STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the transfer or discharge is documented in the resident's medical records and appropriate information is communicated to the receiving healthcare institution or provider for 1 of 2 (Resident #2) reviewed for discharges. 1. The facility failed to ensure the transfer or discharge was documented in the Resident #2's medical records.2. There was no documentation from the physician indicating that Resident #2 had specific needs that could not be met in the facility. These failures affected discharged residents and could place the residents at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and appeal process.The findings included: Record review of the face sheet for Resident #2 dated 08/08/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included myocardial infarction (heart attack), acute kidney failure, thrombocytopenia (a medical condition characterized by low platelets count, which can lead to excessive bleeding and bruising), sepsis due to methicillin resistant staphylococcus aureus (a life-threatening medical emergency caused by the body's overwhelming response to an infection), dehydration (loss of fluids in the body), and acute pulmonary edema (a serious condition characterized by the rapid accumulation of fluid in the lungs, leading to severe breathing difficulties and requiring immediate medical attention). Review of Resident #2's admission MDS assessment, dated 07/29/25, reflected the resident had a BIMS score of 13, which reflected the resident was cognitively intact. Section BO300 indicated adequate hearing and clear speech. Resident #2 had no behavioral problems but was dependent with most ADLs. Review of Resident #2's care plan dated 07/08/25 reflected Resident #2, relative expressed a desire to return to community, the resident will be discharge to. An attempt to interview the RP for Resident #2 was made on 08/06/25 at 9:25 and on 08/08/25 at 1:12p.m without success. During interview with ADON 2 on 08/08/25 at 11:07a.m, she stated she was an Assistant Director of Nursing for the facility. She said she communicated with Resident #2's family during his discharge from the facility on 07/29/25. ADON 2 explained she was not the nurse that discharged the resident. She stated the residents were discharged by the floor nurse on that hall. She said RN A discharged the resident. ADON 2 noted she checked Resident #2's EHR and did not see documentation for a discharged resident as required, including physician's order for discharge, social worker notes, discharge assessment, and therapy notes. During an interview and record review on 08/08/25 at 11:21a.m, RN A stated she was responsible for Resident #2 and discharged him on 07/29/25. RN A reviewed Resident #2's closed EHR and said she did not document the discharge instructions for Resident #2, including all special instructions or precautions for ongoing care as appropriate and comprehensive care plan goals. RN A also stated she did not have documentation for the basis for discharging Resident #2 and the specific resident needs that could not be met at the facility. She explained the facility's policy started with receiving an order from the doctor for discharge. RN A stated she assessed the resident's health status including vital signs, and ensured the resident's belongings and medication were assembled before discharge. She would communicate with the resident's representative and document the result. During interview with the DON on 08/07/25 at 10:27a.m, she said Resident #2 was discharged to a hospice agency on 07/29/25 because the facility was unable to control his pain. She explained the discharge was temporary, and she was expecting resident to come back to the facility. The DON stated she checked, but did not see any documentation in the EHR from the MD regarding the facility-initiated discharge of Resident #2. This may be, she stated, because they were expecting the resident back to the facility. Review of the facility's policy for Transfer and Discharge, dated 10/10/2017 reflected the following [in part]: Policy StatementThis facility complies with federal regulations to permit each resident to remain in the facility. and not transfer ordischarge unless the following criteria is met:Fundamental Information1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.2) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the service provided by the facility.Policy Explanation and Compliance Guidelines:Non-Emergency Transfers or Discharges - initiated by the facility, return not anticipated.a) Document the reasons for the transfer or discharge in the resident's medical record. and in the case of necessity for the resident's welfare and the resident's needs cannot be met in the facility, document the specific resident needs that cannot be met, facility attempts to meet the resident needs and the service available at the receiving facility to meet the needs. Document any danger to the health or safety of the resident or other individuals that failure to transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs) to meet the needs for 1 of 6 residents (Resident #61) reviewed for pharmaceutical services. 1. LVN-B facility failed to administer medications to Resident #61 according to physician's orders.2. LVN-B left Resident #61's medication with her in a pill cup to take later. This failure could place residents who received medications at risk for not receiving the intended therapeutic benefit of the medications.The findings included: Record review of face sheet dated 08/06/2025 revealed a [AGE] year-old female admitted most recently on 05/26/2023 with diagnoses to include: right below knee amputation (leg surgically removed below the knee); muscle weakness (condition where muscles are not as strong as they should be); bipolar disorder (mental health condition characterized by extreme mood swings); acute kidney failure (sudden rapid decrease in kidney function); and peripheral vascular disease (circulation disorder where blood vessels outside the heart and brain become narrowed, weakened or blocked affecting blood flow to the limbs and other organs). Record review of Resident #61s medication administration record and corresponding physician orders on 08/05/25 at 11:15AM revealed the following medications were to be administered at 9:00 AM: · Acidophilus (Lactobacillus) oral 1 capsule, in the morning · Alendronate Sodium 10mg oral 1 tablet in the morning for osteoporosis · Aripiprazole 15mg oral 1 tablet in the morning, for bipolar disorder · Ascorbic Acid 500mg oral 1 tablet in the morning, for wound healing · Azithromycin 250mg oral 1 tablet in the morning, for upper respiratory infection for 4 days · Bumetadine 1mg oral 1 tablet in the morning, for fluid retention, hold if SBP less than 100, or DBP less than 60. Residents blood pressure was 134/68. · Divalproex Sodium delayed release, 500mg oral 1 tablet in the morning, for bipolar disorder · Levothyroxine Sodium 25mcg oral 1 tablet in the morning for hypothyroidism · Meloxicam 15mg oral 1 tablet in the morning, for arthritis, take with food and fluids to avoid GI distress · Multivitamin oral 1 tablet in the morning, for supplement (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	· Oxybutynin Chloride extended release, 10mg oral 1 tablet in the morning, for bladder spasms · Oyster Cal 500 1 tablet oral in the morning, for supplement · Spironolactone 50mg oral 1 tablet in the morning, for hypertension · Uloric 80mg oral 1 tablet in the morning, for gout · Vitamin D3 25mcg (1000 UT) oral 1 tablet in the morning, for supplement · Buspirone HCl 10mg oral 1 tablet every morning and at bedtime, for generalized anxiety · Colace 100mg oral 1 capsule every morning and at bedtime, for constipation · Duloxetine HCl delayed release 60mg oral 1 capsule every morning and at bedtime, for depression · Omeprazole 20mg oral 1 capsule two times a day, for GERD · Quetiapine Fumarate 200mg oral 2 tablets every morning and at bedtime, for bipolar · Senna 8.6mg oral 1 tablet every morning and at bedtime, for constipation · Tylenol extra strength 500mg oral 2 tablets every morning and at bedtime, for pain In an observation and interview on 08/05/2024 at 11:04 AM with Resident #61, revealed the resident’s room door was open and her bedside table had multiple medication cups with tablets/capsules in each. Upon entry, Resident #61 was sitting in her wheelchair facing her bed. Behind her was her bedside table with 8 medication cups that contained 2-3 tablets/capsules in each cup with hydration available. Resident turned her wheelchair around towards the bedside table and stated she was getting ready to take her medications then take a shower. The Resident stated she takes around 40 medications a day and that “the nurses only do this for me” (pointing at the medication cups with pills) “so that I can take them when I want” and that they were all from that morning. In an observation on 08/07/2025 at 10:44am of Resident #61’s room revealed her privacy curtain was partially pulled across, but she was not in her room. Observed, on Resident #61’s bedside table, there were 2 clear plastic medicine cups that contained several medications in each and there were other empty medicine cups stacked up on the table with a handwritten note from Resident #61 to not throw them away. After exiting Resident #61’s room, a nurse observed at end of this hallway (400) with a medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/07/2025 at 10:48am, LVN B (hall 400) stated she had worked there for 13 years. She stated the expectations were when she administered oral medications to residents, she would inform the resident what medication she had for them before handing it to the resident to take. She stated she then would discard the medication cup, perform hand hygiene, and move on to the next resident. LVN B stated if she left the medications unattended and did not watch the resident swallow the medications, an adverse outcome might be the resident forgetting to take them, the resident may get a double dose if they had another one scheduled for noon or the next administration time, or another resident could pick them up and swallow them, and could possibly have a reaction to the medication. In an observation on 08/07/2025 at 10:55am, LVN B walked back into Resident #61’s room, pulled the curtain, and spoke to the Resident. In an interview on 08/07/2025 at 11:00am, LVN C stated she had worked at this facility for almost 6 years, and when passing medications, the expectation was to watch the resident swallow the medication before leaving the room; stating she has never left medications sitting on the table for the resident to take whenever. She stated an adverse outcome would be the resident not taking the medication as ordered, or any other resident could take them and have a negative reaction. In an interview on 08/07/2025 at 11:05am, the DON stated the procedure and her expectation for administering oral medications was to knock, introduce herself, explain to the resident what medications they were taking, and ensure the resident swallowed the medication. She further stated an adverse outcome would be the resident not taking them properly, or another resident might get a hold of them and take them. In an interview on 08/08/2025 at 12:03pm, RN A stated she had worked at this facility for 4 years. She stated when she passed medications she knocked, announced herself, informed the resident of the medications she had for them, gave the resident the medicine cup that contained the medications and made sure they took them. RN A stated if a resident was not in his/her room at that time, she would look for them and if she could not find the resident, she would lock the medications in the locked drawer in the medication cart until she could find them. RN A stated the facility’s expectation was to find the resident and administer the medications in a timely manner. She stated the only time she would leave medications sitting in a room was if there was an emergency, but that she did not leave medications in a room without the resident taking them. RN A stated she would leave medications if the resident were alert, oriented, and able to take them later. She stated an adverse outcome if the medications were left unattended could be that another resident might pick them up and have an allergic reaction or adverse reaction, and they would not know what they were taking. In a follow up interview on 08/08/2025 at 12:08pm, RN A returned to say, After speaking with the DON, the facility expects that nurses/medication aides do not leave medications in a resident's room unattended. Review of the facility’s policy statement titled “Medication-Treatment Administration and Documentation”, origination date 1/9/2014 (Revised 4/6/2023) included [in part]: “Policy Interpretation 4. Administer the medication according to the physician order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Document e-signature for medication and treatments administered on the EMAR or ETAR immediately following administration. 7. Medication or treatments that were not administered should be documented as not administered on the EMAR/ETAR with the reason for the not administration. 12. Review the EMAR/ETAR after each medication and treatment administration is completed and prior to the end of the shift to validate documentation is completed and supports services provided according to physician orders.” **Requests for documentation of Oral Medication Administration in-services or skills review forms were not provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455931	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Vernon	4401 College Dr Vernon, TX 76384

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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, for the facility's only kitchen residents as evidence by: The facility failed to ensure:A. The temperature of the walk-in freezer was below 0 degrees Fahrenheit; B. The [NAME] counter drawers and cabinets in the dining room were clean and not soiled;C. The refrigerator in the Activity Room was clean and not soiled, opened food items were placed in sealed containers and were labeled with a use by date. 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 included: In an observation on 08/05/25 at 9:67 AM, during the initial tour of kitchen, the temperature of the walk-in freezer was 21 degrees Fahrenheit. Inside the freezer there was a tub of ice cream, soft to the touch and not frozen. In the dining room, the [NAME] counter drawers and cabinets edges were sticky and soiled with wet and dry coffee. The inside of the drawers and cabinets were sticky and contained dirt, food crumbs, liquid coffee, and dried brown areas/spots. Items in the drawers and cabinets included soiled coffee cups and lids with wet and dried coffee on them, soiled napkins with brown spots on them, packets of coffee creamer and salt were soiled with brown spots on them and wadded up paper/trash. In an observation on 08/05/25 at 11:51 am, the refrigerator in the activity room was dirty with dirt, food crumbs, and dried food. The freezer contained a milkshake open to air, not dated, and a tub of sherbet that was opened and not dated. The refrigerator contained a dried-out piece of cake open to air not dated; a taco, burrito, and sandwich wrapped in paper not dated; dried out refried beans in a container not dated; a gallon of tea opened and not dated; a bowl of soup not dated; and green icing without a lid not dated. In a follow-up observation on 08/06/25 at 8:41 am, the walk-in freezer temperature was 9 degrees Fahrenheit The [NAME] counter in the dining room and the refrigerator in the Activity Room remained soiled. In an interview with the Activity Director on 08/06/25 at 9:58 am, she said the refrigerator was used by everybody and was not aware of who was responsible to clean it. In a follow-up observation on 08/07/25 at 10:37 am, the walk-in freezer temperature was 10 degrees Fahrenheit. The [NAME] counter in the dining room and the refrigerator in the Activity Room remained soiled. In a record review on 08/07/25 at 10:55 am, the temperature log for the freezer revealed the temperatures from 08/01/25 to 08/07/25.08/01/25: 5:00 am 0 degrees; 6:50 pm 3 degrees.08/02/25: 5:00 am 1 degree; 6:00 pm 7 degrees.08/03/25: 5:05 am 2 degrees; 6:00 pm 7 degrees. 08/04/25: 5:00 am 4 degrees; 6:00 pm 11 degrees.08/05/25: 5:05 am 3 degrees; 2:15 pm 3 degrees. 08/06/25: 5:07 am 0 degrees; 4:00 pm 8 degrees.08/07/25: 5:12 am 3 degrees. Afternoon check had not been completed. In an interview on 08/07/25 at 11:00 am, the Dietary Manager said the temperature of the freezer should be between 0 degrees and -10 degrees Fahrenheit. She was aware of the temperature of the freezer being elevated and the Maintenance Director turned down the temperature setting yesterday (08/06/25). She said the temperatures of the freezer were logged in the morning at 5:30 am, and acknowledged the temperature had not been below 0 degrees Fahrenheit. The findings concerning the [NAME] counter in the dining room and refrigerator in the activity room were observed with the Dietary Manager, and (he/she) said they would get it cleaned and fix the issue. In an interview on 08/07/25 at 11:05 am, the Maintenance Director said he turned down the temperature of the freezer down to -10 degrees Fahrenheit yesterday (08/06/25) and was not able to turn it down any further. He said he would contact the vendor to have the freezer serviced. In an interview and record review on 08/07/25 at 3:45 pm, the Dietary Manager said the freezer was serviced that afternoon and provided an invoice of service completed. The temperature of the freezer was -1 degrees Fahrenheit and the food was frozen. In an interview on 08/08/25 at 4:00 pm, the Administrator said it was her expectation for the [NAME] counter in the dining room and the refrigerator in the activity room to be cleaned when soiled. She was not aware of the concerns. She said there had been some confusion between the kitchen and maintenance departments over who was responsible to clean those items. In an interview on 08/08/25 at 5:09 pm, the Dietary Manager said there had been some confusion over who was responsible to clean the [NAME] table in the dining room and the refrigerator in the activity room and as a result it had been missed. She said the issues had the potential to attract bugs and rodents and food born illnesses. Record review of the facility policy Frozen and Refrigerated Food Storage, dated as revised 12/5/2017, revealed the following [in part]:Policy Statement: PHF/TCS (Potentially hazardous/Time temperature control for safety) foods will be properly refrigerated or frozen to