STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance for 2 (03/30/2026 and 03/31/2026) of 31 days reviewed for sufficient staffing. The facility failed to provide sufficient CNAs on 03/30/2026 and 03/31/2026 leaving the secured unit without a CNA on the overnight shift of 10 p.m. to 6 a.m., leaving residents without proper supervision and care. This failure could place residents at risk of inadequate supervision and an unsafe environment which could lead to falls, serious harm and injury, exacerbations of disease processes, and abuse and neglect. Findings included: Record review of Resident #1's admission record generated on 04/08/2026 reflected a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of sequelae of cerebral infarction (post-stroke complications affecting physical, cognitive, and emotional health), dementia, chronic pain, chronic pulmonary edema (fluid in the lungs), communication deficit, and history of transient ischemic attack and cerebral infarction (stroke). Record review of Resident #1's significant change MDS dated [DATE] reflected Resident #1 had a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #1 required substantial/maximal assistance with oral and toileting hygiene. Resident #1 was always incontinent with bowel and urine and was at risk of developing pressure ulcers. Record review of Resident #1's care plan last revised on 03/02/2026 reflected supervision was needed for bed mobility, transfers, eating, and toileting. She was an elopement risk with Interventions: Supervise closely and make regular compliance rounds whenever resident is in room. The resident had shortness of breath and interventions included, monitor and document changes in orientation, increased restlessness, anxiety, and air hunger. Record review of Resident #1's POC documentation for the month of March 2026 reflected no documented evidence that Resident #1 had any care on the overnight shift (10 p.m. to 6 a.m.) on 03/30/2026 and 03/31/2026. Required documentation fields were blank, including ADL assistance performed during shift, C.N.A care, bowel incontinence, urine incontinence, Medication Side Effects, report any new skin changes to ADON and/or DON, behaviors, Shortness of breath while lying flat, and Turn/Reposition. Record review of Resident #1 ?s order summary as of 04/08/2026 reflected she was prescribed morphine sulfate (concentrate) oral solution 20 MG/ML by mouth every two hours as needed for pain. Record review of Resident #2's admission record generated on 04/08/2026 reflected an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of urinary tract infection, gastrointestinal hemorrhage (bleeding in stomach), hyperkalemia (high potassium), vascular dementia, congestive heart failure, chronic kidney disease, and chronic pain syndrome. Record review of Resident #2's admission MDS dated [DATE] reflected Resident #2 had a BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS indicated Resident #2 required substantial/maximal assistance with toileting hygiene and was totally dependent on personal hygiene, dressing, (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower/bathing, rolling, sit to stand, transfers. Resident #2 was occasionally incontinent with bowel and urine and was at risk of developing pressure ulcers. Record review of Resident #2's care plan last revised on 03/04/2026 reflected resident will be monitored for adverse medication effect and behavior monitoring with interventions of each shift monitor for and report any potential medication side effects or behaviors in the kiosk. If noted, also verbally report to a licensed nurse. The resident also had a potential for pressure ulcer development due to moderate to maximum assistant with ADLs and repositioning and interventions included, Ensure heels are floated with the use of pillows; the resident needs assistance to turn/reposition. She was an elopement risk with Interventions: Supervise closely and make regular compliance rounds whenever resident is in room. Record review of Resident #2's POC documentation for the month of March 2026 reflected no documented evidence that Resident #2 had any care on the overnight shift (10 p.m. to 6 a.m.) on 03/30/2026 and 03/31/2026. There are blanks for ADL assistance performed during shift, ADL more assistance, C.N.A care, behaviors, bowel incontinence, Medication Side Effects, report any new skin changes to ADON and/or DON, High Risk for falls, and snack. During an interview on 04/07/2026 at 11:40 a.m., CNA A stated there were 12 residents housed in the secured memory care hallway, which always required at least one CNA due to residents wandering, nighttime wakefulness, and the need for rounding every two hours. She stated staffing was often insufficient and that although there was generally one CNA assigned per hallway, she did not know how many CNAs were assigned to the secured hallway during the night shift. CNA A stated she arrived prior to her scheduled 6:00 a.m. shift on multiple occasions and observed no staff present in the secured memory care hallway. She could not recall any specific dates and stated she did not report it to anyone. She could take care of the residents herself and asked for help when needed. CNA A stated the residents appeared okay and she was not aware of any resident harm related to the lack of staff coverage. During an interview on 04/07/2026 at 2:33 p.m., NA stated that on 03/30/2026, during the 10:00 p.m. to 6:00 a.m. shift, she was the only NA working in the facility. She reported that level of staffing was insufficient to meet residents' care needs. She stated although two additional CNAs were scheduled, they did not report for duty. NA stated she was approved by the ADON and the DON to work only until 4:00 a.m. due to the 16ˆhour work limit and this left the building without any CNAs until the morning shift came in at 6 a.m. NA stated RN G and RN H were present during the shift but did not assist with resident care. NA stated she rounded on all residents only once during the shift due to limited time and the care needed, except those in the secured unit on hallway six, which she did not enter due to lack of experience and discomfort. NA stated she informed RN G and RN H of her concerns; however, neither nurse checked on residents in the secured unit during the shift. NA reported she was not aware of any resident harm. During an interview on 04/07/2026 at 3:05 p.m., the ADON stated she was responsible for scheduling nurses and CNAs. She stated she was not aware of any facility policy specifying minimum staffing levels or actions required when staff failed to report for duty.The ADON stated she typically scheduled 2-3 CNAs and two RNs for the overnight shift and believed that was adequate for an average resident census of 70 and acuity. She stated that on 03/30/2026, two CNAs called in, and NA offered to cover the shift. The ADON stated she attempted to obtain additional CNA coverage but was unsuccessful. The ADON stated an RN should supervise NA but believed NA could perform all routine CNA duties. She stated that everyone in the building was expected to round on residents every two hours and that there were two seasoned RNs working on 03/30/2026. The ADON stated that NA was the only NA in the building from 10:00 p.m. to 4:00 a.m. and stated NA reported that RN G and RN H were not supportive. There was not a CNA in the building from 4:00 a.m. to 6:00 a.m. The ADON stated that it was the only occurrence of having one CNA for the entire facility and stated she was not aware of any resident harm or neglect during the shift. During an interview on 04/07/2026 at 3:35 p.m., CNA C stated staffing levels were frequently insufficient to provide timely resident care and the overnight shift had it worse with staff frequently calling in or not showing up for their shift. She stated there were often only two CNAs assigned to the entire building, whereas she believed at least three to four (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNAs were needed due to the number of residents. She stated that usually she was assigned to one hallway and responsible for 10 residents. CNA C stated she was often asked to work late or pick up additional shifts, and everyone knew about the staff shortages because the schedule was posted and they could look on it daily to see that staff called in or did not show up for their shift. She stated there should always be at least one CNA assigned to the secured unit on hallway six due to dementia and supervision needed. CNA C reported she was not aware of any resident harm related to the staffing levels. CNA C stated did her best to round on residents once every two hours, but it was overwhelming and tough. During an interview on 04/07/2026 at 4:00 p.m., a family member of Resident #1 stated she was aware there was only one CNA working in the entire facility on the overnight shift from 10:00 p.m. to 6:00 a.m. on 03/30/2026, based on information provided by a facility staff member. The family member declined to identify the source. She stated Resident #1 had a camera in her room and that no staff were observed checking on the resident from approximately 9:30 p.m. on 03/30/2026 to 5:30 a.m. on 03/31/2026. She stated Resident #1 was on hospice care, did not get out of bed, had restless behaviors, and could have fallen out of bed. During an interview on 04/08/2026 at 9:55 a.m., CNA D stated the facility was frequently shortˆstaffed, primarily on weekends, with only two CNAs assigned to the entire building, when she believed three to four CNAs were needed due to having 65 to 75 residents, with some requiring 2-person assistance transfers, assisting with feeding, and one always needed on the secured unit (hall 6) due to confusion and dementia. She stated insufficient staffing made it difficult to provide timely care and that some nurses refused to assist when asked. CNA D stated she arrived early for work at approximately 5:15 a.m. and on multiple occasions observed the secured unit unattended but could not recall a specific date. CNA D stated that the ADON and the DON knew this because they were always trying to call and get more staff to cover shifts. She stated she believed there should always be two staff members assigned to the secured unit on hallway six. CNA D stated all residents were required to be rounded on every two hours. She reported she was not aware of any resident harm related to the staffing concerns. During an interview on 04/08/2026 at 10:08 a.m., the ADON stated there was no facility policy addressing staffing levels or scheduling. She stated it was the responsibility of the charge nurse on each shift to notify the DON if staffing was inadequate. The ADON stated she did not receive a call from the charge nurse on 03/30/2026 regarding understaffing. The ADON stated NA reported that RN G and RN H were not assisting; however, both RNs told her that everything was under control. She stated there were no behaviors reported on the secured unit on hallway six and that residents slept through the night. The ADON stated she was not aware NA did not round on residents in the secured unit overnight on 03/30/2026 but was not concerned because RN H was responsible for the secured unit and reported that everything was under control. During an interview on 04/08/2026 at 10:38 a.m., RN I stated Resident #1 was on hospice care, bedfast, and nearing end of life. He stated Resident #1 exhibited restless movements and was prescribed lorazepam for those behaviors. RN I stated Resident #1 required monitoring every two hours due to the risk of falling from bed. He further stated he would be very concerned for residents in the secured memory care unit if no staff were present to supervise them because they required rounding on every two hours. During an interview on 04/08/2026 at 10:44 a.m., LVN F stated the facility was understaffed approximately once a week, which affected the ability to provide timely resident care. She stated that on the morning of 03/31/2026, when she arrived prior to her scheduled 6:00 a.m. shift, there was no CNA present in the building and no staff assigned to the secured memory care unit. LVN F stated she reported that to the DON and the ADON, who were responsible for scheduling. LVN F stated she worked in the memory care unit and would never leave residents unattended due to risks of confusion, wandering, restlessness, and falls. She stated that while residents in the secured unit generally slept through the night and she was not aware of adverse behaviors during that time, residents were required to be rounded on every two hours. LVN F stated it was ultimately the charge nurse's responsibility to ensure required rounding occurred. She stated that during the overnight shift of 03/30/2026 to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/31/2026, there was only one CNA assigned to the entire building, which she believed was inadequate for the residents' level of care. She stated appropriate staffing would include one CNA per 15 residents during the day, one CNA per 20 residents at night, and one dedicated CNA assigned to the memory care unit. During an interview on 04/08/2026 at 10:44 a.m., LVN E stated staffing levels were often insufficient to provide timely resident care, although she reported improvement after recent staff hires. She stated that on more than one occasion when she arrived for her 6:00 a.m. shift, staffing in the building was inadequate, but could not recall a specific date. LVN E stated appropriate staffing included one CNA assigned to each hallway, with hallways three and four combined, and one to two CNAs assigned to the secured memory care unit on hallway six. She stated all residents required rounding every two hours and that residents in the memory care unit had Alzheimer's disease and dementia, with behaviors that included wandering, entering other residents' rooms, and agitation, requiring continuous supervision to ensure safety. LVN E stated she was not aware of a time when the secured memory care unit was left without staff due to the importance of supervision. LVN E stated adequate nursing staffing required at least two nurses on each shift due to residents requiring blood glucose monitoring, tube feedings, medication administration, wound care, and twoˆperson transfers using a mechanical lift. During an interview on 04/08/2026 at 12:46 p.m., a family member of Resident #2 stated no staff were observed entering the resident's room during the overnight hours of 03/30/2026 to 03/31/2026, based on electronic camera monitoring. She stated that when she visited Resident #2 on the morning of 03/31/2026, dried urine was observed on the bed sheets, and the resident appeared to have remained in the same position overnight. The family member stated LVN E informed her the facility was shortˆstaffed because four staff members had left early or called in and did not report to work. The family member stated she texted the DON regarding her concerns and received a response stating, We are not shorthanded. The 1:10 ratio is good . During an interview on 04/08/2026 at 1:02 p.m., the DON stated he was responsible for preparing the nursing schedule or that charge nurses made assignments in his absence. He stated the state did not mandate CNA or nursing staffˆtoˆresident ratios. He stated based on an average census of approximately 70 residents and what he described as low acuity, the minimum staffing should include two nurses and three CNAs per shift, with a goal of four to five CNAs. The DON stated it was the responsibility of the charge nurse to notify him if staff failed to report to work and that he would otherwise be unaware of staffing deficits. He stated that if staffing was below what was considered safe, the DON, the ADON, and the ADM would come in to assist. The DON stated it was not unsafe to have two RNs and one CNA assigned to the overnight shift. The DON stated he was not aware that student NA was the only CNA working the overnight shift on 03/30/2026 until the surveyor requested schedules and timesheets on 04/07/2026. He stated having no CNAs in the building would be unsafe and that the two RNs should have requested additional support after NA left at 4:00 a.m. on 03/31/2026. The DON stated inadequate staffing could result in delays in resident care and stated all residents required rounding every two hours due to possible changes in condition. He stated he was not aware residents in the secured memory care unit were not rounded on overnight on 03/30/2026 and stated that it did not meet his expectations. The DON stated memory care residents required supervision for safety due to confusion and callˆlight use. The DON stated he was not aware of any written policies addressing staffing or scheduling. During an interview on 04/08/2026 at 1:28 p.m., the ADM stated the DON and the ADON were responsible for determining staffing levels based on census and acuity. He stated the state did not mandate CNA or nursing staffˆtoˆresident ratios. He stated that for an average census of 67 to 70 residents, staffing should include two nurses, one medication aide, and four CNAs on day shift, and two nurses with one to two CNAs on night shift. The ADM stated two nurses and one CNA, including a student CNA, would be considered sufficient staffing for the overnight shift. He stated residents were expected to be rounded on frequently or every two to three hours for safety. The ADM stated he became aware on 03/31/2026 that a single student CNA worked the overnight shift after it was discussed during the morning meeting. He stated two RNs covering the facility overnight would (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still be safe and feasible and that he was not concerned about staffing. The ADM stated he was not aware NA did not round on the secured memory care unit and stated it was RN H's responsibility to ensure rounding occurred. He stated the facility did not have policies addressing staffing or scheduling. During a telephone interview conducted after exit on 04/15/2026 at 12:31 p.m., RN H stated she worked from 6:00 p.m. to 6:00 a.m. shifts four days per week and that staffing was insufficient at least twice per week, but could not recall any specific dates besides 03/30/2026. She stated inadequate staffing made it difficult to complete required tasks and resulted in some residents not receiving showers or being gotten out of bed. RN H stated that based on resident acuity with having residents with feeding tubes, pressure ulcers, diabetes, and 2-person transfers, and census averaging around 70, staffing should include four staff capable of administering medications and at least one CNA assigned to each hallway, including a dedicated CNA for the secured memory care unit. She stated management was aware of low staffing on the overnight shift of 03/30/2026 because NA was asked to stay and pick up an additional shift. RN H stated NA was the only CNA in the facility overnight, had worked a 16ˆhour shift that day, and left at approximately 4:00 a.m. on 03/31/2026, leaving only RN H and RN G in the building. RN H stated due to low staffing, medications were administered late and residents were not rounded on every two hours. She stated twoˆhour rounding was necessary for resident safety, monitoring for changes in condition, repositioning to prevent skin breakdown, and incontinent care. RN H stated no staff member was assigned to the secured memory care unit overnight on 03/30/2026. She reported she intermittently listened to doors and observed residents from hallways but stated residents were not checked every two hours and rooms were not entered. RN H stated management was aware of the staffing concerns and reported her belief that staffing schedules were intentionally presented as fully staffed when they were not. RN H was not aware of any adverse outcomes for the residents due to lack of staffing. Record review of the Facility Daily Assignment for the overnight shift 10 p.m. to 6 a.m. reflected: 03/30/2026 - NA was scheduled to leave at 4 a.m., no CNA assigned to hall 6 (secured unit), and no CNA scheduled from 4 a.m. to 6 a.m. Record review of the Facility Nurse Aide Daily Sign-In Sheet dated 03/30/2026 reflected NA signed in at 12:29 p.m. and signed out at 4:04 a.m. Record review of the facility time sheets reflected NA was the only NA that clocked in for the overnight shift from 12:24 p.m. on 03/30/2026 to 4:04 a.m. on 03/31/2026. RN H was clocked in from 5:59 p.m. on 03/30/2026 to 8:24 a.m. on 03/31/2026; and RN G was clocked in from 5:48 p.m. on 03/30/2026 to 6:26 a.m. on 03/31/2026. Record review of the facility's census on 03/30/2026 reflected 67 residents, with 11 of those residents on hall 6 (secured unit).