

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455893	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Grace Care Center of Henrietta		STREET ADDRESS, CITY, STATE, ZIP CODE 807 W Bois D Arc Henrietta, TX 76365	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to ensure menus were followed for 2 of 2 meals reviewed for Food and Nutrition Services.1. The facility failed to ensure the menu was followed on 07/27/25 and food substitutions were made for the planned lunch menu.2. The facility failed to ensure the menu was followed on 07/28/25 and food substitutions were made for the planned dinner menu. These failures could place residents at risk for weight loss and compromised nutritional health status. The findings include: 1. Record review of the current resident roster, provided 7/27/25, revealed the facility census was 18. Record review of the resident diet order list, printed 7/27/25, revealed all facility residents received oral nutrition. No residents received nutritional support by feeding tubes. Record review of the weekly planned menus revealed they were issued by the food vendor. The menus were signed by the food vendor's Registered Dietitian on 3/08/2025 and were valid until 3/31/2026. Record review of the planned lunch menu for Sunday, 7/27/25, revealed it consisted of chopped steak, mushroom gravy, mashed potato casserole, multi-color cauliflower, wheat dinner roll, margarine, marbled cheesecake, 2% milk and coffee. Observation and interview on 7/27/25 at 10:02 AM revealed whole kernel corn in a rectangular stainless-steel pan was being heated on the stove top. Observation of the oven's interior revealed a baking sheet with sizzling breaded meat patties. The DM stated the breaded meat patties were pork fritters" and they were being substituted for the Salisbury steak for lunch. The DM stated she had the Salisbury steak, but she was out of brown gravy to serve with it and would order brown gravy the next day. She stated food was ordered on Monday and Thursday and was delivered on Tuesday and Friday. Observation on 7/27/2025 at 12:31 PM revealed the lunch meal service was in progress in the dining room. There were 12 residents present and seated at the tables. The residents were served and were eating. A white board was mounted to the wall and had the lunch menu written on it: pork fritters; mashed potatoes; corn. 2. Record review of the planned menu for the evening meal on 7/28/25 revealed it consisted of Italian beef sandwich, mixed waffle fries, sauteed peppers and onions, rocky road pudding, 2% milk and coffee. In an interview on 7/28/25 at 4:35 PM, the DM stated turkey bologna sandwiches with lettuce and sliced tomato were being substituted for the beef sandwiches, due to beef roast being too expensive for the budget. The DM stated she had a substitution log, and she proceeded to open a drawer under the island counter and removed a spiral notebook with substituted food items written down. The DM stated she took pictures of the food substitutions and sent them by email to the RD Consultant. Observation on 7/28/25 at 4:45 PM revealed the following food substitutions were prepared for the dinner meal:- turkey bologna and cheese sandwiches for the Italian beef sandwiches;- regular French fries for the waffle fries;- Italian blend vegetables for the sauteed peppers and onions for the mechanical soft diets;- zucchini and yellow squash for the pureed diets;- carnival chocolate chip cookies for the rocky road/chocolate pudding. In an interview on 7/29/25 at 9:00 AM, the DM provided the food substitution notebook for review. She stated there was not a documented reason for the food substitutions due to the budget being the reason the substitutions were being made. In an interview on 7/29/25 at 1:39 PM, the DM stated she was working on alternate menus. She stated the food vendor had a program with menu (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455893
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	substitutions that would fit into the facility's budget. She stated she was working on sample menus but had not yet submitted them to the RD Consultant for approval. Record review of the DM's menu substitutions notebook revealed handwritten food items that were on the planned menu and the food items that were being served as substitutions. There were no reasons documented for the substitutions. The entries for July 2025 were documented on 7/5/25, 7/7/25 lunch, 7/16/25, 7/17/25 - 2 meals. There were no documented food substitutions for 7/27/25 lunch or 7/28/25 dinner. Record review of the facility's, undated, policy for Menus included documentation [in part]:Policy StatementMenus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy.Policy Interpretation and Implementation 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences).2. Menus for regular and therapeutic diets are written at least two (2) weeks in advance, and are dated and posted in the kitchen at least one (1) week in advance .4. The Dietician reviews and approves all menus .6. Deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived.7. Copies of the menus (as served, including substitutions) are kept on file for reference.8. Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal.9. If a food group is missing from a resident's daily diet (e.g. dairy products), the resident is provided an alternate means of meeting his or her nutritional needs (e.g. calcium supplementation or fortified non-dairy alternatives).10. Menus are updated periodically.11. Copies of menus are posted in at least two (2) resident areas, in positions and in print large enough for residents to read them. Record review of the facility's, undated, policy for Substitutions, included documentation [in part]:Policy StatementFood substitutions will be made as appropriate and necessary.Policy Interpretation and Implementation1. The Food Services Manager, in conjunction with the Clinical Dietician, may make food substitutions as appropriate or necessary. The Food Services Shift Supervisor on duty will make substitutions only when unavoidable.2. The Food Services Manager will maintain an exchange list identifying the seven (7) exchanges of food groups. When in doubt about an appropriate substitution, the Food Services Manager will consult the Dietitian prior to making the substitution.3. Residents' likes and dislikes will be considered when making substitutions.4. All substitutions are noted on the menu and filed in accordance with established dietary policies. Notations of substitutions must include the reason for the substitution.5. The Food Services Manager will review the substitutions regularly to avoid recurrences when possible.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services.1. The facility failed to ensure Paper towels were available for drying hands at the handwashing sink.2. The facility failed to ensure food was covered and not stored room temperature on the stove top and a shelf above the stove top.3. The facility failed to ensure the residential style chest freezer did not have thick frost build-up on its interior side surfaces.4. The facility failed to ensure opened food item packages were placed in sealed containers and were labeled and dated with a use by date in the refrigerator.5. The facility failed to ensure cooked food items stored in resealable plastic bags were not stored on a sheet pan with a thawing raw pork loin.6. The facility failed to ensure expired milk was not stored in the refrigerator. These failures could place residents at risk for foodborne illness, compromised nutritional health status, and being served food items that may not be fresh, taste stale, or be contaminated.The findings include: Observations and interviews starting on 7/27/25 at 9:55 AM, during the initial tour of the kitchen, revealed the following:- The paper towel dispenser, mounted on the wall by the handwashing sink, was empty. - A rectangular stainless-steel pan, containing whole kernel corn with 3 large mounds/lumps of butter on top of the corn, was uncovered and was positioned on the stove top on 2 gas burners, which were not lit. The side of the pan was cold to touch. - A baking sheet with 11 pieces of raw dough (dinner rolls) was uncovered and positioned on the stainless-steel shelf above the gas oven and grill. Observation and interview on 7/27/25 at 10:01 AM revealed the DM entered the kitchen and washed her hands at the handwashing sink. She walked across the room to the 2-compartment sink and pulled a paper towel from a roll of paper towels on a roll holder mounted to the wall above the second sink compartment. When asked about the paper towel dispenser being empty near the handwashing sink, the DM stated, We haven't been able to get towels for that type of dispenser for a while. Observation on 7/27/25 at 10:02 AM revealed the DM proceeded to turn on the 2 gas burners at a low setting, beneath the pan which contained corn on the stove top. Observation on 7/27/25 at 10:04 AM revealed a residential style chest freezer which contained pails of ice cream and an unopened/sealed plastic bag which contained breaded meat patties. The chest freezer had thick frost build up on the 4 interior sides. Observation on 7/27/25 at 10:06 AM revealed the industrial style stainless steel 3-compartment refrigerator unit contained the following: - A baking sheet with sealed raw pork loin thawing on it was positioned on the bottom shelf. The same metal baking sheet held plastic gallon-sized resealable bags as follow: honey mustard pork loin, dated 7/14/25; sweet potatoes with fluid in the bag with no label and no date; sliced sausage, dated 7/20/25; breaded chicken patties, dated 7/13/25; sliced turkey in gravy dated 7/26/25; sliced ham, dated 7/25/25; and sausage patties, dated 7/27/25. In an interview on 7/27/25 at 10:10 AM, the DM stated all the food in the plastic bags were cooked and they were left over food. She stated the bags were dated when the food was placed in them and did not include use by dates. The DM stated left over food should be used within a week of being cooked. Observation and interview on 7/27/25 at 10:11 AM revealed the wire rack shelf units above the thawing pork loin held containers with food which were not dated or were outdated:- A 5-pound container with sour cream was opened and contained less than 1/3 and was, dated 6/17/25, on the lid. The manufacturer date indicated best when used by 7/20/2025. The DM stated the container of sour cream was dated on the lid when it was received, and it was opened for use during the weekend.- A plastic storage container with a lid had a label identified as scrambled eggs and was dated 7/23/25. - A plastic storage container, dated 7/23/25, was not labeled and appeared to contain white/cream gravy. - An 8-pound carton of potato salad was opened to the air and was not resealed and dated 7/22/25. Observation on 7/27/25 at 10:20 AM revealed the second compartment of the refrigerator held large pitchers with tea, dated 7/20/25, on their lids; an open (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gallon of milk which was half full, dated 7/20/25, on the lid; and an open 60 ounce bottle with cranberry juice, dated 7/22/25, on the lid. In an interview on 7/27/2025 at 10:28 AM, the DM stated the milk and cranberry juice were opened that morning. Observation on 7/27/25 at 10:28 AM revealed the dry/non-perishable food storage room had wire rack shelves. An open 5-pound container with creamy peanut butter was dated 5/17/25 on the lid. The lid had not been securely replaced on the container and there was a small gap of space between the lid and the top rim of the container. In an interview on 7/27/25 at 10:30 AM, the DM stated the peanut butter had a shelf life of one year, even after the container was opened. She stated the date on the container lid was the received date. Observation and interview on 7/28/2025 at 4:18 PM revealed the cooked food in resealable bags that were stored on the sheet pan with the raw pork loin on the bottom shelf of the refrigerator during the initial tour on 7/27/25 were removed from the refrigerator. The DM stated the bags were contaminated with blood from the pork loin and she had to throw away all the bags with food that were on the pan. She stated two bags with food were outdated. The DM stated the resealable bags were on the shelf above the pork loin but were put on the pan with the pork loin on the bottom shelf. Observation revealed the container with scrambled eggs, dated 7/23/25, remained in the refrigerator. The DM stated she used them to make the pureed eggs for breakfast and she still had a day to use them. Record review of the facility's, undated, policy for Refrigerators and Freezers, included documentation [in part]: Policy StatementThis facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines.Policy Interpretation and Implementation7. All food shall be appropriately dated to ensure proper rotation by expiration dates. ?Received' dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened.8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes.9. Supervisors will inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs will be initiated immediately.10. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. Record review of the Food and Drug Administration Food Code 2022 specified [in part]:Chapter 3 Food3-202.15 Package Integrity.Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation did involve abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 1 of 16 residents (Resident #2) reviewed for abuse or neglect. ^ The facility failed to report to the State Survey Agency allegations of abuse after Resident #2 said CNA B was rough and used profanity. ^ This failure could place residents at risk of not having incidents of abuse and neglect being reviewed and investigated in a timely manner by the facility and the State Survey Agency. The findings include: Record review of Resident #2's face sheet, dated 7/29/2025, revealed [AGE] year-old female who was admitted to the facility on [DATE]. ^ Resident #2 had diagnoses which included: dementia (loss of memory, language, problem-solving, and other thinking abilities), chronic pain (persistent pain that lasts longer than 3-6 months), anemia (not enough healthy red blood cells to carry adequate oxygen to the body tissues), diabetes (disease that affects how your body regulates blood sugar levels), schizoaffective disorder (mental health condition), bipolar disorder (extreme shifts in mood, energy, and activity levels), anxiety (repeated episodes of sudden feelings of intense fear or terror) and seizures (abnormal surge of electrical activity in the brain). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed [in part]: Section C - Cognitive patterns Resident #2 had a BIMS score of 13, which indicated the resident was cognitively intact. Section E - Behavior Resident #2 did not exhibit any behavioral symptoms. Section GG - Functional Abilities, Resident #2 required a wheelchair, partial to moderate assistance with eating, dependent with oral hygiene, toileting hygiene, shower/baths, upper/lower dressing and putting on/taking off footwear, and substantial to maximal assistance with personal hygiene. As well as dependent in all transfers, sit to stand, sit to lie, and rolling left to right while in bed. Record review of Resident #2's Care plan, dated 05/29/25, revealed [in part]: At risk for decline ADLs, cognition, and communication. Date initiated 05/29/2025 Intervention: Encourage, remind the resident to ask for help and aid as needed. At risk for pain related to: Left knee and generalized pain. Date initiated 05/29/2025 Goal: Will show signs/symptoms of pain control as evidenced by participation in daily activities. Intervention: Observe non-verbal signs/symptoms of pain to include but not limited to; facial grimacing, guarding, restlessness, agitation. Reposition as needed for comfort and notify nurse. Potential for communication deficit and injury related to minimal hearing deficit. Date initiated: 05/29/2025 Goal: Needs will be anticipated and met by staff as evidenced by being clean, appropriately dressed, and comfortable. Interventions: Allow resident extra time to communicate needs/concerns. Introduce self to resident, explain care/procedure to be performed. Repeat instructions as needed. Do not rush when assisting. At risk for spontaneous fracture related to diagnosis of Osteoporosis. At risk for complications related to Medications. Date initiated: 05/29/2025 Diagnosis of bipolar disorder and is at risk for increased episodes of depression driven behaviors and side effects to medications. Date initiated 05/29/2025 Goal: Will have no reports of increased signs or symptoms of depression and no signs or symptoms or reports of side effects to medication. Interventions: Approach in calm manner, introduce self and explain procedure/care to be provided. Observe for/document increased signs and symptoms of depression to include but not limited to crying, tearfulness, withdrawn, decrease in activity participation, change in appetite, restlessness, negative statements and notify nurse. ADL self-care performance deficit and is at risk for further decline and injury related to vision deficit and generalized weakness. Date initiated: 05/29/2025 Goal: Maintain current level of function in all ADLs and will be free from injury. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Provide total assistance of 1 person for bathing/showering. Provide total assistance of 1 person for bed mobility. Provide total assistance of 1 person for upper/lower body dressing. Provide extensive assistance of 1 person for eating. Provide extensive assistance of 1 person for personal hygiene/grooming. Provide total assistance of 1 person for toileting. Provide total assistance of 1 person for transfers. Encourage the resident to discuss feelings about self-care deficit. Encourage the resident to participate to the fullest extent possible with each interaction. Praise all efforts at self-care. Record review of Resident #2's progress notes, dated 7/29/2025 at 12:28 PM, revealed [in part]: Effective date: 07/25/2025 08:30AM. Documented by LVN A [Recorded as a Late Entry on 07/27/2025 at 1:43PM] Entry states: While administrating medications, Resident #2 stated who was that girl that worked last night? Asked her which one, the nurse or the aid. Asked if she is referring to CNA B. Resident stated yes. LVN A told Resident #2 the CNA Bs name. Resident #2 stated yes that's her, I had a very bad night, CNA B is not nice to me. I asked CNA B to do me a favor, and she told me I don't have to do any favors for you. Resident said what, why? CNA B stated because I don't have to do anything for you're a**. Resident #2 stated to LVN A I just needed to be changed, and CNA B is very rough and throws me around like a rag doll when she changes me and I don't like that, it hurts me. Resident #2 went on to say, Then you know what else she did, I asked CNA B to please not shut my door and guess what she did, she closed the door, I don't like my door closed because I am claustrophobic.I do not want CNA B taking care of me anymore LVN A informed Resident #2 that she would report that to the DON and that it is not acceptable and was very sorry that she was treated that way. Resident #2 thanked LVN A for listening to her and understanding. 09:30 AM, LVN A Notified the DON and RN C weekend nurse of the above information. 10:10 AM, LVN A asked the DON if she would come talk to the resident as Resident #2 was talking about it again to LVN A. The DON, RN C and LVN A went back to Resident #2's room. When the DON asked how Resident #2's night went, Resident #2 stated the above information to the DON and RN C. The DON informed the resident she would handle this issue and talk to CNA B about her concerns. Record review of TULIP on 07/29/25 revealed: The facility called in a Facility-Reported Incident regarding Resident #2's allegations against CNA B from 07/25/25 on 7/29/25. The allegation was Resident Abuse. In an observation and interview on 7/27/2025 at 10:30 AM, revealed Resident #2 was awake in bed, staff present at bedside upon entry into the room. Staff assisted resident with TV remote, left the room. Resident #2 was alert and maintained conversation well. The resident reported she lost track of time and lived at the facility longer than she thought. The resident stated the day staff was wonderful but the other shift (3-11) staff was not great and she related this to a specific night shift CNA B but was unable to recall her name at the time of this interview. In an interview on 7/29/2025 at 9:25 AM, LVN A stated on Friday (7-25-25) during shift report LVN G informed her Resident #2 made a complaint during her shift about care received by CNA B. LVN G stated to LVN A that she handled it with the CNA B and had told her if it happened again LVN G would write her up. LVN A stated LVN G did not report this to the DON or ADMN. LVN A stated during medication pass on 07/25/2025, Resident #2 asked her who was the female aide taking care of her last night. Resident #2 described the staff member to LVN A as being CNA B who provided care the previous shift. Resident #2 reported to LVN A that CNA B was rude and told the resident she didn't have to do her any favors and was rough with brief changes and it hurt her. LVN A stated Resident #2 said she requested CNA B leave the door open when she left the room and then CNA B closed the door, and that Resident #2 stated she didn't want CNA B to provide care for her anymore. LVN A informed the DON of the complaint at this time. LVN A went back into Resident #2's room to follow up on medications and the resident immediately brought up her complaint again. LVN A went to the DON office and requested they go together to Resident #2s room together and address her concern being she has brought it up again and was still upset about it. At the bedside, Resident #2 repeated the same concerns with consistency that she had reported to LVN A. LVN A stated she heard about 2 other complaints regarding CNA B without knowing specific complaints or what residents were involved in. At this time LVN A was unaware if the DON had any (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further follow up with the complaint after they met with Resident #2 on 7/25/2025. LVN A stated since this complaint, CNA B provided care to the resident the night before. LVN A stated at shift change last night, Resident #2 had not returned from the hospital, but she did share the concerns with the oncoming LVN F, during report. LVN A stated during shift report this morning, there were no reports of concerns with Resident #2's care last night. LVN A reported she visited with the resident this morning and there were no complaints or concerns voiced. In an interview on 07/29/2025 at 9:40 AM, HR stated there were no complaints made to her in the last week regarding any staff being rude, rough or abusive to residents. She stated an employee, CNA B, was recently suspended for 3 days (July 9) while a self-report investigation was completed. After investigation was completed, CNA B was retrained on some skills and there was an in-service to all staff related to the self-report. HR reported CNA B attended all in-service trainings since she was hired in January. In an interview on 07/29/2025 at 11:05 AM, Resident #2 stated all but one staff member treated her with kindness. The resident stated CNA B was rough and flipped her around like a pancake, flipped the covers around and was just rough and mean. The resident denied any issues with any other staff members; she stated they were all supportive and very nice. In an interview on 07/29/2025 at 12:40 PM, the DON stated her start date was 7/21/2025. The DON stated her responsibility if abuse or neglect was reported to her was to report it to the state within 24 hours. She then reported she received 2 grievances, regarding care provided by CNA B and her language, late yesterday' (7/28/2025) and she started to investigate them. She stated one was from Resident #2, complained to the DON and the SW. She stated Resident #2 alleged CNA B was rough with care and when asked told the resident that she didn't have to do her a** any favors. Resident #2 also requested the door remain open, and CNA B intentionally closed the door. The DON stated after she was made aware of these grievances on 7/28/2025 regarding CNA B and how she spoke to the resident and how CNA B was rough during incontinence care. The DON stated she came back to the facility the evening (around 9PM) of 07/28/2025, to discuss the complaints with CNA B, who denied having any trouble with the residents. The DON stated she followed CNA B into the resident's rooms and watched her interaction with the residents, and she felt like there was no fear or uneasiness from the residents. She stated when Resident #2 returned to the facility, CNA B aided with transfer from the cot to the resident's bed as well as performed incontinent care and Resident #2 had no complaint. The DON stated she had not spoken with Resident #2 since this interaction but when she was watching CNA B interact with the residents, she observed her with a soft tone and personality. She stated her expectation was for the nurses and aides to report what they witnessed or were told immediately to her or ADMN. The DON stated she wanted them to write a report about the allegation or incident. The DON stated she also expected staff to report it to her immediately so she could appropriately report to the state survey agency. She stated she was unclear on what self-report constituted. The DON stated negative outcomes that could result from not reporting abuse or neglect would be the abuse would continue, it was degrading, and if it was unresolved, it would snowball and could cause a decline in physical and emotional health of the resident. She stated after a complaint, if an employee then retaliated against the complainant, she reported that would be an elevation in the process. She stated she would have to check the policy, but her initial thought was the employee would at a minimum be suspended pending the investigation and off the clock. She stated she was unsure what the criteria was for immediate termination, but elder abuse wasn't tolerated. She stated she planned to do in-service education on protocols for reporting and abuse, neglect and exploitation policies. The DON stated she was very new to her position as DON in this facility and she would go to RCN and ADMN for guidance. 1st Request for copies of grievances made on 07/28/2025 from the DON who verbalized understanding to provide the documents as soon as possible. In an interview on 7/29/2025 at 2:30 PM, a 2nd request for a copy of the grievances filed on 7/28/2025 was made from the DON, who stated SW was still working on finishing them but expected her to email them to her. In an interview on 7/29/2025 at 3:25 PM, the ADMN provided documents labeled QA Rounds that were completed by (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Grace Care Center of Henrietta		STREET ADDRESS, CITY, STATE, ZIP CODE 807 W Bois D Arc Henrietta, TX 76365	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the RCN as well as 1 unsigned grievance form, dated 7/25/2025 at 9:00am regarding Resident #2. In an interview on 7/29/2025 at 3:55 PM with the ADMN, DON, and RCN, the DON stated the SW came to her on 7/28/2025 with concerns reported by Resident #2, during her normal visits with them. The RCN stated any claim of abuse is to be report to the state within 2 hours of when it was made. The RCN stated LVN A did not document the conversation with Resident #2 on 07/25/2025, until 07/27/2025 and then the resident told the SW on 7/28/2025. The ADMN reported when she checked the progress notes on Sunday morning (7/27/2025) for the last 24 hours she did not see the entry made by LVN A referring to the statements made by Resident #2. (RCN was able to access the chart during the interview and confirm the late entry was made on Sunday around 1PM.) The DON stated the failure in reporting/communicating the resident complaint from Friday she stated, I didn't perceive it as abuse at the time. I have been here for just about a week and I have been overwhelmed. it was an oversight on my part. The DON then explained how to identify the 5 forms of abuse. The ADMN stated she heard about the grievance on 7/28/2025 late afternoon around 2:30-3:00PM. She stated she made a self-report around 10:30-11:00am today (7/29/2025) and still at that time felt it was more of a grievance. The ADMN looked at her paperwork for the self-report and stated LVN A came to her around noon to follow up regarding the resident's complaint and the ADMN felt like the wording of the grievance was questionable for requiring a self-report and stated she completed the self-report at 12:43 PM. The RCN stated the DON came back to the facility last night to address the grievances and their grievance policy allowed them 5 days to resolve any resident grievance, and this was within the timeline if truly a grievance. The DON stated when she asked the residents about CNA B continuing to provide their care she was allowing the residents autonomy and to participate in decisions involving their care. In a telephone interview on 7/29/2025 at 4:28 PM, RN C stated she started work at the facility last Monday 7/21/2025. She stated she worked last Monday, Wednesday and Friday with the DON. RN C stated LVN A came to her and the DON one of those days and reported Resident #2 reported verbal abuse. She stated they, all 3, went to Resident #2's room and the resident stated CNA B was rough with her in repositioning, used vulgar language, and when asked to do something for her (can't remember exactly what it was but something like moving her pillow or getting her the remote), CNA B told the resident I don't have to do anything for you. RN C stated Resident #2 asked CNA B to leave the door open but she shut the door and Resident #2 felt like it was on purpose. RN C stated after leaving the resident room the DON said she was going to interview CNA B and probably give her a write up. RN C stated she never followed up on if a write up was given or not but she was told yesterday (7/28/2025). In an interview on 7/29/2025 at 4:50 PM, LVN A stated the late entry was made on Sunday (07/27/2027), not on Friday (07/25/2025) in real time. She stated she was the only nurse working Friday (7/25/2025). was very busy and ran out of time. She also stated the facility did not allow any extra hours so staying late to chart was not an option. In a telephone interview on 7/29/2025 at 5:54 PM, the SW stated at around 1PM on 7/28/25 she was informed by CNA E about the complaint Resident #2 had regarding the other night with CNA B that occurred last Thursday (07/24/2025) during the 6p-6a shift. The SW was informed CNA B was being rough and used profanity. The SW stated she and the DON went to the resident's room to investigate and felt it was more of a grievance than abuse at that point, so she did not inform the ADMN or Abuse Coordinator at that time. Record review of the facility's, undated, policy and procedure titled Standards of Conduct revealed [in part]: Report any suspected violations of laws, regulations, or facility policies to appropriate management. C. Reporting Violations: 1. Any employee who witnesses or suspects a violation of these Standards of Conduct is obligated to report it immediately to their direct supervisor, the Director of Nursing, Human Resources, or the Administrator. 2. Reports can be made confidentially and without fear of retaliation. The facility will investigate all reports promptly and thoroughly. Record review of the facility's, undated, policy and procedure titled Mandatory Reporting Acknowledgement revealed [in part]: I. Purpose: The purpose of this policy is to ensure that all employees of [the facility] are aware of their mandatory reporting obligations regarding suspected abuse, neglect, (continued on next page)		

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exploitation, or certain communicable diseases, as required by federal and state laws. All employees, volunteers, and contractors are mandatory reporters under federal and state laws and are required to immediately report any suspected instances of such situations without fear of retaliation. Failure to comply with these mandatory reporting requirements is a serious violation of this policy and applicable laws and will result in disciplinary action up to and including termination of employment. 2. Immediate Reporting: Any employee who has a reasonable suspicion of any of the above reportable incidents must report it immediately upon discovery. Immediately means as soon as the individual becomes aware of the situation, without delay for further investigation. c. External Reporting to Authorities 1. Primary Responsibility: The administrator, director of nursing, or their designated representative is primarily responsible for making the required external reports to the appropriate state and federal agencies. 2. Timelines: External reports will be made within the timeframes mandated by federal and state laws (e.g., 2 hours for serious bodily injury, 24 hours for other allegations, specific timelines for communicable diseases). Record review of the facility's, undated, policy and procedure titled: Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation and Reasonable Suspicion of Crime revealed [in part]: 6. Verbally or non-verbally cursing, vilifying, degrading or threatening physical or emotional harm to an individual receiving services. 7. Any act or omission by an employee, contractor, or volunteer that places an individual receiving services at risk of physical or emotional injury. I acknowledge my responsibility as an employee, contract employee, or volunteer to report abuse, neglect, and exploitation. I understand that i should report any incident that i suspect may be abuse, neglect, or exploitation even if I am not sure. I realize I may be criminally liable for failing to report abuse, neglect, or exploitation. (in-service completed, signed by staff involved, and 07/29/2025) Record review of the facility's, undated, policy titled Abuse Prevention Program, revealed [in part]: Administration will: 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 3 residents (Resident #18) reviewed for care plans. 1. The facility failed to ensure a care plan was developed to address Resident #18's hospitalizations on 2/27/25-3/04/25, 4/24/25-5/05/25, and 5/28/25-6/09/25 related to urinary tract infection. 2. The facility failed to ensure a care plan was developed to address Resident #18's admission to Hospice care services on 7/03/25. 3. The facility failed to ensure a Significant Change Minimum Data Set Assessment was completed for Resident #18 after the resident had a significant change on 07/11/25. These failures could place residents at risk for not receiving care and services to meet individual needs and a continued decline in health status. The findings include: Record review of Resident #18's admission Record, dated 7/29/2025, revealed an [AGE] year-old female with an original admission date of 10/20/2023, and initial admission date on 9/26/2024, and a current admission date on 6/09/2025. The resident's diagnoses included: cerebral infarction due to thrombosis of unspecified middle cerebral artery (stroke due to a blood clot in the brain); diabetes mellitus type 2 with chronic kidney disease (high blood sugar levels due to insulin resistance and insufficient insulin production with loss of kidney function); hypertension (high blood pressure); atrial fibrillation (irregular heart rhythm); hypothyroidism (thyroid disorder); gastro-esophageal reflux disease (back-flow of stomach acid into the throat); major depressive disorder (depressed mood state), and presence of insulin pump. Record review of Resident #18's Nurses Notes revealed she was hospitalized on [DATE]-[DATE], 4/24/25-5/05/25 and 5/28/25-6/09/25 related to UTI with E.coli (Escherichia coli - intestinal bacteria) - resistant to multiple antibiotics and IV antibiotic therapy. Record review of Resident #18's Nurses Notes, dated 7/04/25, revealed an order for the antibiotic medication Macrobid 100 mg by mouth 2 times daily for 14 days for UTI. Record review of Resident #18's Order Summary Report, dated 7/29/2025, revealed an order, dated 7/03/25, to admit the resident to Hospice services with a diagnosis of cerebral infarction due to thrombosis of unspecified middle cerebral artery. Record review of Resident #18's Significant Change MDS assessment, dated 7/11/25, revealed the resident received antibiotic medication and Hospice care services. The diagnosis of UTI had not been selected in the infection diagnosis section. Record review of Resident #18's comprehensive care plan revealed, it was dated 10/27/2023 and was revised 10/18/2024, the comprehensive care plan had not been updated following the completion of the Significant Change MDS assessment and did not include care plans to address frequent/recurrent UTIs, urinary incontinence, and Hospice care services. During an interview and record review on 7/29/25 at 12:36 PM, the RN Corporate Nurse reviewed Resident #18's comprehensive care plan in the electronic health record. Following review of the resident's comprehensive care plan, the RN stated she did not locate a care plan addressing recurrent/frequent UTIs. The RN reviewed Resident 18's Significant Change in Condition MDS assessment, dated 7/11/2025, and saw the resident was receiving an antibiotic medication. The RN Corporate Nurse stated she was at the facility a few weeks ago and was told at time Resident #18 had frequent/recurrent UTIs and had been hospitalized for IV antibiotics for UTI with resistance to multiple antibiotics. The RN Corporate Nurse stated she was not aware the resident had been admitted to hospice services. She stated the family was considering it when she was at the facility a few weeks ago. The Corporate Nurse did not find a care plan for hospice services in Resident #18's comprehensive care plan. During an interview on 7/29/25 at 12:47 PM, the RN Corporate Nurse called the LVN Care Plan Nurse and placed her on speaker phone. The LVN stated she had only been in the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position for 2 weeks. The Care Plan Nurse stated she completed the comprehensive care plans and reviewed them every 3 months. She stated the facility nurses could enter acute care plans between assessment and care plan review dates. She instructed the Corporate RN to look at the resolved care plans. The Corporate RN looked at Resident 18's resolved care plans and stated she did not see an acute care plan or any care plans addressing UTIs. In an interview on 7/29/25 at 1:42 PM, the Corporate RN stated the expectation was for the DON to enter acute care plans and/or care plans addressing new issues as needed between the comprehensive reviews. She stated the charge nurses did not enter care plans into the residents' electronic health records. The Corporate RN stated she would provide a facility policy and procedure for care plans, timing, and revision for review. Record review of the facility's, undated, policy for Care Plans, Comprehensive Person-Centered, revealed the following [in part]:Policy StatementA comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation1.The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.14. The Interdisciplinary Team must review and update the care plan:a. When there has been a significant change in a resident's condition;b. When the desired outcome is not met;c. When the resident has been readmitted to the facility from a hospital stay; andd. At least quarterly, in conjunction with the required MDS assessment		