STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455986	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health & Rehabilitation Center	1010 W Main St Henderson, TX 75652

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review the facility failed to ensure residents were free from abuse for 1 of 5 residents (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #1 was free from physical abuse on 8/17/25 at approximately 4:00 p.m. when Resident #2 pushed her down and kicked her causing two skin tears and pain rated as a 10/10 on a numeric pain scale following the incident. This failure could place residents at risk of pain, injury, hospitalization, and diminished quality of life.Findings included:1.Review of an admission Record for Resident #1 dated 9/16/2025 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dementia (altered cognition), peripheral vascular disease (poor circulation in legs), and bilateral (both left and right sides) osteoarthritis of hip.Review of a quarterly MDS for Resident #1 dated 9/6/2025 indicated she had severely impaired thinking with a BIMS of 3. She had exhibited difficulty focusing attention and being easily distracted. She had exhibited no verbal or aggressive physical behaviors directed toward others.Review of the care plan for Resident #1 dated 2/1/24 indicated she resided in a secured unit related to cognitive impairment and elopement risk secondary to dementia. Review of the care plan for Resident #1 dated 4/15/24 indicated she had behavioral problem of rummaging in other residents' rooms and/or belongings. Appropriate interventions were in place including anticipating the resident's needs, intervening early, and providing as many daily care activity choices as possible for resident.Review of an admission Record for Resident #2 dated 9/16/25 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of dementia, cognitive communication deficit, and aphasia (communication disorder).Review of a quarterly MDS for Resident #2 dated 9/2/25 indicated a BIMS was not conducted due to the resident being rarely or never understood. She had exhibited difficulty focusing attention and being easily distracted. She had exhibited no verbal or aggressive physical behaviors directed toward others.Review of the care plan for Resident #2 dated 8/28/25 indicated she had a behavior problem as evidenced by potential for physical aggression if bathroom is used by another resident. Appropriate interventions were in place including intervening early when resident shows agitation by guiding away from source of distress, engaging calmy in conversation, or attempting over interventions, and if response is aggressive approach at a later time after ensuring resident's safety. Resident #2 had no aggressive behaviors identified in the care plan prior to 8/28/25.Review of an incident report titled Physical Aggression Initiated dated 8/17/25 by RN A indicated .staff stopped and removed [Resident #2] from another pt that was in her room. Staff witnessed pt pushing her. The same incident report indicated immediate action was taken in placing Resident #2 on 1-to-1 supervision and completing assessments and notifications to the family and providers for Resident #1.Review of an incident report titled Physical Aggression Received dated 8/17/25 by RN A indicated .Staff stopped other resident after she starting kicking this [Resident #1] after pushing her to the floor. the same incident report indicated Resident #1 was assessed for injuries and two new skin tears to her right arm were identified. Her level of pain on a PAINAD (observational pain scale) was assessed as 7/10 which indicated severe pain. Predisposing factors were identified as Resident #1 went into Resident #2's room.Review of a nurse's progress note dated 8/17/25 at 4:43 p.m. by RN A indicated .[Resident #1] received physical aggression from other patient.pt was assessed and Stat x-rays were ordered for R hip, pelvis, R femur (thigh bone), pain 10/10 after incident. Was witnessed by staff member, pt did not hit head, but hit right arm and caused two skin tears.Review of a provider progress note dated 8/18/25 indicated [Resident #1] has two skin tears on her RUE.X-rays were negative for fractures or dislocations. Neuro is intact.During an observation and interview on 9/16/25 at 10:30 a.m., Resident #2 was observed in a common sitting area, sitting on a couch. She appeared clean and well-groomed and she had no visible marks, bruises, or skin tears. Resident #2 was not able to recall the altercation with Resident #1 due to her diagnosis of dementia.During an interview on 9/16/25 at 10:33 a.m., LVN B said she did not witness the altercation between Residents #1 and #2 and only knew of the incident through report. LVN B said Resident #2 had a history of getting into verbal altercations with any resident who went into her room. LVN B said the CNA was responsible for monitoring the residents and redirecting them from entering other residents' rooms.During an interview on 9/16/25 at 10:43 a.m., CNA C said Resident #2 was known to be verbally aggressive toward residents who tried to enter her room. CNA C said she had not witnessed any physical aggression from Resident #2. CNA C said CNAs were responsible for monitoring the residents and redirecting them from entering other residents' rooms During an