vape. During an observation on 04/08/2026 at 1:43 p.m. of a smoke break revealed Resident #11 used an electronic vape. During an interview on 04/08/2026 at 2:11 p.m. with Resident #11, she said she smoked using a vape. She said she went on smoke breaks 4 times a day. She said she had no issues with it, and staff provided her with the vape for smoke breaks. During an interview on 04/09/2026 at 11:41 a.m. with the interim DON, she said smoking assessments were done upon admission, quarterly, and with change of conditions for residents. The interim DON said whether Resident #11 was considered nicotine dependent or a smoker, it should have been in her care plan. The interim DON said nicotine was being inhaled, and it needed to be care planned because of how it could affect a medical diagnosis. She said care plans were how there was communications with all providers which included CNAs and nurses. During an interview on 04/09/2026 at 12:07 p.m. with the Activities Director, she said she did care plans and smoking assessments for residents. The Activities Director said she did the smoking care plans and Resident #11's care plan should include that she vaped. She said even vaping had to be considered smoking. She said accurate care plans were important so that the information was correct and other providers could follow it and did not want misleading information. During an interview on 04/09/2026 at 2:35 p.m. with RN A, she stated care plans were important so staff knew what care to provide to residents. She said without care plans, staff would not know anything and there would be a lack of communication between nursing shifts. Record review of the facility's Care Plan policy, dated 03/2022, reflected: Policy StatementThe interdisciplinary team is responsible for the development of resident care plans.Policy Interpretation and ImplementationResident care plans are developed according to the timeframes and criteria established by S483.21.Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).The IDT includes but is not limited to:the resident's attending physician;a registered nurse with responsibility for the resident;a nursing assistant with responsibility for the resident;a member of the food and nutrition services staff;to the extent practicable, the resident and/or the resident's representative; andother staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident.The resident, the resident's family and/or the resident's legal (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	04/09/2026

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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.Care plan meetings are scheduled at the best time of the day for the resident and family when possible.If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure at the time each resident was admitted , the facility had physician orders for the resident's immediate care for 1 of 7 residents (Resident #12) review for physician orders upon admit. The facility failed to ensure Resident #12's hospital discharge order were followed.This failure could place residents at risk of not receiving care to meet the physical, mental, and psychosocial needs. Findings include: Record review of Resident #12's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #12 had a primary diagnosis of fracture of neck, subsequent encounter (fracture of neck that received treatment). Other pertinent diagnoses included chronic obstructive pulmonary disease (COPD, progressive lung disease making it difficult to breathe), chronic respiratory failure with hypoxia (lungs unable to bring oxygen to blood or get rid of carbon dioxide), difficulty in walking, and cognitive communication deficit (impaired communication). Record review of Resident #12's progress notes reflected:01/29/2026: [AGE] year-old female with PMH significant for hypertension and COPD who presented to the ED on 1/14/2026 following a fall. CT [neck] showed fractures . Neurosurgery was consulted and she underwent [surgery] on 1/19. She developed respiratory insufficiency [post-surgery] and was admitted to the ICU. Resident continues to require skilled nursing service for [neurological] monitoring, respiratory assessment, pain management, and reinforcement of [neck] precautions to prevent complications. Record review of Resident #12's care plan, dated 3/20/2026, reflected: [Resident #12] has a fracture of cervical spine. Interventions included checking pulses on extremities (i.e. arms, legs), encourage therapy to regain abilities, monitor alignment of extremities (to not put too much pressure on side where injury to the neck was), and turn and reposition to prevent skin issues. Record review of Resident #12's hospital notes, dated 01/27/2026, reflected Discharge Instructions.Instructions: contact their office directly to schedule a hospital follow up appointment with the neurology surgeon. Further details stated Plan. From neurosurgery standpoint, the patients okay to be discharged . [sic] Will see her in neurosurgery clinic in 4 weeks for further evaluation and recommendation. During an observation and interview on 04/07/2026 at 4:35 p.m. with Resident #12, she said she wanted to see her doctor from her survey she had on her neck. Resident #12 said she fell at home and had 4 screws put in so the bones did not break again. She said the surgeon told her she needed to rehab and she had been getting physical therapy and it had gone well. Resident #12 said she was supposed to see the surgeon a couple weeks after the surgery, and it had been a couple months since the surgery. She said she did not even know who the surgeon was who did her procedure. Observation at this time revealed Resident #12 was sitting upright on her bed, did not appear to be in distress or pain. During an interview on 04/09/2026 at 9:51 a.m. with LVN B revealed when a resident admitted to the facility, nurses were expected to look at their diagnoses, diets, orders, allergies, and progress notes. LVN B said they were supposed to review orders and send them to the DON and to the doctor to get approved. He said as a charge nurse, it was his responsibility to let them know about the orders. He said the risk of not reviewing admission orders was the resident could have medication interactions, could be allergic to something, and could be hospitalized . He said if a resident needed a follow-up appointment, staff were to let the doctor, DON, transportation, and other nurses know. LVN B said a progress note needed to be made, transportation needed to be set up, the family needed to be notified of where the appointment would be. During an interview on 04/09/2026 at 11:41 a.m. with the interim DON, she said nurses were expected to go through new admitted resident's paperwork and input the medically necessary item in their chart, which included medications and diagnoses. She said nurses were expected to review orders which included their medication orders and admission orders. The interim DON said nurses were expected to communicate about follow-up appointments and set up transportation. She said the risk of residents not receiving a follow-up appointment was, they needed continuity of care. The interim DON reviewed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 and the facility's calendar and said she could not find a follow-up appointment for Resident #12. She said charge nurses were responsible for communicating the follow-up appointment and then the ADON and DON. She said she would review Resident #12's hospital paperwork and find the doctor for the follow-up appointment, to set up an appointment. During an interview on 04/09/2026 at 3:29 p.m. with RN C, she said she was working when Resident #12 admitted to the facility and was the charge nurse. RN C said she reviewed Resident #12's paperwork and could not recall about a hospital follow-up appointment. She said she was new and getting used to the (electronic) system at that time. RN C said the importance of communicating the follow-up was for continuity of care. During an interview on 04/09/2026 at 3:38 p.m. with Resident #12's MD, he said he just heard a staff member making a follow-up appointment for Resident #12. He indicated he did not know how the follow-up appointment was not in place for Resident #12 because she had been at the facility for a few months. The MD said there was a lot of recent changes in nursing staff. Record review of the facility's admission Notes policy, dated 09/2012, reflected: Policy StatementPreliminary resident information shall be documented upon a resident's admission to the facility.Policy Interpretation and Implementation1. When a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol:a. The date and time of the resident's admission;b. The resident's age, sex, race, and marital status;c. From where the resident was admitted (i.e., hospital, home, other facility);d. Reason for the admission;e. The admitting diagnosis;f. The general condition of the resident upon admission;g. The time the attending physician was notified of the resident's admission;h. The time the physician's orders were received and verified;i. Description of any lab work completed or the time specimens were sent to the lab;j. The presence of a catheter, dressings, etc.;k. The time the dietary department was notified of the diet order;l. The time medications were ordered from the pharmacy;m. A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.);n. Any known allergies;o. Prosthesis required (i.e., glasses, dentures, hearing aid, artificial limbs, eye, etc.);p. The height and weight of the resident;q. A statement indicating that the nursing history and preliminary assessment is completed or has been started;r. Notation of any signs or symptoms of an infectious or communicable disease;s. Notation as to whether or not advance directives apply; andt. The signature and title of the person recording the data.2. This initial information-gathering precedes the complete history and physical assessment that also accompanies the resident admission process.3. The nurses' original admission note must remain on the resident's chart maintained at the nurses' station.4. Should a resident be discharged from and readmitted to the facility, new admission data must be recorded.