

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2026
NAME OF PROVIDER OR SUPPLIER  Balch Springs Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  4200 Shepherd LN Balch Springs, TX 75180	

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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to obtain documentation that the residents representative has been delegated the necessary authority to exercise the resident's rights and must verify that a court-appointed representative has the necessary authority for the decision-making at issue as determined by the court. For example, a court-appointed representative might have the power to make financial decisions, but not health care decisions. Additionally, the facility must make reasonable efforts to ensure that it has access to documentation of any change related to the delegation of rights, including a resident's revocation of delegated rights, to ensure that the resident's preferences are being upheld for 1 (Resident #13) of 5 residents (Resident #32, #40, #77, and #80) reviewed for resident representative rights. The facility failed to ensure Resident #13, who was cognitively impaired when admitted to the facility, had a representative who had the authority to make decisions on his behalf. This failure could lead to the facility making decisions without the resident's right to designate a surrogate or representative to make treatment or transfer decisions for the resident; and could deny the resident through the resident representative their wishes and preferences. The findings included: Record Review of Resident #13's face Sheet dated 05/06/2026 Revealed a [AGE] year-old male, and was initially admitted to the facility on [DATE] with diagnoses that included: Cerebral infarction (bleeding incident in the brain), Bipolar Disorder, Schizoaffective Disorder, Bipolar Type, Altered mental Status, Legal Blindness, Malignant Neoplasm of the Larynx (Abnormal/Cancerous Cells Develop in the Voice Box), Dementia, and Cognitive Communication Deficit. No listings were found for any family members or resident representatives. Record Review of Resident #13's Comprehensive Care Plan dated 04/17/2026, revealed goals and interventions that included: Cognitive Impairment: Resident [#13] has impaired cognition and is at risk for a further decline in cognitive and functional abilities related to dementia. Resident [#13] needs supervision/assistance with all decision making. Resident [#13] is dependent on staff for cognitive stimulation, activity attendance, and social interaction related to cognitive impairment and is at risk for isolation. Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, and meals. Record Review of Resident #13's Nursing Home Comprehensive MDS, dated [DATE], revealed that Resident #13 had a BIMS score of 02 (Severe Cognitive Impairment), meaning Resident #13 required high-level supervision and support with daily activities. Record a Review of a Progress note dated 06/06/2023 at 1:33 PM and written by AD reflected that: [Resident #13] is a new admit 06/03/23, transfer from the Hospital [Resident #13] is alert resident is able to communicate seem[ed] to be confuse[d] at time[s] [Resident #13] is [a] blind resident require[ing] full care, no family member is listed on the admission sheet. In an observation on 05/05/2026 at 9:36 AM, Resident #13 was observed laying down on his bed with only his eyes exposed from a sheet covering him. Resident #13 appeared to be awake but would not respond to any questions from the surveyor. In an interview on 05/05/2026 at 10:52 AM, CNA B revealed that they had worked extensively with Resident #13. Resident #13 rarely spoke but could indicate some needs and if he was in pain. CNA B stated that he had never seen Resident #13 have any visitors and was not aware of any family members or a Resident Representative. In and interview on 05/05/2026 at 11:05 (continued on next page)</p>

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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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>AM, CNA C stated That she had worked with Resident #13 many times. She stated that he is generally quiet, did not attempt to answer many questions. She stated that the staff were generally aware of his routine and could generally anticipate when he needed to be changed or to remove his food tray after he was assisted with feeding. She was not aware of Resident #13 having any family members or any type of Resident Representative. In an interview on 05/06/2026 at 10:07 AM, the SW revealed that Resident #13 had no known family members. She stated that the facility had not pursued getting a guardianship (Resident Representative). She stated that the facility does do Care plan Meetings with Resident #13 in his room, but Resident #13 does not participate in the meeting. She stated that Resident #13 cannot make decisions for himself and that the facility should consider getting a Court Appointed Guardian for him. In an observation on 05/06/2026 at 2:34 PM, Resident #13 was observed in his room. He was not responsive to questions. Resident #13 was observed laying on his side, bed in low position, mostly covered in blankets, room cold/clean. No lingering foul odors. No obvious bruising on visible exposed skin. In an interview on 05/07/2026 at 10:41 AM, the DON stated that it was important for a resident that can't communicate to have a guardian or a representative to be able inform us (the staff) of the residents wishes and for proper care. Not having a representative could endanger the resident to isolation and possible lack of care. If they [the Resident] have no family or representative, then we [the facility] have to reach out to the physician and make sure that the resident has a representative. She stated that it was a state-run program for guardianship. She stated that she had dealt with getting guardians for residents before, and that it does not take too long to process. In an interview on 05/07/2026 at 11:29 AM NP revealed that Stated [Resident #13] can communicate immediate needs but not to the level of making decisions about care plans/activities. She stated that she had never seen any family members of any type, and she is unaware of any guardians [for Resident #13]. She stated that some benefits for Resident #13 to have a representative would be to advocate for him. She stated that [after reviewing orders] that there were no orders designating anyone as a guardian or representative [Resident #13's] orders. She stated that it may not be sufficient to have no one as a representative for him. Record review of facility's Resident Rights policy dated revised 05/2017 read: The Resident has the right: .to have a legal representative .</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on interview and record review the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the residents through the means other than a postal service for 6 (confidential residents) of 75 residents reviewed for rights to forms of communication with privacy. The facility failed to deliver mail to the residents within twenty-four hours of delivery on premises or the facility's post office box according to their policy. This failure could place residents at risk of not receiving mail in a timely manner and could result in a decline in residents' psychosocial well-being and quality of life. The findings were: During a confidential group interview, 6 of 9 members in the group stated they never received mail 3 of 9 residents stated mail was not distributed at the facility on Saturdays because the Activity Director did not work on Saturdays. During an interview on 05/06/2026 at 11:47 a.m., the AD revealed that she is responsible for delivering mail. She stated that she passed residents' mail Monday through Friday. She stated that she is not here on the weekends and was not sure if there were any staff assigned to pass mail on Saturdays. The AD stated that when she arrived on Monday mail was in her box to pass out. During an interview on 05/06/2026 at 1:12 PM the Administrator stated that her expectation was for mailed to be passed on Saturday by the weekend staff. The Administrator stated that there was not just one person on the weekend staff assigned to pass mail, just the nursing staff in general. Attempted phone calls to staff who worked on weekends, but was unsuccessful. Record review of facility policy titled Resident Right to Privacy in Communication, revealed, Promptly, means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box and delivery of outgoing mail to the postal office within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of the State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move for 1 resident (Resident #8) of 5 reviewed for notifying the LTC Ombudsman of the residents' discharge. The facility failed to ensure Resident #8 was not discharged on 04/13/2026 without a notice to the LTC state ombudsman. This failure could place residents at risk of not knowing their rights or receiving the services of the state LTC Ombudsman. The findings included: A record review of Resident #8's nursing home discharge MDS Assessment, dated 04/13/2026, reflected the Resident #8 was a [AGE] year old male who was admitted to the facility on [DATE]. Resident #8 had an active diagnosis of Ischemic cardiomyopathy (heart muscle becomes weakened and enlarged, reducing its ability to pump blood, caused by long-term damage from restricted blood flow) and the resident BIMS score was blank. During an interview on 05/05/2026 at 11:47 a.m., the Ombudsman revealed she had never received a discharge notification from the facility. She stated that the facility was required to submit discharge notification every time they do an involuntary discharge, transfer or present discharge paperwork to any resident related to discharge, they are supposed to notify the ombudsman and send a monthly discharge notification to the Ombudsman, but this facility does not ever send the notifications as required. During an interview on 05/06/2026 at 12:45 p.m., the SW stated she had been the facility's SW since February 2026. She stated she had no evidence for a report to the state Ombudsman for Resident #8's discharge. She stated that she was not aware she was supposed to send discharge notification to the Ombudsman monthly. During an interview on 05/07/2026 at 1:12 p.m., the Administrator stated she was unaware of the rule to notify the state ombudsman of any resident discharges. Record review of facility policy titled Transfer and discharge date d October 2017 revealed 7. Non-emergency transfer or discharges - initiated by the facility, return not anticipated. At least 30 days before the resident is transferred or discharged, the Social Services Director will notify the resident and the resident's representative in writing in a language and manner they understand. d. A copy of the notice shall be provided to the representative of the Office of the State Long-Term Care Ombudsman. k. Social Services Director, or designee shall provide notice of transfer to a representative of the State Long Term Care Ombudsman via monthly list.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to coordinate assessments with the PASRR program for 1 of 5 residents (Resident #55) reviewed for PASRR assessments. The facility failed to ensure Resident #55 was referred to the appropriate state-designated mental health authority for review when she received a new diagnosis of schizoaffective disorder, bipolar disorder and anxiety disorder. This failure could place residents at risk of not being evaluated and receiving needed PASRR services. Findings included: Record review of Resident #55's quarterly MDS Assessment, dated 02/10/2026, reflected the Resident #55 was a [AGE] year old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #55 had an active diagnosis of schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), bipolar disorder (mental health condition characterized by extreme, dramatic shifts in mood, energy, and activity levels, alternating between intense highs (mania or hypomania) and lows) and anxiety (a natural human emotion characterized by feelings of worry, nervousness, or unease, typically about an event with an uncertain outcome), and the resident had severe cognitive impairment with a BIMS score of 13. Record review of Resident #55's Care plan, undated reflected Focus: Behavior Problem: Resident has a behavior problem as related to delusional with hallucinations, making false allegations toward others. Goal: The Residents behavior will not interfere with the delivery of care or services or result in harm to self or others through next review date. Interventions/Task: Psychiatric consult per indication or physician order, intervene as necessary to protect the rights and safety of others, and Administer medications as ordered. Monitor and document for effectiveness and potential adverse side effects. Record review of Resident #55's PASRR Level 1 Screening, dated 06/18/25, reflected she did not have a mental illness. PASRR Level 1 screening did not indicate Resident #55 had primary diagnosis of dementia, but had mental illness diagnoses of schizoaffective disorder, bipolar disorder, and anxiety. During an interview on 05/06/25 at 04:04PM, the DON stated if a new diagnosis was given to a resident a new PASRR evaluation should be completed. The DON stated the facility will not accept a resident without a PASRR. The DON stated that the MDS nurse is no longer at the facility and unable to state why a new PASRR had not been completed on Resident #55. The DON stated that the MDS Nurse is the primary person as they import each resident diagnosis onto the MDS. He stated The MDS nurses are monitored by regional MDS Nurse. During an interview on 05/07/2026 at 12:11 p.m., the Regional MDS Nurse stated the facility's MDS Nurse recently left the facility and she was over nine facilities. The Regional MDS Nurse stated that if a new mental health, Intellectual disability, or a developmental disability diagnosis was given to a resident a new PASRR Level 1 evaluation should be completed. The Regional MDS Nurse pulled up Resident #55's medical chart and reviewed her medical chart and stated Resident #55 did not have a Dementia diagnosis and had a diagnosis of schizoaffective disorder, bipolar disorder and anxiety disorder schizophrenia on 06/18/25. She pulled up Resident #55 PASRR Level 1 and stated it was completed on 06/18/2025 the day Resident #55 admitted to the facility. She stated Resident #55 PASRR Level 1 was negative, and she does not how Resident #55 had no next to mental health diagnoses. The Regional MDS Nurse stated she was unable to state why the MDS facility did not draft a new PASSRR Level 1 once new diagnoses were found. She stated she would generate one and submit it for Resident #55. She stated failure to perform screening and involving the authority's resident failed to get required assessments and could lead to her not receiving services that could have benefited her. The Regional MDS Nurses stated there were limited risk to Resident #55 she was already on medication, had psychiatric services and her core morbidities would limit her from activities outside the facility, but she would have missed the local authority (continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>visitation. During an interview on 05/07/2026 at 1:12 p.m., the ADM stated that it was her expectation that the MDS Nurse ensure residents have a PASRR completed prior to resident admission to the facility and to review for accuracy and if error found to send it back to the facility for them to fix. She stated we cannot admit a resident without a PL1. The ADM stated that if any resident while in the facility received a new MI, DI the facility MDS nurse was responsible for creating a PL1 to submit to the local authorities. The ADM stated that they currently do not have an MDS on-site and they utilize the Regional MDS Nurse. Record review of new PASRR Level 1 screening for Resident #55 completed on 05/07/2026. Record review facility PASRR policy dated June 2020 revealed, It is the intent of Advanced Health Care Solutions to meet and abide by all State and Federal regulations that pertain to resident preadmission and screening resident review rules. Referring Entity completes PASRR Level 1: If Negative (Preadmission, Exempted Hospital Discharge or Expedited):If the resident has a qualifying MI or ID diagnosis and the nursing facility feels resident should be positive, they should talk to the referring Entity and ask them to correct the PL1 or complete the 1012.What happens if a referring entity refuses to complete the PL1 Screening Form? The nursing facility must not accept admission from a hospital without a PL1. The nursing facility should contact the referring entity to let them know they cannot admit without the PL1.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #18) of five residents, reviewed for infection control. 1. The facility failed to ensure CNA A performed hand hygiene during incontinence care for Resident #18 and changed her soiled gloves before placing items in her pocket. This failure placed residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #18's Quarterly MDS Assessment, dated 03/13/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 13. Her cognitive skills for daily decision making were moderately impaired. Her diagnoses included end-stage renal failure and diabetes. Record review of Resident #18's Care Plans reflected: Revised 11/11/22 - Resident had an activity of daily living self-care performance deficit. Facility interventions: Toileting - extensive assistance of two staff In an observation on 05/06/26 at 2:40 PM, CNA A prepared supplies to perform incontinence care for Resident #18. CNA A unfastened the brief, grabbed wipes, and cleaned the vaginal area of the resident. CNA A used the same soiled gloves to pick up trash bags, pulled one off, and laid it on the bed. CNA A then placed the roll of trash bags in her pocket. The resident was turned to her left side. CNA A cleaned the resident's buttocks and changed gloves but did not perform hand hygiene. CNA A placed a clean brief under the resident. In an interview on 05/06/26 at 2:50 PM, CNA A said she was supposed to perform hand hygiene when she changed her gloves. CNA A said she was trained to use hand sanitizer, but she forgot to; it slipped her mind. CNA A said she was not supposed to place clean trash bags in her pocket with soiled gloves. CNA A said failure to change soiled gloves and perform hand hygiene could cause infection. In an interview on 05/07/26 at 10:35 AM, the DON said staff were supposed to perform hand hygiene between glove changes and use clean gloves to place things in their pockets. The DON said past in-services with staff included return demonstrations of hand hygiene. He said he monitored staff daily for hand hygiene. Record review of the facility policy, Infection Prevention and Control Program, revised 03/26/24, reflected: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines.</p>		