

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: 675053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Chisolm Trail Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to request, refuse, and/or discontinue treatment, to participate in experimental research, and to formulate advance directives for 3 of 10 residents (Resident #1, #4 and #65) reviewed for advance directives. The facility failed to ensure that Resident #1's out of hospital DNR was uploaded to the electronic health record and the care plan was updated. The facility failed to ensure that Resident #4's out of hospital DNR was signed by the physician and uploaded to the electronic health record on [DATE]. The facility failed to ensure that Resident #65's out of hospital DNR was signed by the physician and uploaded to the electronic health record on [DATE]. These failures could place residents at-risk of having their wishes dishonored, and of having CPR performed against their wishes. Findings included: Record review of Resident #1's Face sheet dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included pneumonia, dysphagia pharyngoesophageal phase (inability to empty from the throat to the esophagus), hypertension (high blood pressure), dementia (memory, thinking, difficulty), history of falling, pain in shoulder, asthma, dependency on wheelchair, chronic obstructive pulmonary disease (chronic progressive lung disease), anemia (not enough healthy red blood cells), hyperlipidemia (high cholesterol), respiratory failure, kidney failure, and urinary tract infection. Record review of Resident #1's admission MDS dated [DATE] reflected she had a BIMS Score of 07, indicating severe impairment (significate limitation of basic work activity). Record review of Resident #1's Care Plan dated [DATE] revealed Resident # 1's advance directive was a full code. Record review of Resident #1's electronic health record on [DATE] at 02:23 PM reflected no Out of Hospital DNR in the electronic health record. Record review of the Out of Hospital DNR revealed an Out of Hospital DNR was signed on [DATE] and uploaded to Resident #1's medical record on [DATE] at 3:45pm. Record review of Resident #1's Doctor's Orders revealed a doctor's order dated [DATE] was signed for a DNR directive. Record review of Resident #4's admission record, dated [DATE], revealed an [AGE] year-old female, admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), hyperlipidemia (abnormally high level of fats in the blood), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs). Record review of Resident #4's Quarterly MDS, dated [DATE], revealed a BIMS of 01, which indicated severe cognitive impairment. Record review of Resident #4's order summary, dated [DATE], revealed Do Not Resuscitate with an order date [DATE]. Record review of Resident #4's electronic health record revealed an out of hospital DNR form dated [DATE]. Review of Resident #4's out of hospital DNR revealed under the section titled Physician's Statement no signature by the physician, no date, no printed name, and no license number. Further review revealed under All persons who have signed above must sign below, acknowledging that this document has been properly completed, no (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signature by the physician. Record review of Resident #4's care plan, dated [DATE] and last revised on [DATE], revealed Resident #4 had chosen to do not resuscitate with goal Patient's wishes will be honored. Review of Resident #65's face sheet dated [DATE] revealed Resident #65 was admitted on [DATE] and readmitted on [DATE] with a primary diagnosis of cerebral infarction (a stroke occurs when the blood vessels in the brain are blocked). The advance directive listed was DNR. The resident was in the secured unit. Review of Resident #65's care plan dated [DATE] revealed resident selected a DNR code status. Goal listed was patient's wishes will be honored. Review of Resident #65's quarterly MDS dated [DATE], revealed a BIMS score of 09, which indicated moderate cognitive impairment. Review of Resident #65's clinical record revealed an OOH-DNR form dated [DATE]. Further review revealed that under the section all persons who have signed above must sign below, acknowledging that this document has been properly completed there was no signature from the physician. During an interview on [DATE] 03:23 PM with the DON, he stated there was not a central location for DNR forms. He stated all residents' DNRs should be in their electronic health record. During an interview on [DATE] at 03:11 PM with the WC LVN, she stated a physician's signature was required on the out of hospital DNR for it to be valid. She stated medical records was responsible for uploading valid out of hospital DNRs to the electronic health record. The WC LVN stated if a valid out of hospital DNR was not in the electronic health record, then the resident may be given CPR even though their wishes were for do not resuscitate. During an interview on [DATE] at 04:10 PM with the MDS LVN, she stated all out of hospital DNR forms require the physician to sign in 2 separate areas on the form for it to be valid. She stated the SW was responsible for ensuring the DNR form was completed correctly and uploaded to the electronic clinical record. The MDS LVN stated if there was not a valid DNR in the electronic health record then the facility must act as if the resident is a full code, and they are required to start CPR. During an interview on [DATE] at 04:40 PM with the SW, she stated that a valid out of hospital DNR required 2 signatures from the physician for it to be valid. She stated she thought medical records, or the nursing department was responsible for ensuring out of hospital DNRs are completed correctly. The SW stated medical records were responsible for uploading the out of hospital DNRs to the residents' electronic health record. She stated if a valid DNR was not in the electronic health record then that could be a huge situation because [the facility staff] would not know [the resident's] preferences in an emergency. During an interview on [DATE] at 04:49 PM with the MR LVN, she stated the physician must sign an out of hospital form in 2 places for it to be valid. She stated she and the SW were responsible for ensuring out of hospital forms are completed correctly. She stated if there was an order for the resident to have DNR as their code status, then the resident's wish would be honored in the facility, but if the resident were sent out to the hospital, their wishes might not be honored in route to the hospital because of not having a valid DNR. During an interview on [DATE] at 5:06 PM with the DON, he stated a physician's signature is required on the out of hospital DNR form for it to be valid. He stated the SW, and nurses were responsible for ensuring the out of hospital DNRs were completed correctly and were valid. The out of hospital DNR was supposed to be uploaded immediately after obtaining all the necessary signatures. He stated if a valid DNR was not in the electronic health record, then families may get upset because a resident might be revived despite their/the family's wishes. During an interview on [DATE] at 05:35 PM with the ADM, he stated a physician's signature was required on the out of hospital DNR form to make it valid. He stated previously nursing leadership was responsible for ensuring the out of hospital DNR was completed correctly, but with the new company it is the SW's responsibility. He stated the SW was responsible for uploading valid DNR forms to the residents' electronic health record. The ADM stated, if a valid out of hospital DNR is not in the electronic health record, then the resident may get CPR against their wishes. Record review of, undated, facility policy titled, Self Determination End of Life Measures revealed .Competent adults may issue advance directives in accordance with applicable state laws. Upon admission, the facility will provide the individual with a copy of his/her rights under Texas law concerning the right to make decisions concerning medical care, including the (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right to accept or refuse medical or surgical treatment and the right to formulate advance directives.If the resident has already executed an advanced directive, the facility will obtain a copy and place it on the clinical record. The facility will respect the wishes of the resident as outlined in the advance directive. The primary nurse will note the resuscitation status of the resident on all applicable clinical records. Also, document whether the resident has executed the advance directive.The facility will ensure compliance with the requirements of Texas law concerning appropriate health care provisions when a resident has not provided written documentation for his/her advance directive, has not made a decision regarding his/her advance directive, or is incapacitated.Record review of health and safety code 166.083(b)(4)(6) dated [DATE] revealed an OOH-DNR order at minimum must contain statement that the physician signing the document is the attending physician of the person and that the physician is directing health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue certain life-sustaining treatment on behalf of the person and places for the printed names and signatures of the witnesses or the notary public's acknowledgment and for the printed name and signature of the attending physician of the person and the medical license number of the attending physicianFurther review of health and safety code 166.089(3) dated [DATE], revealed an OOH-DNR order form appears valid when it includes the signature or digital or electronic signature of the declarant or persons executing or issuing the order and the attending physician in the appropriate places designated on the form for indicating that the order form has been properly completed.		

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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. 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 1 of 1 kitchen and 1 of 1 nourishment room reviewed for food and nutrition services. 1) The facility failed to properly seal food product bags in the walk-in freezer to prevent exposure to air. 2) The facility failed to label and date food items in the walk-in freezer, and the nourishment refrigerator. 3) The facility failed to maintain the proper temperature of the refrigerator in the nourishment room. This failure could have placed residents at risk for food contamination and foodborne illness. Findings included: Observation of the kitchen's walk-in freezer on 08/05/2025 at 09:03 AM revealed several boxes of frozen food stacked on top of each other. The boxes were crushed, smashed, wet from condensation, and ice was piled on top of some of the boxes. Several boxes of frozen food were not properly sealed, exposed to air, and not dated. One box of frozen garlic bread was not properly sealed and exposed to air. One bag of frozen cookie dough was not properly sealed, exposed to the air, not labeled nor dated. The freezer cooling machine was observed with condensation water dripping off and landing on boxes of frozen food and the shelving unit. Observation of the nourishment room's refrigerator on 08/06/2025 at 09:16 AM revealed temperature log for the refrigerator, which listed the temperature at 44 degrees on 08/04/2025, 08/05/2025, and 08/06/2025. The thermostat inside the refrigerator listed the temperature at approximately 47 degrees. The contents included two opened bottles of soda, a pack of unopened canned sodas, an unopened bottle of salad dressing, a few unopened bottles of nourishable shakes, and a plastic bag that contained some type of food, all of which were not labeled nor dated. Observation of the nourishment room's refrigerator on 08/07/2025 at 09:33 AM and 10:57 AM revealed temperature log for refrigerator listed at 48 degrees on 08/07/2025. The thermostat inside the refrigerator listed the temperature at appropriately 48 degrees. The contents included six pudding cups from the kitchen that were dated 08/07/2025. Observation at 12:57 PM revealed thermostat inside the refrigerator listed the temperature at appropriately 49 degrees. In an interview on 08/06/2025 at 09:20 AM, RN F stated that the nourishment refrigerator was used for residents' drinks and food. Residents did not have access to the refrigerator because it was inside the locked medication room. Only the nursing staff had access to the room. The nighttime nurse was responsible for monitoring and checking the temperature and it was posted on the temperature log on the outside of the refrigerator door. RN F did not know what the temperature should be as that was monitored by the night nursing staff. RN F stated that it was the facility's policy to label and date all items that go into the refrigerator to ensure the items were not given to the wrong resident and to ensure the items did not go bad. RN F did not know how long food could stay in the fridge, but stated sodas could stay in the fridge for months. It was the responsibility of whoever put the items in the fridge to label and date them. If items were not labeled and dated, they should be thrown away to avoid germs that could make the residents sick. In an interview and observation on 08/06/2025 at 09:25 AM, the DON stated he did not know the correct temperature range for the refrigerator and would have to check the facility's policy. His expectation if the temperature were out of range, was that the nursing staff would adjust the temperature control in the inside of the refrigerator, retake the temperature, and clean the inside of the fridge. The DON stated it was important to maintain proper temperature to ensure food did not spoil, bacteria did not grow, there were no germs and to keep food therapeutic. He stated serving food to residents out of a fridge with a temperature above the recommended range would cause gastrointestinal symptoms. The DON stated he did not know when the night nurse took the temperature or how long the temperature had been out of range. The DON stated that all items put in the fridge should be labeled and dated. If items were not labeled and dated, they should be thrown away to ensure food was not spoiled or given to the wrong resident. The DON was observed to throw out all the items in the fridge that were not labeled and dated. In an interview on 08/06/2025 at 09:25 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM, MA D stated that she did not know the proper temperature for the refrigerator, but she thought it might be 100 degrees. She stated serving residents food out of a refrigerator that was above the recommended temperature could give the residents food poisoning. She did not know how long the temperature had been out of range because it was the night nurse that monitored the inside refrigerator temperature, and their shift ended at 6 AM. In an interview on 08/06/2025 at 02:58 PM, CK B stated she had been trained on how to label, date, and store food. Once a food item was opened, the policy was to seal the food in a plastic bag, label it with the open date, the use by, or the expiration date, and put it back in the refrigerator or freezer. This avoided potential cross contamination with other foods in the refrigerator or freezer or physical contamination. For foods going into the freezer, it was important to properly seal the food to avoid freezer burn. Freezer burn could make the food bad or cause residents to get sick. CK B stated that ultimately it was the dietary manager's responsibility for checking to ensure that all food was properly labeled, dated, and stored. She stated that she did not store items like that in the freezer and had not noticed the food in the freezer was not properly sealed. CK B stated that food not properly sealed in the freezer could have cross contamination from the condensation from the freezer unit. This did not meet her expectations. If she saw foods not properly labeled, dated, or stored, she would take out the food and properly seal, label, and date the food and put it back if it appeared it was okay. If the food appeared spoiled or had freezer burn, she would throw it away. In an interview on 08/06/2025 at 03:14 PM, the DM stated he had been trained on how to label, date, and store food. Once a food item was opened, the policy was to seal the food in a plastic bag, label it with the open date and date received and put it back in the refrigerator or freezer. For foods going into the freezer, he stated it was important to properly seal in the leftovers to avoid freezer burn. Freezer burn could make the food bad, grow bacteria, and potentially cause residents to get sick. If the food container were open and exposed to the elements and air inside the freezer, that could make the food go bad. The DM stated it was all kitchen staff's responsibility to check to ensure that all food was properly labeled, dated, and stored. Food containers not properly sealed, labeled, and dated would not meet his expectations. The DM stated he did not have a routine or schedule of checking to ensure his staff were properly labeling, dating, and storing food, but he did try to check after every meal. If he saw food in the freezer that was not properly sealed, labeled, and dated, he would have an in-service training with the staff to review policy and expectations. He would ask staff if they knew when the food was opened and if the food looked good, he would properly label, date, and seal the food. If the food appeared to have freezer burn, he would throw it out. The DM did not answer if he was aware of the food containers in the freezer that were not properly sealed, labeled, or dated but stated the freezer was being cleaned out because they were expecting a food delivery and there was little space in the freezer. In an interview and observation on 08/07/2025 at 09:33 AM, the DON stated he did not know how long the temperature of the nourishment refrigerator was out of range or when the temperature was taken, because it was done by a night nurse who was no longer at the facility as her shift ended at 6 AM. The DON stated that the temperature range should be between 35 degrees and 46 degrees, and 48 degrees would be out of range. He could not say if any correction action had been taken by the night nurse, but stated he would turn the inside temperature control knob from 3 to 2 and he would recheck the temperature in one hour. The DON stated he did not have the manufacture's instruction manual, but based on his personal refrigerator at home, the control knob 0 was equal to 0 degrees and the higher numbers were warmer, not colder. The DON was observed to leave the kitchen prepared pudding cups labeled 08/07/2025 in the fridge. In the same interview, the DON stated he did not know what the facility's policy was for labeling, dating, and storing food in the kitchen was as that was the dietary manager's responsibility. The DON stated that food in the freezer that was not properly sealed, labeled, or dated should be throw out because food exposed to air and elements in the freezer could get freezer burn, which would potentially cause food to spoil and cause residents gastrointestinal disturbances. In an interview on 08/07/2025 at 10:24 AM, CK C stated that she had (continued on next page)		

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If she saw food in the freezer that was not properly labeled, dated, or stored, she would throw it away. The CDM stated the food in the freezer that was opened to the elements had all been thrown away. This would not meet her expectations and could make the residents sick. It was the dietary manager's responsibility to check and ensure all food was properly labeled, dated, and sealed. In an interview on 08/07/2025 at 10:34 AM, DA A stated that she had received training on how to label, date, and store food. She stated once food was opened, it needed to be covered and dated. She could not say why that was important or how it might harm a resident, but stated she would report it to her manager if she saw any food that was not covered or dated in the freezer. DA A stated everyone was responsible to ensure all food was covered. She could not say if she had noticed any food in the freezer that was not properly covered and dated. In an interview on 08/07/2025 at 10:40 AM, LVN G stated that the temperature of the nourishment refrigerator should be 32 degrees. If it were out of range, she would report it to the DON, check the inside temperature control knob and adjust it. LVN G stated she would throw out any food that was not labeled and dated. LVN G stated it was important to monitor the temperature to ensure food did not go bad. Serving food to residents that was kept in a refrigerator that was out of temperature range could cause food poisoning such as e. coli. In an interview and observation on 08/07/2025 at 12:57 PM, the DON stated he thought the temperature of the inside of the nourishment refrigerator read 40 degrees earlier today; however, that was incorrect. He stated the temperature was almost 50 degrees and he would take corrective action by turning the temperature control knob in the opposite direction to see if that lowered the temperature. He was observed to leave the pudding in the fridge. In an interview on 08/07/2025 at 5:41 PM, the ADM stated that he had been trained in on how to label, date, and store food. He stated once food was opened, it needed to be sealed, labeled, and dated with the received date and open date. The ADM stated that it was the dietary manager's responsibility to ensure all food was labeled, dated, and stored properly. The ADM stated that it was important to know how long food had been opened. He also said it was important to use the food in the correct time frame to ensure quality and sanitation. He would expect food not labeled, dated, or properly sealed to be thrown away to avoid residents getting ill. The ADM stated that refrigerators should be kept at 32 degrees. The nursing staff were responsible for monitoring the temperature of the nourishment refrigerator. He stated the nourishment refrigerator held residents' food, and it was important to monitor to ensure food was kept at the proper temperature to avoid food spoiling and making the residents sick. Food should be labeled and dated. He would expect the nursing staff to notify the Assistant Director of Nursing or the DON if the temperature was out of range and to advise the residents their food needed to be disposed of. The ADM stated that the cups of pudding in the nourishment refrigerator would be thrown out. The condition of the boxes of food in the freezer on 08/05/2025 and the nourishment refrigerator temperature would not meet his expectations. Review of facility kitchen in-service trainings revealed kitchen staff were trained on food storage and supplies on 07/22/2025 and 08/06/2025 and food safety on 08/06/2025. Review of the facility policy titled Food Storage and Supplies from the Dietary Services Policy & Procedure Manual 2012 reflected: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects. Procedure: 4. Open packages of food are stored in closed containers with covers or in sealed (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bags and dated as to when opened. 8. On perishable foods, microorganisms such as molds, yeasts, and bacteria can multiply and cause food to spoil. Spoiled foods will develop an off odor, flavor, or texture due to naturally occurring spoilage bacteria. If a food has developed such spoilage characteristics, it should not be eaten. There are two types of bacteria that can be found on food: pathogenic bacteria, which cause foodborne illness, and spoilage bacteria, which causes foods to deteriorate and develop unpleasant characteristics such as an undesirable taste or odor making the food not wholesome, but do not cause illness. Perishable foods have been processed/treated and sealed to eliminate pathogenic bacteria, but spoilage bacteria can multiply, and this is what causes the food to deteriorate in quality and taste. If perishable food items are not stored at the proper temperature, spoilage bacteria can grow faster than anticipated and food becomes spoiled and should not be served. Review of the facility policy titled Food Safety from the Dietary Services Policy & Procedure Manual 2012 reflected: We will ensure all food purchased shall be wholesome and manufactured, processed, and prepared in compliance with all State, Federal, and local laws and regulations. Food shall be handled in a safe manner. Procedure: 2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated, and stored properly. 4. Potentially hazardous food shall be maintained at: 41 degrees F or less, or 140 degrees or above. Review of the facility's undated policy titled Information sheet for Food brought into the facility for Families reflected: 4. If the resident does not have a personal refrigerator, then the facility's resident nourishment room will be used to store resident food that needs to remain chilled. This refrigerator will be cleaned by facility staff and will remain at 40 degrees or less at all times. Please be sure to label the food item with the resident's name and the date prepared. Be aware that all foods will be discarded according to Texas Food Establishment Rules for leftovers according to the date on the label or expiration date, whichever comes first This is normally within 7 days of preparation as long as the food has remained in storage at 40 degrees or less.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure it formulated, adopted, and enforced policies regarding smoking, smoking areas, and smoking safety for 3 of 5 residents (Residents #5, Resident #20, and Resident #78) reviewed for smoking. The facility failed to keep Residents #5, Resident #20, and Resident #78's cigarettes and lighters in a safe place per their policy. This failure placed all residents at risk for serious injury, harm, and/or death due to possible fire or smoking inside the building. Findings Included: Resident #5 Record review of Resident #5's Face sheet dated 08/06/2025 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included end stage renal disease, unsteadiness on feet, limitation of activities due to disability, atrial fibrillation (abnormal heart rhythm), chronic obstructive pulmonary disease (chronic progressive lung disease), dementia (memory, thinking, difficulty), low back pain, hyperlipidemia (high cholesterol), legal blindness, hypertension (high blood pressure), insomnia (difficulty sleeping), and tobacco use. Record review of Resident #5's Annual MDS dated [DATE] reflected he had a BIMS Score of 12, indicating moderate impairment. The MDS revealed Resident #5 was a current tobacco user. Record review of Resident #5's Care Plan dated 06/22/2025 revealed Resident #5 was an everyday smoker. Interventions in place was Keep lighter at nurses' station along with cigarettes in smoking box, maintain appropriate level of supervision as determined by smoking assessment, Resident #5 will only smoke in designated smoking areas and smoking apron as indicated. Record review of Resident #5's Smoking assessment dated [DATE] revealed that resident is safe to smoke unsupervised at this time, and all smoking materials will be kept at the nurses station. Resident #20 Record review of Resident #20's Face sheet dated 08/06/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 had diagnoses which included cerebral infraction (stroke), dementia (memory, thinking, difficulty), seasonal allergies, non-ST elevation myocardial infarction (a type of heart attack characterized by reduced blood flow to the heart, leading to heart muscle damage), type 2 diabetes mellitus with unspecified complications (high blood sugar), hyperlipidemia (high cholesterol), and cardiomyopathy (a disease of the heart muscle). Record review of Resident #20's Quarterly MDS dated [DATE] reflected he had a BIMS Score of 09, indicating moderate impairment. The MDS did not indicate Resident #20 was a current tobacco user. Record review of Resident #20's Care Plan dated 05/29/2025 revealed Resident# 20 was an everyday smoker. Interventions in place was Assist to and from designated smoking area, assure smoking material is extinguished prior to patient leaving smoking area, observe patient for unsafe smoking behaviors or attempts to obtain smoking materials from outside sources, patient not to have cigarettes or smoking material on person, provide smoking apron while smoking and place patient in position to assure visualization of ashtray. Record review of Resident #20's Smoking assessment dated [DATE] revealed that resident is safe to smoke unsupervised at this time, and all smoking materials will be kept at the nurses station. Resident # 78 Record review of Resident #78's Face sheet dated 08/06/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #78 had diagnoses which included multiple fractures of the pelvis, protein-calorie malnutrition (inadequate intake of both protein and calories), type 2 diabetes mellitus without complications (high blood sugar), and personal history of transient ischemic attack (a short period of symptoms like those of a stroke). Record review of Resident #78's admission MDS dated [DATE] reflected he had a BIMS Score of 09, indicating moderate impairment. The MDS did not indicate Resident #78 was a current tobacco user. Record review of Resident #78's Care Plan dated 07/31/2025 revealed Resident# 78 smoked. Interventions in place was Ensure smoking occurs in designated smoking areas, ensure that no oxygen is located in the smoking area while the resident is smoking, no smoking materials or igniter's will be stored in the resident rooms, safe smoking assessment every month, and this resident is safe to smoke unsupervised, at this time. Record (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #78's Smoking assessment dated [DATE] revealed that resident is safe to smoke unsupervised at this time, and all smoking materials will be kept at the nurses station. Observation of smoking on 08/05/2025 at 4:08 p.m., revealed there were five residents outside for the smoke break. Resident #20 was observed with a pack of cigarettes in her bra, Resident #5 was observed pulling a pack of cigarettes and a lighter out of his pocket. Resident #78 was observed with a pack of cigarettes in her pocket. During an interview on 08/06/2025 12:00 PM with Resident #5 revealed that he had been given instructions on smoking. He said it covered where he goes to smoke and the times that he can smoke. He said the smoking area is outside of Hall 3. He said staff are available when they smoke. He said that the facility gave all the smoking residents a smoking apron. He said he was able to keep his cigarettes on him until recently. He said that the facility just took them from him yesterday because State was here. He said when he had his cigarettes he would keep them in a drawer in his room. During an interview on 08/06/2025 12:05 PM with Resident #20 revealed that she was given the smoking instructions. She said it covered that she could not smoke inside the facility. She said that she had to go outside to the smoking area to smoke. She said that the smoking area is at the end of Hall 3. She said she does not use an apron when she is in the smoking area. She said that she was able to keep her cigarettes and lighter. She said they took her cigarettes and lighter yesterday. She said that she would keep her cigarettes in her bra or in her drawer. She also said that she had people come in and take things from her room in the past. During an interview on 08/06/2025 2:25 PM with Resident #78 revealed that the facility let her keep her cigarettes until 08/05/2025. She said she wanted to know why the facility took her cigarettes from her. She said the facility let her keep them when she got to the facility. She said that the facility did go over the instructions on smoking today with her. She said the facility told her they would start keeping the cigarettes in a clear box. She said the facility instructed her that the staff would take the residents out to smoke during the designated smoking times. She said the smoking area was at the end of hall 3. She also said when she was able to keep her cigarettes she would put them in her top drawer. During an interview on 08/07/2025 11:50 AM with the AD revealed that she had been trained on the smoking policy. She said the training covered the residents must wear aprons, staff must be present while residents are smoking, and the residents are allowed only two cigarettes during the smoke break. She said that there was a list of staff that take the residents out to smoke. She was not sure how often the residents were assessed for safe smoking. She said that residents were not allowed to keep their cigarettes and lighters on them. She said they have never been able to keep them. She said the smoking material is kept in a box at the nurse's station. She said the residents could burn themselves or another resident could get ahold of the cigarettes if the resident kept them. She said that all staff were responsible for monitoring to ensure that the residents did not keep their cigarettes and lighters. She said the staff monitor it by taking the cigarettes after the smoke breaks. She said that Residents #5, Resident #20, and Resident #78 have not had any smoking accidents. She said she did not know why Residents #5, Resident #20 and Resident #78 had their cigarettes and lighters. During an interview on 08/07/2025 3:46 PM with MA E revealed that he had been trained on smoking policy. He said the policy for smoking was that the resident had to smoke outside in the designated area. He said that the residents had to put the smoking apron on before they smoked. He said that the residents were allowed to have two cigarettes and staff had to be present while the residents smoked. He said that different staff take the residents out at different times. He said the residents were educated daily on the smoking policy because they wanted to go outside to smoke all day long. He said the interventions were that the facility had specific times, aprons and staff were there when residents smoked for interventions. He said the residents are a part of the interventions planning and it is discussed when the facility does the residents care plan. He said that residents are not allowed to keep their smoking materials. He also said the residents have never been allowed to keep their smoking materials. He said if residents kept their smoking materials, they could hurt themselves or others. He said that everyone was responsible for monitoring to ensure residents do not have their (continued on next page)		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking materials. He said that he did not know why Residents #5, Resident #20 and Resident #78 had their cigarettes and lighters on them. He said that Residents #5, Resident #20, and Resident #78 have not had any smoking related accidents. During an interview on 08/07/2025 5:05 PM with the DON revealed he had been trained on smoking policy. He said the smoking policy was that the facility did a smoking assessment to ensure they are safe to smoke. He said staff take the residents out to smoke and keep the residents in the line of sight. He said that when the residents are done smoking the staff were to collect all the cigarettes and lighters from the residents. He said that the safe smoking assessments were done quarterly. He said that the residents were educated daily on smoking rules because they want to go outside all day long. He said that the interventions in place were aprons, red cigarette cans, the safe smoking assessments and staff present when residents are smoking. He said that the activity director does include the resident in the decision of the interventions. He said the residents were not allowed to keep their smoking materials on them. He said if residents kept their cigarettes and lighters other residents could get ahold of them. He said that all staff were responsible for ensuring the residents do not have their smoking materials. He said staff monitored it by observations and when the smoking break is over. He said he did not know why Residents #5, Resident #20 and Resident #78 had their smoking materials. He also said that none of the residents have had any smoking accidents. During an interview with the ADM on 08/07/2025 at 5:35pm revealed that he had been trained on smoking policy. He said the policy for smoking was that the resident could smoke during the designated times with staff present. He said that staff were assigned to take the residents out to smoke during the smoking times. He said that residents were assessed for safe smoking monthly. He also said that the residents were educated on the smoking rules at least quarterly. He said that interventions in place were the assessments, the residents wearing the aprons, and staff monitoring the residents. He said residents are a part of the smoking intervention decisions. He said that residents were not allowed to keep their smoking materials on them. He said if residents kept their smoking material they might try to smoke in their room or give cigarettes to other residents. He said all staff were responsible for ensuring that residents did not have their smoking materials. He said that it was monitored through observation and the staff would confiscate it when they see a resident with smoking materials. He said he did not know why Residents #5, Resident #20 and Resident #78 had their smoking material on them. He said Residents #5, Resident #20 and Resident #78 have not had any smoking related accidents. Record review of the Smoking Policy dated 11/1/2017 revealed matches, lighters or other ignition sources for smoking are not permitted to be kept or stored in the resident's room.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care that included measurable objectives and timeframes to meet the residents' medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment for 2 of 10 residents (Residents #1 and #7).1. The facility failed to ensure the care plan was updated when Resident #7's code status was changed from full code to DNR on [DATE].2. The facility failed to ensure the care plan was updated when Resident #1's code status was changed from full code to DNR on [DATE].This failure could place residents at-risk of having their wishes dishonored, and of having CPR performed against their wishes.Findings included:Record review of Resident #7's admission record, dated [DATE], reflected a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), and bipolar disorder (a mental illness that causes extreme mood swings). The advance directive listed was DNR. Record review of Resident #7's change of condition MDS, dated [DATE], reflected she had a BIMS of 11, indicating moderate cognitive impairment.Record review of Resident #7's care plan, dated [DATE], dated [DATE], reflected Resident #7 was a full code. Record review OOH revealed an Out of Hospital DNR was signed on [DATE]. Record review of Resident #7's Order Summary, dated [DATE], revealed an order Do Not Resuscitate with a start date [DATE]. Record review of Resident #1's Face sheet dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included pneumonia, dysphagia pharyngoesophageal phase (inability to empty from the throat to the esophagus), hypertension (high blood pressure), dementia (memory, thinking, difficulty), history of falling, pain in shoulder, asthma, dependency on wheelchair, chronic obstructive pulmonary disease (chronic progressive lung disease), anemia (not enough healthy red blood cells), hyperlipidemia (high cholesterol), respiratory failure, kidney failure, and urinary tract infection. Record review of Resident #1's Quarterly MDS dated [DATE] revealed she had a BIMS Score of 07, indicating severe impairment. Record review of Resident #1's Care Plan dated [DATE] revealed Resident #1 was a full code. Record review of the OOH revealed an Out of Hospital DNR was signed on [DATE] and uploaded to Resident #1's medical record on [DATE].Record review revealed a doctor's order dated [DATE] was signed for a DNR directive. During an interview on [DATE] at 04:10 PM with the MDS LVN, she stated the SW was responsible for updating care plans when the advance directives change. She stated if the care plan did not align with the resident's decision for advance directives, then the resident might get CPR even though they chose DNR. During an interview on [DATE] at 04:40 PM with the SW, she stated when a resident chose to change their advance directives to DNR, then the DNR is uploaded to the electronic health record, and the care plan should be changed. She stated she was unsure if she was supposed to update the care plan or if it was the MDS LVN that was responsible. She stated if the care plan did not reflect the resident chose to be DNR then in an emergency the staff would be unaware of how to proceed and may give the resident CPR against their wishes. During an interview on [DATE] at 04:49 PM with the MR LVN, she stated when a resident chose DNR as their advance directives, then their care plan needed to be updated. She stated the facility had transitioned to new owners and was unsure who was responsible for updating the care plans. The MR LVN stated if the care plans were not updated to reflect the resident's choice for DNR then it might cause confusion in the event of an emergency, and the resident could be given CPR. During an interview on [DATE] at 05:06 PM with the DON, he stated once a resident completes the paperwork to change their code status to DNR, then the paperwork is uploaded into the electronic health record, their title bar is changed and their care plan should be updated. He stated he believed it (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the MDS LVN's responsibility to change the care plan, but it could be a shared responsibility. He stated this was checked during the resident's quarterly care plan meeting. He stated if the care plan did not reflect the resident chose DNR, then the resident may be revived with CPR, and it could affect their future quality of life. During an interview on [DATE] at 05:35 PM with the ADM, he stated that once a change in advance directives was received, then it was documented in the electronic health record, the DNR form was uploaded into the chart, and the care plan was updated to reflect the resident's wishes. He stated that all changes in advance directives was reviewed in the morning meetings by management. He stated if the care plan was not updated with the resident's wishes for DNR, then the facility may go against the resident's wishes and start CPR. Record review of undated facility policy titled, Comprehensive Care Planning reflected, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: .the right to refuse treatment. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices, and goals during their stay at the facility. Person-centered care means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Residents' preferences and goal may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one of two residents (Resident #4) reviewed for pressure injuries. The facility failed to ensure wound care was performed as ordered by the wound care doctor for Resident #4. Resident #4 missed 6 wound care treatments in July 2025 and August 2025. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain. Findings included: Record review of Resident #4's admission record, dated 08/06/2025, revealed an [AGE] year-old female, admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included unspecified dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgement), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), hyperlipidemia (abnormally high level of fats in the blood), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs). Record review of Resident #4's Quarterly MDS, dated [DATE], revealed a BIMS of 01, which indicated severe cognitive impairment. Section M (Skin Conditions) revealed she had one or more pressure ulcers/injuries. Record review of Resident #4's care plan, dated 07/17/2025 and last revised on 07/29/2025, revealed Focus: The resident has a pressure ulcer or potential for pressure ulcer development with Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #4's order summary, dated 08/06/2025, revealed Cleanse stage IV pressure wound to right heel wound with normal saline or wound cleanser, apply collagen and cover with calcium alginate and protective foam secured with kerlix and tape one time a day for right heel wound with an order date of 07/08/2025. Record review of Resident #4's treatment administration record for July 2025 and August 2025 revealed Resident #4 had no wound care treatment signed off on the following dates: 07/19/2025, 07/20/2025, 07/24/2025, 08/02/2025, 08/03/2025, and 08/04/2025. Record review of Resident #4's most recent wound care physician note, dated 07/29/2025, revealed Wound Progress: Improved evidenced by decreased necrotic [dead] tissue, decreased surface area. Attempted phone interview with wound care physician on 08/07/2025 at 02:23 PM, no answer, voicemail was left but no return call prior to exit. During an interview on 08/07/2025 at 03:11 PM with the WC LVN, she stated she was responsible for wound care treatments when she was scheduled to work. She stated when she is off work the charge nurses are responsible for providing wound care to the residents. The WC LVN stated wound care was signed off on the treatment administration record after completion of wound care. She stated Resident #4 had a stage IV (a pressure injury that is characterized by full-thickness tissue loss that exposes underlying muscle, tendon, or bone) pressure wound to the right heel. She stated the wound care for Resident #4 was to clean with saline/wound cleanser, the apply collagen powder, cover with calcium alginate, the secure with a foam dressing. The WC LVN stated wound care was ordered for Resident #4 to be performed daily. She stated Resident #4 had a wound care physician assess the wound on a weekly basis. She stated, after reviewing the treatment administration record, that it appeared no wound care treatments were performed on 07/19/2025, 07/20/2025, 07/24/2025, 08/02/2025, 08/03/2025, and 08/04/2025. The WC LVN stated she worked on 08/04/2025 and performed wound care but forgot to check it off on the treatment administration record. She stated she was upset after providing wound care on 08/04/2025 because she removed the same dressing that she applied on 08/01/2025. She stated the dressing she removed had her initials and the date of 08/01/2025 indicating that no wound care was provided the two days prior. The WC LVN stated she notified the DON but did not document it in the chart. She (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the wound did not show signs of deterioration from not receiving wound care over the previous two days. The WC LVN stated if wound care was not performed as ordered on a daily basis, then the wound could deteriorate or get worse. During an interview on 08/07/2025 at 04:10 PM with the MDS LVN, she stated the WC LVN was responsible for wound care during the week and the charge nurses were responsible for wound care on the weekends. She stated she thought the ADON did a weekly audit to ensure treatments and medications were administered as ordered. The MDS LVN stated it was policy to sign off on the treatment administration record once the treatment was performed. She stated if wound care was not being performed as ordered, then the wound could deteriorate even with one missed treatment. Attempted a phone interview on 08/07/2025 at 04:49 PM with the charge nurse responsible for wound care on 08/02/2025 and 08/03/2025, but no answer. A voicemail was left but a return call was not received prior to exit. During an interview on 08/07/2025 at 05:06 PM with the DON, he stated the WC LVN was responsible for wound care, but when she was not at work, then the charge nurse was responsible for providing the treatment. The DON stated he and the ADON were responsible for running an audit report to ensure treatments were being performed as ordered. He stated it is policy to sign off in the treatment administration record once the wound care had been performed. He stated the effectiveness of the wound care treatment was determined by the measurements and reports received from the wound care physician provided with their weekly visits. The DON stated the nurse that was responsible for wound care on 07/19/2025 and 07/20/2025 was no longer working at the facility. The DON stated if wound care was not done, the wound could get worse, the resident could get septic (a life-threatening medical emergency caused by the body's extreme response to an infection), or the resident could develop osteomyelitis (an infection in the bone). He stated, even a few days can make it go from good to horrible. During an interview on 08/07/2025 at 05:35 PM with the ADM, he stated the WC LVN or charge nurses were responsible for performing wound care treatments as ordered by the wound care physician. He stated he expected staff to sign off on the treatment administration record once the treatment has been performed. He stated he was unsure of the current wound care being provided to Resident #4. He stated if wound care was not performed daily as ordered then the progression of healing could be reversed, and the wound could get worse. Record review of facility policy titled Wound Treatment Management, dated 2021, revealed Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.-Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 7. Treatments will be documented on the Treatment Administration Record.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) (for Resident #8) to meet the needs of each resident for 1 of 1 medication storage room and 1 of 3 (hall 1 nurses' medication cart) medications cart reviewed for pharmacy services. The facility failed to ensure expired medications were removed from the medication storage room and the hall 1 nurses' medication cart on 08/07/2025. The facility failed to ensure that the narcotic count sheet accurately reflected the amount of Resident #8's phenobarbital (a controlled medication used in the treatment of seizures) stored in the hall 5 nurses' medication cart. This failure could place residents at risk of receiving an expired medication, not reaching the intended therapeutic dose, and/or adverse reactions from receiving medications past their expiration date. Findings included: 1. Record review of Resident #8's admission record, dated 08/07/2025, reflected a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including epilepsy (a long-term neurological disorder characterized by recurrent, unprovoked seizures), cognitive communication deficit (problem with communication caused by cognition rather than a language or speech deficit), and cerebral palsy (a neurological disorder that affects body movement and muscle coordination caused by abnormal brain development or damage to the brain during pregnancy, childbirth, or shortly after birth). Record review of Resident #8's quarterly MDS, dated [DATE], reflected a BIMS was not conducted due to him rarely/never being understood. Section C - Cognitive Patterned reflected Resident #8 had memory problem with short-term and long-term memory. Record review of Resident #8's order summary, dated 08/07/2025, reflected Phenobarbital Oral Elixir 20MG/5ML (Phenobarbital) Give 15 ml via PEG-tube [a tube surgically inserted directly to the stomach for nourishment and medication administration] two times a day for seizures. An observation on 08/07/2025 at 08:26 AM of hall 5 nurses' medication cart with the WC LVN revealed a bottle of phenobarbital that was full, manufacturer label stated 473ml, 2/2 was handwritten on the top of the bottle. The bottle of phenobarbital had a prescription label for Resident #8. The narcotic count sheet revealed under the amount remaining column 1397. Record review of Resident #8's phenobarbital narcotic count sheet reflected 2 bottles of phenobarbital was received from the pharmacy on 07/17/2025 in the amount of 946 ml, but the staff member that received the medication doubled that starting amount to 1892 ml. During an interview on 08/07/2025 at 08:28 AM with the WC LVN, she stated she had just received the keys and did not count with the previous person due to being nervous about medication administration observation. She stated it appeared the staff member who received the medication doubled the amount of medication received because there were two bottles, and everyone had just subtracted the amount taken instead of counting what was there. During an observation and interview on 08/07/2025 at 08:48 AM, the DON was notified of the miscalculation and medication reconciliation (corrected medication count) with 973 ml was completed by the DON and WC LVN together. The DON stated the medication form appeared to be miscalculated due to the first incorrect calculation. He stated it was his expectation that staff count the medication in front of them and not calculate the remaining amount based off previous totals. He stated he would start an in-service for staff related to correctly counting narcotics. An observation on 08/07/2025 at 11:22 AM of the medication storage room (facility had only one) with the ADON revealed three bottles of Oyster Shell Calcium with Vitamin D 500mg-5mcg with an expiration date of 06/2025. During an interview on 08/07/2025 at 11:28 AM with the ADON, she verified the three bottles of medication (Calcium with Vitamin D) were expired. She stated all nursing staff with access to the medication room were responsible for checking for expired medications. The ADON stated there was not a specific staff member or timeline assigned for checking the medication storage room for expired (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chisolm Trail Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. She stated the DON periodically checked to ensure staff were checking the medication storage room for expired medications. The ADON stated medication may lose their effectiveness if given to a resident past the expiration date. An observation on 08/07/2025 at 12:42 PM of the hall 1 nurses' medication cart with LVN G revealed one bottle of Bismuth Subsalicylate 525mg/30ml with an expiration date of 08/2024. During an interview on 08/07/2025 at 12:53 PM with LVN G, she verified the bottle of medication (Bismuth Subsalicylate) was expired. LVN G stated she had worked at the facility for 2 weeks. She stated she was unsure who was responsible for checking for expired medications on the medication carts. She also was unsure of how often the carts were checked for expired medications. LVN G stated if an expired medication was administered to a resident, then the medication may not be as effective, or the resident could develop an illness including an upset stomach. During an interview on 08/07/2025 at 03:11 PM with the WC LVN, she stated all the nurses were responsible for checking the medication storage room for expired medications, and she stated she was unsure how often the medication storage room was being checked. The WC LVN stated she was unsure if anyone verified the medication storage room was being checked for expired medications. She stated the nurses and medication aides assigned to the medication cart were responsible for checking for expired medications daily. The WC LVN stated she was unsure if anyone verified the medication carts were checked for expired medications. The WC LVN stated if an expired medication was administered to a resident, the medication may not be as effective. She stated the off-going and on-coming nurse are responsible for counting the controlled medications anytime the keys to the medication cart changed hands. She stated the resident could negatively be impacted by not counting each time the keys changed hands, because the resident may run out of medication faster than reflected on the count sheet and miss a dose. During an interview on 08/07/2025 at 04:10 PM with the MDS LVN, she stated she was unsure who or how often the medication storage room was checked for expired medications. The MDS LVN stated the nurses were responsible for checking all medication carts for expired medications, but she stated she was unsure how often the medication carts were checked. The MDS LVN stated if an expired medication was administered to a resident, the medication may not have the intended effect. She stated the charge nurse was responsible for counting the controlled medications between each shift. She stated if the medications were not counted correctly, then the resident could run out of medication sooner than expected which could possibly lead to seizures. During an interview on 08/07/2025 at 04:49 PM with the MR LVN, she stated all nursing staff with access to the medication storage room were responsible for checking the medication storage room for expired medication at least one time a month. She stated the nurses and medication aides responsible for the medication carts were responsible for checking the medication carts for expired medications weekly. The MR LVN stated if an expired medication were administered to a resident, then the resident might have an adverse reaction like, diarrhea, stomach pain, or an intolerance to the medication. She stated the nurses were responsible for counting all controlled medications at shift change. She stated she did not think that by not counting the medication accurately, it could negatively affect a resident. During an interview on 08/07/2025 at 05:06 PM with the DON, he stated he expected the central supply person and charge nurses to check the medication storage room daily for expired medications. He stated there was not a process in place for ensuring the medication storage room was checked. The DON stated he expected the nurses and medication aides to check the medication carts every shift for expired medications. He stated there was not a process in place for ensuring the medication carts were checked for expired medications. The DON stated if a resident was given an expired medication, then the resident could have an adverse reaction like anaphylaxis (an allergy to something that can cause the throat to swell and close) and it would also me a medication error. The stated he expected the charge nurses and medications aides to count the controlled medications in the medication carts each shift. He stated he sign off sheets that indicated staff counted together every other day or so. He stated if the controlled medication count sheets were not accurate then the resident might be billed for more medication than is allowed or the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident could possibly miss a dose due to lack of medication. During an interview on 08/07/2025 at 05:35 PM with the ADM, he stated he expected the nursing team to check the medication room for expired medications at least monthly. He stated he expected the nurses to check the medication carts for expired medications daily. The ADM stated the nursing administration team was responsible for verifying expired medications were removed from the medication carts weekly. The ADM stated he was unsure how administering expired medication could negatively impact a resident. He stated the nurses were responsible for counting all controlled medications in their medication cart during shift change. He stated nursing management monitored for the nurses to count the controlled medications daily. The ADM stated if the controlled medications were not counted accurately, then a resident may miss a dose of medication. Record review of facility policy titled Medication Storage in the Facility, dated 2025, revealed: Policy.Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Procedure.13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists[spelling?]. Record review of facility policy titled Storage of a Controlled Substance, dated 2003, and facility policy titled Medication Storage in the Facility, dated 2025, revealed no mention counting medication.Record review of facility in-service titled Narcotic Count, dated 08/07/2025, revealed .Accurate count when receiving medication and narcotic count each shift is crucial.1. When receiving any type of controlled substances whether it is from pharmacy or an admission, two signatures are required for verification.2. Narcotic count is required at shift change or when another staff member takes over the cart at any time.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 3 (hall 1 nurse's medication cart) Nurse's medication carts reviewed. 1. The facility failed to ensure the nurses' medication cart for hall 1 was secured by a lock when it was left unattended by LVN G on 08/07/2025. These failures could place residents at risk of illness or injury due to missing medication or if unattended medication were consumed. Findings included: An observation on 08/07/2025 at 10:23 AM on hall 1 revealed the nurses' medication cart for hall 1 was left unattended and unlocked. During an interview on 08/07/2025 at 10:25 AM with LVN G, she stated she was responsible for the hall 1 nurses' medication cart that was left unlocked. She stated she forgot to lock the medication cart when she walked down hall 1. She stated leaving the medication cart unlocked could negatively impact a resident because anyone could get into the medication cart and take something they are not supposed to. During an interview on 08/07/2025 at 03:11 PM with the WC LVN, The WC LVN stated the policy of the facility was to lock the medication cart to secure it any time staff walked away from it. She stated it was the responsibility of the staff member who had the keys to the cart to lock the cart. The WC LVN stated if a medication cart were left unlocked, then a resident could get into the medications, take a medication that was not meant for them, and have an adverse reaction, or a medication may go missing and the resident might miss a dose. During an interview on 08/07/2025 at 04:10 PM with the MDS LVN, The MDS LVN stated the policy for securing the medication carts was to take the keys and lock it anytime staff walk away from the medication cart. She stated the staff member with the keys to the medication cart was responsible for ensuring it was secured when they walk away from it. She stated securing the medication carts was monitored daily during walking rounds by management staff. The MDS LVN stated a resident could take a medication that was not meant for them, or a resident could access an ointment meant for the skin and eat it. During an interview on 08/07/2025 at 04:49 PM with the MR LVN, The MR LVN stated the facility's policy was too close and lock the medication cart anytime the staff member responsible for the cart walked away from it. She stated nursing management did walking rounds two times a day and ensuring the medication carts were closed and locked was included in the rounds. The MR LVN stated, if a medication cart was left unlocked, then a resident could take a medication not meant for them and it could cause adverse reactions like dizziness and falls. During an interview on 08/07/2025 at 05:06 PM with the DON, The DON stated the policy was to lock all medication carts when left unattended. He stated it was the responsibility of the staff member who was signed off responsibility of the cart at the beginning of their shift to keep the cart locked when left unattended. He stated all staff were responsible for monitoring if a cart was left unlocked. The DON stated if a medication cart were left unlocked, then residents could take something out of the medication cart or put something in the medication cart that did not belong there. He stated, it is a serious safety issue. During an interview on 08/07/2025 at 05:35 PM with the ADM, The ADM stated it was his expectation that staff lock the medication carts anytime they walk away from it. He stated all staff monitor for the medication carts to be locked during their rounds. The ADM stated, if a medication cart were left unlocked, then there is a possibility a resident could get into the medication cart and get something that is not theirs and take it, and that could lead to side effects. Record review of facility policy titled Medication Storage in the Facility, dated 2025, revealed Policy. Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure. 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g., medication (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.		