STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455957	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Health & Rehabilitation Center	1205 Santa Fe Dr Weatherford, TX 76086

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to inform residents, both orally and in writing in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility for 1 of 3 residents (Resident #1) reviewed for resident rights.The facility failed to maintain written acknowledgment that Residents #1 was informed prior to or at admission of their rights, the rules governing resident conduct, and their responsibilities during their stay at the facility This deficient practice could place residents at risk of not being aware of their rights, responsibilities, the facility's policies on admission.The findings included:Review Resident #1's face sheet, dated 03/10/26, revealed a [AGE] year-old female admitted on [DATE] with diagnoses of major depression (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems, heart failure, pulmonary hypertension (a condition characterized by abnormally high blood pressure in the arteries of the lungs, which can strain the right side of the heart and lead to heart failure and dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). Review of Resident #1's facility record revealed there was no signed acknowledgement that Resident #1 was informed of her rights and responsibilities.Observation and interview of Resident #1 revealed she was lying in bed. The resident was alert, oriented to name and place. She stated she did not know she was not receiving her major depression medication until the daughter informed her. She said the daughter felt her behavior changed and started asking questions about her medication. The Resident stated she did not have any interest in participating in activities because she was depressed.During interview on 05/06/26 at 11:25a.m, with Resident #1's RP, she stated she was the responsible party for Resident #1. She said Resident #1 was taking off her major depression medicine Lexapro without informing her. She stated the resident behavior was not normal. The RP stated Resident #1 was refusing meals, waking up at night and losing interest in everything. She stated she could not figure out what the problem was. She stated she requested the resident's medication list and found out Resident #1 was not taking her depression medication of Lexapro. She said the facility did not notify her before discontinuing the medication. She said she immediately informed the staff and medication was restored. The RP stated she did not receive notice of rights and services during admission either orally or in written form. She said she did not know her expectations and that of the facility. The RP stated she did not sign any admission documents as at the time of this interview.During interview with the ADM on 05/07/26 at 4:36p.m, he said there was no evidence that resident #1 was provided with written information regarding her resident rights on admission or after. He said they did not have any admission packet for Resident #1. The ADM stated the facility was working to ensure residents get their packets and their rights explained to them. He stated he was not aware that Resident #1 was not provided with her resident rights before admission to the facility. He said he looked and could not find Resident #1's packet. The ADM stated the facility admission was a work in progress and the facility is trying to get it right. Record review of the Facility policy on Resident Rights dated 02/23/16 reflected the following:Policy:The facility will inform the resident both orally and in writing in (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alanguage that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing.Policy Explanation and Compliance Guidelines:1. Prior to or upon admission, the social service designee, or another designated staff member, will inform the resident and/or the resident's representative of the resident's rights and responsibilities.2) Information about resident rights and responsibilities will be given to the resident both orally and in writing.3) Information about resident rights will be given to the resident in a language that the resident understands to the extent possible, considering impediments which may be created by the resident's health and mental status.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record review, the facility failed to immediately notify the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was an accident involving the resident for 1 of 2 residents (Resident #1) reviewed for resident rights. The facility failed to inform the Resident #1 responsible party (RP) that her depression medications were discontinued.The Findings:Observation and interview of Resident #1 revealed she was lying in bed. The resident was alert, oriented to name and place. She stated she did not know she was not receiving her major depression medication until the daughter informed her. She said the daughter felt her behavior changed and started asking questions about her medication. The Resident stated she did not have any interest in participating in activities because she was depressed.Record review of Resident #1 MAR for April 1 through 30, 2026 revealed the resident started receiving Lexapro oral tablet 20 mg by mouth in the morning on 04/01/26. Record review of Resident #1 MAR for May 1 through 7, 2026 revealed the resident stopped receiving Lexapro oral tablet 20 mg by mouth in the morning on 05/07/26.During interview on 05/06/26 at 11:25a.m, with Resident #1's RP, she stated she was the responsible party for Resident #1. She said Resident #1 was taking off her major depression medicine Lexapro without informing her. She stated the resident behavior was not normal. The RP stated Resident #1 was refusing meals, waking up at night and losing interest in everything. She stated she could not figure out what the problem was. She stated she requested the resident's medication list and found out Resident #1 was not taking her depression medication of Lexapro. She said the facility did not notify her before discontinuing the medication. She said she immediately informed the staff and medication was restored. The RP stated she did not receive notice of rights and services during admission either orally or in written form. She said she did not know her expectations and that of the facility. The RP stated she did not sign any admission documents as at the time of this interview.During interview with DON on 05/07/2026 at 4:42p.m, she stated she was not aware Resident #1's RP was not informed when her depression medication was discontinued. She stated Resident #1 was transferred to hospice care. She said all Resident #1's medications were discontinued because hospice determines what medication is required for care moving forward. She stated she did not know if the hospice informed the RP. The DON stated the facility deferred to hospice after change in care status.