

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: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Homeplace Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SW Ave F Hamlin, TX 79520	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record reviews, the facility failed to utilize the services of a RN for 8 consecutive hours 7 days a week and designate a RN as a DON on a full-time basis for 1 of 1 facility reviewed for nursing services. The facility failed to ensure an RN worked for 8 consecutive hours for 28 of 79 days reviewed in October and November 2025 until December 18th 2025. The facility failed to designate an RN as a DON on a full-time basis for 2 of 3 months reviewed in October and November 2025 until December 18th 2025. These failures placed all residents at risk for their clinical needs not being met. Findings included During an interview on 12/16/2026 at 10:16 a.m., the AIT stated the facility did not have a DON or RN coverage for eight consecutive hours a day seven days a week. Record review of Monthly Nursing Attendance Calendar for 2025 revealed: RN/DON last date worked was on 11/06/2025. RN/DON hired on 11/04/2025 and her last day worked was on 11/10/2025. 10/01/2025-10/31/2025 had 2 days (10/11/2025 & 10/12/2025) with no RN for 8 consecutive hours. 11/01/2025-11/30/2025 had 3 weeks (the week of 11/10/2025, the week of 11/17/2025, and the week of 11/24/2025) of 4 weeks with no DON. 11/01/2025-11/30/2025 had 11 days (11/13/025, 11/17/2025-11/23/2025, 11/25/2025, 11/27/2025 & 11/29/2025) of 30 days with no RN for 8 consecutive hours. 12/01/2025-12/18/2025 had 2 weeks (the week of 12/01/2025 and the week of 12/08/2025) of 3 weeks with no DON. 12/01/2025-12/18/2025 had 15 days (12/01/2025-12/15/2025) of 18 days with no RN for 8 consecutive hours. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for the facility to have a RN on shift at least eight hours a day seven days a week. She stated she expected the facility to have a DON at least forty hours a week. She stated the facility had a DON but could not find another DON after her last day on 11/10/2025. She stated she had been attempting to get another DON to fill the position with no applicants. She stated on Monday 12/15/2025, they redid their DON position opportunity on the internet and added incentives to try and get more interest in the position. She stated she did not know why there was no RN coverage prior to her starting to work at the facility. She stated her first day was on 11/3/2025. She stated she had corporate oversight, and he was in the building at that time. She stated he had been onsite for 4 days since she had been working as the AIT but had been available by telephone to her. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he was aware the facility did not have RN coverage or an acting DON. He stated he expected the facility to have an RN working eight consecutive hours a day every day of the week. He stated he expected there to be an acting DON in the facility. He stated the facility had been attempting to hire RN staff and a DON, and just recently added incentives to make those positions more desirable. He stated they had one application as of that morning for DON. He stated turnover in management staff led to the failure of those positions not be filled. He stated the AIT was an LVN and the facility had corporate oversight from an RN, but that RN had not worked forty hours a week at the facility. He stated it was the ADMIN who was responsible for making sure there was a DON and the facility had RN coverage. He stated it was his responsibility to monitor the ADMIN filled those positions. He stated he had worked for the corporation for two months and the ADMIN was new as well. He stated there was improvement to be made and the management was aware of the issue prior to today. Record review of (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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility's policy titled, Nursing Services-Registered Nurse (RN), revised on 01/01/2025 reflected 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. 2. The facility will designate a Registered Nurse to serve as the Director of Nursing on a full time basis.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. 1. The facility failed to ensure freezer and refrigerator temperatures were tracked daily. 2. The facility failed to ensure foods were labeled properly. 3. The facility failed to ensure food temperatures were taken before serving. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. The findings included: During an observation on 12/16/2025 at 9:37 AM of the refrigerator revealed: 1. 1 package of food that resembled corn tortillas was in an unopened package, but not in the original box and did not have a label of what the item was, or the date opened or use by date. 2. current temperature showed 33 Fahrenheit. Freezer: 1. 3 slices of food item that appeared to be garlic toast in an opened/unsealed package without label of what it was or a date of when received, date opened, or use by date. 2. 1 opened bag of food items that appeared to be mixed fruit without label or date of when received, date opened, or use by date. 3. 1 opened bag of food items that appeared to be frozen biscuits without date of when received, date opened, or use by date or label. 4. Current temp showed 31 Fahrenheit on external freezer thermometer. Record review of the temperature log of the refrigerator revealed the last documented temperature was on 12/07/2025 in the afternoon of 40 degrees Fahrenheit. There was no further evidence of the temperature logs documented since 12/07/2025. Record review of temperature log of the freezer revealed the last documented temperature was on 12/07/2025 in the afternoon of -2 degrees Fahrenheit. There was no further evidence of temperature logs documented since 12/07/2025. During an interview on 12/16/25 at 9:45 AM, the DM stated temperatures were to be taken from the freezer and refrigerator twice a day and logged by kitchen staff. DM stated she and dietary assistant had been trying to get the kitchen cleaned and corrected from previous dietary staff that had left since the management change. DM stated food temperatures were to be checked before being served by cook and logged on food temperature logs. DM stated foods that were not in original packaging and opened, are to be placed in a sealed container or baggie with the opened date, use by date, and description of what the item is. During an observation of 12/16/2025 at 12:15 pm, Dietary Assistant began taking food temperatures with separate food thermometers on the stove; Lima Beans 125 degrees Fahrenheit; gravy 100 degrees Fahrenheit; carrots 120 degrees Fahrenheit; and chicken 140 degrees Fahrenheit. Dietary staff were not observed documenting the temperatures. During an interview on 12/18/24 8:06 AM, Admin stated the food temperatures should be taken by dietary staff while being prepared and at the time of serving. Her expectation was the food temperatures were completed and logged during each meal. She stated there was a risk to residents of foodborne illness if temps were not within appropriate range for service. ADMIN stated the dietary staff were to check the temperatures inside freezers and refrigerators daily using the thermometer on the inside of the appliance, not the external thermometer. The Admin stated the food temperatures were to be documented on the log completed that was located on the outside of the appliance. The Admin stated the dangers of not having correct food storage temperatures could lead to food spoilage and foodborne illnesses and waste. DMIN stated her expectation for the storage of opened food in refrigerator and freezer was to put food in a baggie or container with a lid with date opened, and date use by, description of the item. Admin stated the dangers of not having the food labeled and dated properly was the possibility of using spoiled or expired food or incorrect food and causing an allergic reaction or a foodborne illness. Record review of the facility's policy titled, Refrigerators and Freezers undated revealed: -Food service supervisors or designated employees will check and record refrigerators and freezer temperatures daily with first opening and at closing in the evening. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates will be (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	marked on cases and on individual items removed from cases for storage. use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. Record review of the facility's policy titled, Pureed Foods Guidelines undated revealed: - For Hot Foods: CCP Reheat to an internal temperature of >165F held for 15 seconds. Maintain at an internal temperature of >140F for only 4 hours. Record review of the facility's policy titled, Food Preparation and Service - The following internal cooking temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms: a. Poultry and stuffed foods - 165 F. b. Ground meat, ground fish and eggs held for service - at least 115 F.c. Fish and other meats - 145 F for 15 seconds.d. Fresh, frozen or canned fruits/vegetables - 135 F.e. Foods cooked in a microwave - 165 in all parts of the food. It is critical to measure the food temperature at multiple sites and allow the food to stand covered for two (2) minutes after microwave beating. Previously cooked food must be reheated to an internal temperature of 165 for at least 15 seconds. Reheated foods that are not consumed within 2 hours will be discarded. Record review of the facility's policy titled, Food Receiving and Storage undated revealed: -All foods stored in refrigerator or freezer will be covered, labeled and dated (use by date); Refrigerated food must be stored at or below 40F unless otherwise specified by law. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the Food Service Manager or designee and documented according to state-specific requirements. Review of the FDA Food Code 2022 https://www.fda.gov/food/guidance-regulation-food-and-dietary-supplements/retail-food-protection reviewed 12/22/2025 revealed: 3 602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents; (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) (5), nutrition labeling as specified in 21 CFR 101 Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and record reviews, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property for 14 of 45 employees (AIT, SW, DM, Maint D, ADON, AD, DOR, RN A, LVN B, LVN C, LVN D, CNA E, CNA F, and CNA G) reviewed for employability. The facility failed to ensure evidence that the criminal history was checked prior to the AIT, SW, DM, Maint D, ADON, AD, DOR, RN A, LVN B, LVN C, CNA E, CNA F, and CNA G being hired or having access to the residents. The facility failed to ensure evidence that the EMR was checked prior to the AIT, AD, DM, Maint D, CNA E, CNA F, and CNA G being hired or having access to residents. The facility failed to ensure evidence that the NAR was checked prior to CNA E, CNA F, and CNA G being hired or having access to the residents. These failures placed residents at risk of receiving care from someone who was unemployable, which increased the risk of abuse, neglect, and exploitation risk. Findings included Record review of the personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence the facility ran a CHC or an EMR check on her prior to her hire date. Record review of the personnel record for the ADON reflected a hire date of 1/04/1994. Further review of personnel record provided by the BO reflected the ADON had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for the AD reflected a hire date of 9/29/2025. Further review of personnel record provided by the BO reflected the AD had no evidence the facility ran a CHC or an EMR check on her prior to her hire date. Record review of the personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence the facility ran a CHC or an EMR check on her prior to her hire date. Record review of the personnel record for the Maint D reflected a hire date of 9/19/2023. Further review of personnel record provided by the BO reflected the Maint D had no evidence the facility ran a CHC or EMR check on him prior to his hire date. Record review of the personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for LVN B reflected a hire date of 9/05/2022. Further review of personnel record provided by the BO reflected LVN B had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for LVN C reflected a hire date of 2/25/1987. Further review of personnel record provided by the BO reflected LVN C had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence the facility ran a CHC on her prior to her hire date. Record review of the personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence the facility ran a CHC, an EMR check, or a NAR check on her prior to her hire date. Record review of the personnel record for CNA F reflected a hire date of 1/09/2023. Further review of personnel record provided by the BO reflected CNA F had no evidence the facility ran a CHC, an EMR check, or a NAR check on her prior to her hire date. Record review of the personnel record for CNA G reflected a hire date of 8/10/2017. Further review of personnel record provided by the BO reflected CNA G had no evidence the facility ran a CHC, an EMR check, or a NAR check on her prior to her hire date. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for all staff to have background checks prior to being allowed to have contact with the residents. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee background checks and employee training into the payroll database for the company because of the change in ownership that occurred in March of 2025. She stated the previous company's employee background checks and previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have background checks, NAR/EMR checks, employee training, and nurse aide annual competency checkoffs on their employees. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July. She stated she had one day when a person sat next to her and trained her. She stated since then, she has had several Team's trainings that she had attended on the computer. She stated she was the housekeeping manager prior to this position. She stated she remembered looking at some of the new hires' background checks but did not know she should have printed them out and could not show proof the background checks had been reviewed. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have background checks prior to being hired along with EMR / NAR checks to unlicensed employees prior to hire. He stated the failure occurred due to change in ownership and change in management. He stated the Admin position had a change over and the facility was currently looking for a DON. He stated it was the Administrator's responsibility to make sure background checks were implemented per regulation and it was his job to monitor that the ADMIN was ensuring those background checks had been done. He stated he was relatively new to the company and did not know why the background checks were not stored in the employee files. He stated he had worked for the company for two months and knew there was improvement to be made. During an interview on 12/18/2025 at 2:45 p.m., the AIT stated the BO manager had run all the employees in question CHCs, EMRs, and NARs and there were no unemployable employees found. Record review of the facility's policy titled, Background Screening Investigations revised on March 2019 reflected, The director of personnel, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment. For any individual applying for a position as a certified nursing assistant, the state nurse aide registry is contacted to determine if any findings of abuse, neglect, mistreatment of individual, and/or theft of property have been entered into the applicant's file. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of individuals, and/or misappropriation of property, the applicant is not employed or contracted. Record review of facility's policy titled, Abuse, Neglect and Exploitation revised on 1/01/2025 reflected, Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, within 14 days after a facility completes a resident's assessment, the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System for 14 (Residents #1, #4, #5, #7, #10, #11, #13, #14, #16, #19, #20, #21, #23, and #24) of 24 reviewed for resident assessments, in that: 1. Resident #1's admission MDS assessment, dated 03/11/2025 and Quarterly MDS's, dated 05/29/2025, 08/26/2025, 09/11/2025, and 11/10/2025 were completed but not transmitted to CMS as of 12/18/2025. 2. Resident #4's admission MDS, dated [DATE] and Quarterly MDS's, dated 05/29/2025, 08/26/2025, 09/11/2025, and 11/10/2025 were completed but not transmitted to CMS as of 12/18/2025. 3. Resident #5's Entry MDS, dated [DATE], admission MDS dated [DATE] and Quarterly MDS's, dated 06/02/2025, 08/25/2025, and 11/24/2025 were completed but not transmitted to CMS as of 12/18/2025. 4. Resident #7's Entry MDS, dated [DATE], admission MDS dated [DATE], and Quarterly MDS's, dated 05/30/2025, 08/19/2025, and 09/08/2025 were completed but not transmitted to CMS as of 12/18/2025. 5. Resident #10's admission MDS, dated [DATE] and Quarterly MDS's, dated 05/29/2025, 08/22/2025, 12/10/2025 and Discharge Return Anticipated dated 09/07/2025 were completed but not transmitted to CMS as of 12/18/2025. 6. Resident #11's Entry MDS, dated [DATE], Admission/Medicare - 5-Day MDS dated [DATE] and Quarterly MDS's, dated 07/25/2025, 07/31/2025, and 10/28/2025 were completed but not transmitted to CMS as of 12/18/2025. 7. Resident #13's Entry MDS, dated [DATE], admission MDS dated [DATE] and Quarterly MDS dated [DATE] were completed but not transmitted to CMS as of 12/18/2025. 8. Resident #14's Entry MDS dated [DATE] and admission MDS, dated [DATE], were completed but not transmitted to CMS as of 12/18/2025. 9. Resident #16's Entry MDS's dated 08/02/2025 and 10/20/2025, admission MDS, dated [DATE], Discharge Return Anticipated dated 10/13/2025 and Significant Change MDS dated [DATE] were completed but not transmitted to CMS as of 12/18/2025. 10. Resident #19's Quarterly MDS's dated 05/28/2025 and 09/20/2025, and Significant Change MDS dated [DATE] were completed but not transmitted to CMS as of 12/18/2025. 11. Resident #20's Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 06/03/2025, 08/15/2025, and 11/14/2025 were completed but not transmitted to CMS as of 12/18/2025. 12. Resident #21's Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 05/26/2025, 08/25/2025, and 11/12/2025 were completed but not transmitted to CMS as of 12/18/2025. 13. Resident #23's Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 08/26/2025, and 12/03/2025 were completed but not transmitted to CMS as of 12/18/2025. 14. Resident #24's Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 04/11/2025, 07/11/2025, and 10/11/2025 were completed but not transmitted to CMS as of 12/18/2025. These failures could place residents at risk of not having their assessments completed timely, which could result in denial of services and or denial of payment for services. The findings were: 1. Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses including Alzheimer's disease, non-insulin dependent diabetes. History of falls, obesity, schizoaffective disorder (a combination of symptoms of schizophrenia and a major mood disorder), major depressive disorder, anxiety, insomnia, high blood pressure, heartburn, difficulty swallowing, stroke, and high cholesterol. Review of Resident #1's MDS assessments list revealed his admission MDS dated [DATE] and Quarterly MDS's, dated 05/29/2025, 08/26/2025, 09/11/2025, and 11/10/2025 had been completed but not transmitted to CMS with a status of export ready. 2. Record review of Resident #4's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses including chronic obstructive pulmonary disease (a progressive lung condition), weakness, anxiety, mood disorder, schizoaffective disorder, heartburn, low back pain, arthritis, difficulty walking, (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia, and need for assistance with personal care. Review of Resident #4's MDS assessments list revealed his admission MDS, dated [DATE] and Quarterly MDS's, dated 05/29/2025, 08/26/2025, 09/11/2025, and 11/10/2025 had been completed but not transmitted to CMS with a status of export ready. 3. Record review of Resident #5's face sheet, dated 05/16/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including epilepsy, intellectual disabilities, malnutrition, depression, anxiety, schizoaffective disorder, obsessive-compulsive disorder, pain, heartburn, multiple contractures (a permanent tightening and stiffening of tissues that cause restriction of movement or deformity in joints), tremors, difficulty walking, and difficulty with speech. Review of Resident #5's MDS assessments list revealed her Entry MDS, dated [DATE], admission MDS dated [DATE] and Quarterly MDS's, dated 06/02/2025, 08/25/2025, and 11/24/2025 had been completed but not transmitted to CMS with a status of export ready. 4. Record review of Resident #7's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including weakness, dementia, epilepsy, low blood calcium, low blood potassium, anxiety, insomnia, stroke, difficulty with speech, pain, amnesia, nausea with vomiting, and urgency of urination. Review of Resident #7's MDS assessments list revealed her Entry MDS, dated [DATE], admission MDS dated [DATE], and Quarterly MDS's, dated 05/30/2025, 08/19/2025, and 09/08/2025 had been completed but not transmitted to CMS with a status of export ready. 5. Record review of Resident #10's face sheet revealed an [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with medical diagnoses including Alzheimer's disease, atrial fibrillation (irregular heart rhythm), chronic obstructive pulmonary disease, weakness, difficulty walking, low heart rate, Parkinson's disease, depression, epilepsy, chronic pain, heartburn, tremor, and abdominal aortic aneurysm (a weakened or building swelling of the aorta, the main artery in the body located in the abdominal cavity). Review of Resident #10's MDS assessments list revealed his admission MDS dated [DATE] and Quarterly MDS's dated 05/29/2025, 08/22/2025, 12/10/2025 and Discharge Return Anticipated dated 09/07/2025 had been completed but not transmitted to CMS with a status of export ready. 6. Record review of Resident #11's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including difficulty walking, high blood pressure, heartburn, weakness, constipation, and pneumonia. Review of Resident #11's MDS assessments list revealed her Entry MDS, dated [DATE], Admission/Medicare - 5-Day MDS dated [DATE] and Quarterly MDS's, dated 07/25/2025, 07/31/2025, and 10/28/2025 had been completed but not transmitted to CMS with a status of export ready. 7. Record review of Resident #13's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including heart failure, difficulty walking, overactive bladder, weakness, high cholesterol, anxiety, high blood pressure, mitral valve disorder, rheumatoid arthritis (an autoimmune disease that attacks the joints), gout (inflammatory arthritis), systemic lupus erythematosus (an autoimmune disease that causes inflammation and damage to joints, skin, kidney, brain, and other tissues), and chronic kidney disease. Review of Resident #13's MDS assessments list revealed her Entry MDS, dated [DATE], admission MDS dated [DATE] and Quarterly MDS dated [DATE] had been completed but not transmitted to CMS with a status of export ready. 8. Record review of Resident #14's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including panic disorder, chronic pain, opioid dependence, depression, and low back pain. Review of Resident #14's MDS assessments list revealed her Entry MDS dated [DATE] and admission MDS, dated [DATE] had been completed but not transmitted to CMS with a status of export ready. 9. Record review of Resident #16's face sheet revealed a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with medical diagnoses including osteomyelitis (a bone infection), difficulty walking, insomnia, heartburn, weakness, methicillin resistant staphylococcus aureus infection (an infection resistant to multiple antibiotics), constipation, obstructive and reflux uropathy (disease of the urinary tract), high blood pressure, and foot ulcer. Review of Resident #16's MDS assessments list revealed (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her Entry MDS's dated 08/02/2025 and 10/20/2025, admission MDS, dated [DATE], Discharge Return Anticipated dated 10/13/2025 and Significant Change MDS dated [DATE] had been completed but not transmitted to CMS with a status of export ready.10. Record review of Resident #19's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including dementia, heart failure, shoulder pain, high cholesterol, edema (swelling), low blood potassium, difficulty walking, and constipation. Review of Resident #19's MDS assessments list revealed her Quarterly MDS's dated 05/28/2025 and 09/20/2025, and Significant Change MDS dated [DATE] had been completed but not transmitted to CMS with a status of export ready.11. Record review of Resident #20's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including Alzheimer's disease, high blood pressure, weakness, edema, low blood potassium, insomnia, constipation, knee pain, anxiety, slow heart rate, and history of falls. Review of Resident #20's MDS assessments list revealed her Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 06/03/2025, 08/15/2025, and 11/14/2025 had been completed but not transmitted to CMS with a status of export ready.12. Record review of Resident #21's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including Alzheimer's disease, weakness, repeated falls, malnutrition, low blood potassium, dementia, delusional disorder, schizoaffective disorder, major depressive disorder, transient cerebral ischemic attacks (temporary blockage of blood flow in the brain, mini stroke), high blood pressure, heart disease, contracture, myalgia (muscle pain), difficulty swallowing, edema, and abnormal posture. Review of Resident #21's MDS assessments list revealed her Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 05/26/2025, 08/25/2025, and 11/12/202 had been completed but not transmitted to CMS with a status of export ready.13. Record review of Resident #23's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including neurocognitive disorder with Lewy bodies (abnormal clumps of protein that forms in the brain), fracture of her left upper arm, weakness, diarrhea, high cholesterol, depression, atrial fibrillation, and fibromyalgia (widespread body pain). Review of Resident #23's MDS assessments list revealed her Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 08/26/2025, and 12/03/2025 had been completed but not transmitted to CMS with a status of export ready.14. Record review of Resident #24's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses including Alzheimer's disease, atrial fibrillation, gout, heartburn, high blood pressure, weakness, anemia, low blood potassium, major depressive disorder, panic disorder, insomnia, sleep apnea, and shortness of breath. Review of Resident #24's MDS assessments list revealed her Entry MDS dated [DATE], admission MDS, dated [DATE] and Quarterly MDS's, dated 04/11/2025, 07/11/2025, and 10/11/2025 had been completed but not transmitted to CMS with a status of export ready. During an interview on 12/18/2025 at 8:10 a.m., the RCN stated the reason the MDS's had not been transmitted was due a change of ownership in progress. He stated the facility was waiting for a new number to be assigned before transmission would be possible. RNC provided the name and contact information for the person at corporate that was responsible for monitoring the MDS's. During an interview on 12/18/2025 at 09:56 a.m., the corporate DOMDS stated she was responsible for oversight of MDS completion for 8 facilities. She stated the delay in transmitting MDS's for the facility was due to waiting for a new contract number and was almost there in receiving the number. She explained the process of transmitting was to upload the completed MDS into an online program which then transmitted the data to CMS. She stated without the contract number the system would not recognize the transmittal. She stated CMS was familiar with the process therefore she anticipated no penalties will be levied by CMS. The DOMDS stated the ADON at the facility was responsible for completing the MDS and preparing for transmission. She stated all MDS's for the facility were completed on time. The DOMDS was unable to state any adverse effect failure to transmit the MDS's may have on the residents. During an interview on 12/18/2025 at 11:22 a.m., the ADON stated her understanding of the reason for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the delay in transmitting was because corporate was waiting for notification that the new provider number had been assigned. She stated when corporate received the number, she would be able to transmit the MDS's. The ADON was unable to state an adverse effect on residents from failing to transmit the MDS's. During an interview on 12/18/2025 at 11:20 a.m., the AIT stated the reason the MDS's had not been transmitted was because the change of ownership was not complete until about a week ago. She stated the ADON was not able to transmit completed MDS's during the change. Record review of the facility's policy, MDS Completion and Submission Timeframes, dated 2001, revealed, Our facility will conduct and submit resident assessments in accordance with the current federal and state submission timeframes.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interviews and record reviews, the facility failed to complete a performance review of each CNA at least once every 12 months, for 2 of 3 (CNA F & CNA G) reviewed for nursing services. The facility failed to complete annual CNA competency evaluations for CNA F and CNA G, based on the personnel file review results. This failure could affect residents by placing them at risk of not receiving consistent, appropriate interventions necessary to meet the residents' needs. Findings included Record review of the Personnel File Review completed on 12/18/2025, reflected CNA F was hired on 1/09/2023. Further review reflected CNA F did not have a competency evaluation on file. Record review of the Personnel File Review completed on 12/18/2025, reflected CNA G was hired on 8/10/2017. Further review reflected CNA F did not have a competency evaluation on file. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she did not have any annual competencies on record for CNA F and CNA G. During an investigation on 12/18/2025 at 9:20 a.m., the RCN stated he would not know where the CNA competencies would be filed if not in CNA F and CNA G's employee files. He stated he was going through the DON's office to look to see if there was any documentation of those somewhere else. He stated CNAs should have training and competency checkoffs per regulation. He stated he had not been working for the company for long, but that would be the DON's responsibility. He stated that he had reached out to the previous DON to see if she would respond on where training and competencies may be if not in their employee files. He stated that CNAs should have training and competencies, and he would monitor that the DON was providing those per requirements. He stated the facility did not have a DON at that time and was actively attempting to hire one. Record review of the Facility Assessment Tool, dated 6/12/2025, reflected Staff training/education and competencies: Annual education, education upon hire and competencies are developed for all staff based on their job title.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 5 (Resident #9, Resident #10, Resident #19, Resident #20, and Resident #23) of 5 residents reviewed for hospice services. 1. The facility failed to maintain the required hospice forms and documentation, that included the Hospice Election Form, for Resident #10, Resident #19, and Resident #20 Resident #23 were. 2. The facility failed to have a communication process, including how the communication will be documented between the facility and the hospice provider, for Resident #9, Resident #10, Resident #19, Resident #20, and Resident #23. 3. The facility failed to ensure a staff member was designated to communicate with hospice agencies. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: Resident #9 Review of Resident #9's electronic face sheet accessed on 12/18/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: depression, anxiety, and pain. Review of Resident #9's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 03 which indicated severe cognitive impairment. Review of Section O revealed Resident #9 was on hospice care. Review of Resident #9's Comprehensive Care Plan last revised 10/23/2025, revealed: The resident has a terminal prognosis related too being admitted to hospice. Review of Resident #9's electronic Physicians Orders revealed: Admit to hospice services for diagnosis of severe protein-calorie malnutrition, dated 11/28/2025. Review of Resident #9's clinical records revealed no evidence of communication between the facility and the hospice provider for Resident #9. Resident #10 Review of Resident #10's electronic face sheet accessed on 12/18/2025, revealed an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease, fracture of vertebra, adjustment disorder. Review of Resident #10's Quarterly MDS dated [DATE], revealed a BIMS score of 06 which indicated severe cognitive impairment. Review of Section O: revealed Resident #10 was on hospice care. Review of Resident #10's Comprehensive Care Plan last revised 12/15/2025, revealed no evidence of Resident #10 being on hospice services and no evidence of code status. Review of Resident #10's electronic Physicians Orders revealed: Admit to hospice services, dated 09/11/2025. Review of Resident #10's clinical records revealed no evidence of the required hospice forms and documentation, that included the Hospice Election Form or any form of communication between the facility and the hospice provider for Resident #10. Resident #19 Review of Resident #19's electronic face sheet accessed on 12/18/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease, mild protein-calorie malnutrition, and heart surgery. Review of Resident #19's Quarterly MDS dated [DATE], revealed no BIMS score completed. Review of Section O: revealed Resident #19 was on hospice care. Review of Resident #19's Comprehensive Care Plan last revised 06/23/2025, revealed: The resident has a terminal prognosis and has been admitted to hospice services for Alzheimer's disease. Review of Resident #19's electronic Physicians Orders revealed: Admit to hospice services for diagnosis of Alzheimer's disease, dated 06/19/2025. Review of Resident #19's clinical records revealed no evidence of the required hospice forms and documentation, that included the Hospice Election Form or any form of communication between the facility and the hospice provider for Resident #19. Resident #20 Review of Resident #20's electronic face sheet accessed on 12/18/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease, mild protein-calorie malnutrition, and heart failure. Review of Resident #20's (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Quarterly MDS dated [DATE], revealed a BIMS score of 02 which indicated severe cognitive impairment. Review of Section O: revealed Resident #20 was on hospice care. Review of Resident #20's Comprehensive Care Plan last revised 04/21/2025, revealed: Focus: The resident has a terminal prognosis related to Alzheimer's disease. Interventions: consult with physician and social services to have hospice care for resident in the facility. Review of Resident #20's electronic Physicians Orders revealed: Admit to hospice services for diagnosis of Alzheimer's disease, dated 03/07/2025. Review of Resident #20's clinical records revealed no evidence of the required hospice forms and documentation, that included the Hospice Election Form or any form of communication between the facility and the hospice provider for Resident #20. Resident #23 Review of Resident #23's electronic face sheet accessed on 12/18/2025, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: fracture of arm, depression, and disorders of bone and structure. Review of Resident #23's Quarterly MDS dated [DATE], revealed a BIMS score of 07 which indicated severe cognitive impairment. Review of Section O: revealed Resident #20 was on hospice care. Review of Resident #23's Comprehensive Care Plan last revised 06/23/2025, revealed: Focus: The resident has a terminal prognosis and is on hospice services for end stage dementia. Review of Resident #23's electronic Physicians Orders revealed: Admit to hospice services for diagnosis of dementia, dated 05/29/2025. Review of Resident #23's clinical records revealed no evidence of the required hospice forms and documentation, that included the Hospice Election Form or any form of communication between the facility and the hospice provider for Resident #23. During an interview on 12/18/2025 at 12:53 PM, the Administrator stated that there was no designated facility staff member to work with and communicate with hospice. She stated that communication was just done verbally with the charge nurses. She stated there was no documented communication. She stated that she was not aware that was a regulation. She stated that the DON was responsible for ensuring that all hospice documents were in the facility but since there currently was no DON it would be the ADON. Review of facility's policy titled, Hospice Program, revised July 2017, revealed in part: Policy Statement: Hospice services are available to residents at the end of life. Policy Interpretation and Implementation . 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual residents' needs. These responsibilities include the following .d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day .12. Our facility is responsible for a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process. B. Communicating with hospice representatives and other healthcare providers participating on the provision of care .d. Obtaining the following information from the hospice . 3.) Physician certification of the terminal illness specific to each resident.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to 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 2 of 2 (CNA-E and CNA-I) staff observed during incontinent care, and the storage of ice scoop for 1 of 1 ice chest reviewed for infection control. 1. The facility failed to ensure CNA E and CNA I performed appropriate hand hygiene during peri-care for Resident #24. 2. The facility failed to ensure the ice scoop for the ice chest was stored outside of the ice chest. These failures placed residents of the facility at risk of infection spread from cross contamination of ice in ice chest and improper hand hygiene. Findings included Record Review of the Resident #24's electronic face sheet, dated 12/18/2025, revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses including Alzheimer's disease a progressive brain disorder that slowly destroys memory and thinking skills, eventually making it difficult to perform simple tasks. Record review of Resident #24's quarterly MDS assessment dated [DATE] reflected a BIMS score of 5 indicating severe cognitive impairment. Further review of the MDS reflected that she was dependent on staff for toileting hygiene, and Resident #24 always had bowel and bladder incontinence. Record review of Resident #24's comprehensive care plan accessed on 12/18/2025 reflected she had self-care performance deficit related to confusion and needed extensive assistance by staff for toileting initiated on 5/14/2025. Further review of the comprehensive care plan reflected she had a urinary tract infection (bladder infection) and antibiotic therapy was ordered with intervention to include caregiver teaching should include good hygiene practices initiated on 11/17/2025. During an observation and interview on 12/16/2025 at 10:59 a.m., the ice chest sitting in front of the nurses' station with the lid closed had the ice scoop sitting inside of the chest in the ice. The ADON/IP was sitting behind the nurses' station and stated that it was the only ice chest for the whole facility. She stated the ice scoop should not be left inside of the chest. She stated she would get the ice dumped and refilled due to having the scoop inside which could cause infection from cross contamination. During an observation on 12/17/2025 at 9:02 a.m., CNA E and CNA I performed incontinent care on Resident #24. Both CNA E and CNA I placed the gloves on their hands after performing hand hygiene using soap and water. They positioned Resident #24 in the bed on a draw mat (mat that lays under a resident to help with positioning in bed). CNA E and CNA I both assisted Resident #24 with lowering her pants and removing them. Resident #24's brief was then folded back in between her legs after the tabs were unsecured on both sides by CNA E. CNA E asked Resident #24 to spread her legs so she could clean her skin, and Resident #24 clinched her legs together. CNA E then assisted Resident #24 to roll toward CNA I with CNA I's assistance, stating she would have to clean her once the brief was removed. CNA E removed the urine soiled brief from Resident #24 when she was positioned on her left side. Resident #24 was assisted back to her back by both CNA E and CNA I without cleaning her skin. Resident #24's skin was cleaned with disposable wipes by CNA E disposing of the wipes into a plastic bag after each use. CNA E wiped the right inner fold, the left inner fold, then down the labia. Resident #24 was then assisted onto her left side again by CNA E and CNA I and the back of her skin was cleaned with disposable wipes three times disposing of the wipes into a plastic bag after each use. CNA E then placed a clean brief under the resident's left side and on top of the soiled draw sheet. CNA E put some of the cream on her right hand and applied that to Resident #24's skin. CNA E removed the gloves from both her hands. After closing and sitting the multiuse skin protectant cream bottle on the bed, CNA E placed new gloves onto both her hands without performing hand hygiene. CNA E then helped CNA I reposition Resident #24 on her back. Both CNAs fastened the brief together after pulling the front through Resident #24's legs. Both CNAs removed their gloves and threw them away in the plastic bag with other trash. Both CNAs helped Resident #24 to cover up with her bed sheet and cover. CNA E then positioned the bed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using the bed control and gave Resident #24 her call light. CNA I had stopped to help Resident #24's roommate find the sink and soap to wash her hands as the roommate was asking where she could wash her hands as she entered the room. CNA I grabbed a paper napkin to hand to Resident #24's roommate out of the dispenser next to the sink. Both CNAs washed their hands with soap and water before they left Resident #24's room. During an interview on 12/17/2025 at 9:15 a.m., both CNA E and CNA I stated they should have put a pad down over the draw mat if they were putting a resident's uncleaned skin after incontinence on it. They stated they should have washed hands after removal of their gloves and prior to touching other items in the room. They stated they were both nervous from being watched perform the task which led to them failing to perform hand hygiene when moving from a dirty task to a clean task. CNA E stated she should have taken her soiled gloves off and performed hand hygiene prior to reaching into the drawer and removing clean supplies. They stated not performing hand hygiene, removing gloves, and placing unclean skin on bedding could cause infection from contaminating clean surfaces. CNA E stated she had been trained by other CNAs when she started to work at the facility and had training during CNA certification on hand hygiene. CNA E stated she had just returned to working in the facility and did not remember getting infection prevention training when she was re-hired. CNA I stated she believed she was also trained by other CNAs during orientation, but that was over a year ago. She stated she wasn't sure but thought she had a skills checkoff after she had been working in the facility. During an interview on 12/17/2025 at 1:37 p.m., the ADON stated she was the IP of the facility. She stated the DON quit working for the facility back in September 9th or 10th of 2025. She stated the facility hired a new DON but she only worked for 3 days then left. The ADON stated the RCN had worked in the facility about 3 weeks ago and then again this week. She stated she could reach out to the RCN with any issues via the telephone when he was not onsite. She stated staff had not received any in-services since the DON quit in September. She stated she attempted to monitor that staff were following infection control prevention, but she had been working the floor and did not have time to monitor them lately. She stated her expectation would be for staff to not place resident's unclean skin on a clean draw mat without changing that draw mat out. She stated she expected for all staff to take off gloves and clean their hands prior to reaching into a drawer. She stated she expected for staff to perform hand hygiene after taking their gloves off prior to touching anything else. She stated the staff needed more education on infection control, and the DON had provided the training in the past. She stated not performing hand hygiene and other infection prevention during incontinent care could lead to residents getting an infection and could spread infection to other residents through cross contamination. Record review of the personnel file for CNA E reflected the facility had no evidence that she had been trained in infection control and her hire date was 11/06/2025. During an interview on 12/18/2025 at 9:20 a.m., the RCN stated he expected the ice scoop not to be stored in the ice chest. He stated he expected what was dirty to remain dirty and not be cross contaminated with a clean environment. He stated he would expect for staff to wash hands with soap and water or use ABHR when changing gloves. He stated staff should not have reached into a drawer with a gloved hand after using that hand to wipe incontinent substances. He stated he expected the draw mat to be changed from the bed if it came in contact with soiled skin during incontinent care. He stated all those failures could cause infection spread from cross contamination. He stated he had coached those CNAs prior to them providing incontinent care and did not feel the facility not being able to show required onboarding and annual training in infection control would have prevented staff from not following infection control. He stated he was told by CNA E and CNA I they were nervous and that led to the failure. He stated he was available to the staff by phone and in person but verified that he does not work at the facility for forty hours a week. Review of facility's policy titled Handwashing/Hand Hygiene, dated October 2023, reflected Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task; after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal.		

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NAME OF PROVIDER OR SUPPLIER Homeplace Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SW Ave F Hamlin, TX 79520	
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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interviews and record reviews, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 9 of 15 (the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on HIV, restraint reduction and prevention of falls. The facility failed to implement and maintain a training program that ensured the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H received required HIV training upon hire. The facility failed to implement and maintain a training program that ensured the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H received required restraint reduction training upon hire. The facility failed to implement and maintain a training program that ensured the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H received required prevention of falls training upon hire. These failures could place residents at risk of being cared for by staff who had been insufficiently trained on the mode of HIV transmission, HIV prevention, behaviors related to substance abuse, precautions, rights of an infected individual and behaviors associated with HIV transmission, reduction of restraint use, and prevention of falls. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected that the AIT had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for the AD reflected a hire date of 9/29/2025. Further review of personnel record provided by the BO reflected the AD had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected that the DOR had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed required orientation HIV training, restraint reduction training or fall prevention training. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee trainings. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. She stated she thought that she had training on HIV, fall prevention and restraint reduction prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July 2025. She stated she had one day when she had a person sit next to her and train her and had attended several training on the computer. She stated prior to being in the BO role, she had worked as the HK supervisor for the facility. She stated she had not been aware of orientation training requirements until now. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including HIV to understand the disease and how to prevent spread, restraint reduction training to understand how to reduce restraint use, and prevention of falls to understand how to prevent falls. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on HIV, restraint reduction, or fall prevention. Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs. 10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file. Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator. The facility did not provide a policy that specifically required staff to be trained on HIV, restraint reduction and prevention of falls.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interviews and record reviews, the facility failed to include effective communications as mandatory training for direct care staff all new and existing staff for 8 of 15 (the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on effective communication. The facility failed to ensure communication training was provided to the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H upon hire. This failure could place residents at risk of not understanding their total health status and not effectively being provided notice of rights and services both orally and in writing in a manner that the resident understands. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed required effective communication training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed required effective communication training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. She stated she thought that she had training on communication prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July 2025. She stated she had one day when she had a person sit next to her and train her and had attended several training meetings on the computer. She stated prior to being in the BO role, she (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had worked as the HK supervisor for the facility. She stated she had not been aware of orientation training requirements until now. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including effective communication to understand how to communicate with residents effectively. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on effective communication but thought she had received training on effective communication from a previous employer. Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs. 10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file. Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator. The facility did not provide a policy that specifically required staff to be trained on effective communication.		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interviews and record reviews, the facility failed to ensure staff members were educated on the rights of the resident and the responsibilities of a facility to properly care for its residents. for all new and existing staff for 9 of 15 (the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on resident's rights. The facility failed to ensure that the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H were educated on the rights of the resident, and the responsibilities of the facility to properly care for its residents upon hire. This failure could place residents at risk of their rights not being honored by uninformed staff. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for the AD reflected a hire date of 9/29/2025. Further review of personnel record provided by the BO reflected the AD had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed required resident rights training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed required resident rights training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. She stated she thought that she had training on resident rights prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end (continued on next page)		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of July 2025. She stated she had one day when she had a person sit next to her and train her and had attended several training meetings on the computer. She stated prior to being in the BO role, she had worked as the HK supervisor for the facility. She stated she had not been aware of orientation training requirements until now. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including resident rights to understand the rights each resident had. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on resident's rights but thought she had been trained on resident's rights from a previous employer. Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs. 10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file. Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator. The facility did not provide a policy that specifically required staff to be trained on resident rights.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interviews and record reviews, the facility failed to provide training to their staff that at a minimum educates staff on (1) activities that constitute ANE and misappropriation of resident property; (2) procedures for reporting incidents of ANE or misappropriation of resident property; (3) dementia management and resident abuse prevention for all new and existing staff for 9 of 15 (the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on abuse, neglect, and exploitation and training for dementia management. The facility failed to ensure the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H were educated on abuse, neglect and exploitation & dementia management upon hire. These failures could place residents at risk of being abused, neglected, or exploited by uninformed staff and could delay the facility's investigation of abuse, neglect, or exploitation. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed either the abuse, neglect, and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for the AD reflected a hire date of 9/29/2025. Further review of personnel record provided by the BO reflected the AD had no evidence she had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed either the abuse, neglect, and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed either the abuse, neglect and exploitation training or the dementia management training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for (continued on next page)		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. She stated she thought that she had training on abuse, neglect, and exploitation prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July 2025. She stated she had one day when she had a person sit next to her and train her and had attended several training meetings on the computer. She stated prior to being in the BO role, she had worked as the HK supervisor for the facility. She stated she had not been aware of orientation training requirements until now. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including abuse, neglect, and exploitation to ensure employees knew what those were and how to protect residents from them. He stated dementia management was important to help staff understand how to care for residents diagnosed with dementia. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on abuse, neglect, and exploitation. She stated she did not get orientation on dementia management. She stated she had been trained on these topics from a previous employer. Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs. 10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file. Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator. The facility did not provide a policy that specifically required staff to be trained on abuse, neglect, and exploitation and training for dementia management.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Homeplace Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SW Ave F Hamlin, TX 79520	
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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interviews and record reviews, the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff on the elements and goals of the facility QAPI program for all new and existing staff for 9 of 15 (the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on QAPI. The facility failed to ensure that the AIT, the SW, the AD, the DM, the DOR, RN A, LVN D, CNA E, and HK H were educated on the facility's QAPI program upon hire. This failure could place residents at risk of their quality of care not being improved upon when a known issue had occurred from staff not being informed on the goals and various elements of the QAPI program. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed QAPI training upon hire or while working at the facility. Record review of personnel record for the AD reflected a hire date of 9/29/2025. Further review of personnel record provided by the BO reflected the AD had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed QAPI training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed QAPI training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. She stated she thought that she had training on resident rights prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July 2025. She stated she had one day when she had a person sit next to her and train her and (continued on next page)		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had attended several training meetings on the computer. She stated prior to being in the BO role, she had worked as the HK supervisor for the facility. She stated she had not been aware of orientation training requirements until now. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including the QAPI program to understand the QAPI process. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on the QAPI program. Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs. 10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file. Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator. The facility did not provide a policy that specifically required staff to be trained on QAPI.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interviews and record reviews, the facility failed to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program for all new and existing staff for 8 of 15 (the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on infection control. The facility failed to ensure the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H were educated on infection control upon hire. This failure could place residents at risk of contracting facility acquired infections from staff not being informed on proper infection prevention and control practices when performing resident care activities that pertain to that staff member's role. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed infection control training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed infection control training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed infection control training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed infection control training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed infection control training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed infection control training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed infection control training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed infection control training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July 2025. She stated she had one day when she had a person sit next to her and train her and had attended several training meetings on the computer. She stated prior to being in the BO role, she had worked as the HK supervisor for the facility. She stated she had not been aware of orientation training requirements (continued on next page)		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	until now.During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including infection control to understand how to prevent infections. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on infection control.Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs.10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file.Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator.The facility did not provide a policy that specifically required staff to be trained on infection control.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on interviews and record reviews, the facility failed to include as part of its compliance and ethics program (1) an effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program; (2) annual training if the operating organization operates 5 or more facilities for all new and existing staff for 8 of 15 (the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H) reviewed for training on compliance and ethics. The facility failed to ensure that the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H were educated on compliance and ethics upon hire. This failure could affect residents and place them at risk of being uninformed of compliance and ethics program due to lack of staff training. Findings included Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed compliance and ethics training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed compliance and ethics training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. During an interview on 12/17/2025 at 2:38 p.m., the BO manager stated she had been in the position of the BO since the end of July 2025. She stated she had one day when she had a person sit next to her and train her and had attended several training meetings on the computer. She stated prior to being in the BO role, she had worked as the HK supervisor for the facility. She stated she had not been aware of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orientation training requirements until now.During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including compliance and ethics to understand compliance and ethics. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the organization operated more than 5 facilities. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on compliance and ethics.Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs.10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file.Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator.The facility did not provide a policy that specifically required staff to be trained on compliance and ethics.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interviews and record reviews, the facility failed to provide behavioral health training consistent with the requirements at 483.40 (behavioral health services) and as determined by the facility assessment for 8 of 15 (the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H) staff reviewed for training on behavioral health. The facility failed to ensure that the AIT, the SW, the DM, the DOR, RN A, LVN D, CNA E, and HK H were educated on behavioral health upon hire. This failure could place residents diagnosed with a mental, psychosocial, or substance use disorder at risk of not receiving the care specific to their individual needs. Findings were: Record review of personnel record for the AIT reflected a hire date of 10/17/2025. Further review of personnel record provided by the BO reflected the AIT had no evidence she had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for the SW reflected a hire date of 3/01/2025. Further review of personnel record provided by the BO reflected the SW had no evidence he had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for the DM reflected a hire date of 11/19/2025. Further review of personnel record provided by the BO reflected the DM had no evidence she had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for the DOR reflected a hire date of 5/08/2025. Further review of personnel record provided by the BO reflected the DOR had no evidence she had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for RN A reflected a hire date of 4/21/2025. Further review of personnel record provided by the BO reflected RN A had no evidence she had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for LVN D reflected a hire date of 8/01/2025. Further review of personnel record provided by the BO reflected LVN D had no evidence she had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for CNA E reflected a hire date of 11/06/2025. Further review of personnel record provided by the BO reflected CNA E had no evidence she had completed behavioral health training upon hire or while working at the facility. Record review of personnel record for HK H reflected a hire date of 11/24/2025. Further review of personnel record provided by the BO reflected HK H had no evidence she had completed behavioral health training upon hire or while working at the facility. During an interview on 12/17/2025 at 1:10 p.m., the AIT stated her expectation would be for staff to have appropriate training during orientation and annual per regulation. She stated there had been a changeover in BO managers that occurred approximately two months ago. She stated the BO manager now was hired from her position as housekeeper with the understanding that corporate BO manager would train her. She stated she was told by the BO manager that her job duty training did not occur. The AIT stated she could not reach out to the corporate BO manager because she quit working for the company yesterday. She stated the corporate BO manager was also supposed to load the employee training into the payroll database for this company because of change in ownership that occurred in March of 2025. She stated the previous company's employee training was not found in the payroll database. She stated prior to yesterday, she was not aware that the facility did not have employee training. During an interview on 12/17/2025 at 2:22 p.m., CNA E stated she had worked at the facility in the past and had just started back working in the facility on 11/06/2025. She stated she remembered getting some training through in-services but thought those happened prior to her re-hire. During an interview on 12/18/2025 at 8:14 a.m., the RDO stated he expected all staff to have orientation with appropriate education on required topics including behavioral health to understand behavioral health. He stated he had worked for the company for two months and knew there was improvement to be made. He stated the failure occurred due to change in ownership and change in management in both the DON and the ADMIN. He stated it was the ADMIN's job to make sure all training was implemented per regulations. He stated he was responsible for (continued on next page)		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring those trainings had occurred. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated she had not received any orientation training on behavioral health. Record review of facility policy titled Orientation, with revision date of 1/02/2025, reflected 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's orientation program. This person works closely with each department head for scheduling orientation sessions and developing orientation plans. 2. Orientation plans are maintained by the Staff Development Coordinator. a. General orientation plans reflect the onboarding process for all newly hired employees, and reflect content that is applicable to all staff. b. Departmental orientation plans reflect the skills and competencies that each new employee will require to fulfill his or her job responsibilities. 3. General orientation must be completed prior to the employee's formal contact with facility residents. 4. Departmental orientation will continue until the employee has demonstrated competency in all the skills necessary for performing his/her job and to meet resident needs. 10. When an employee changes roles or departments, he/she will go through a departmental orientation specific to that new role or department. 11. All documentation to support completion of the orientation process shall be maintained in the employee's personnel file. Record review of facility's document titled Facility Assessment Tool dated 6/12/2025 reflected 3.4. Staff/training/education and competencies: Annual education upon hire and competencies are developed for all staff based on their job title. 3.5. Policies and procedures for provision of care and facility operations: Policies are reviewed and updated on an on-going basis to ensure current professional standards of practice. Events that may trigger a policy review or update include but are not limited to the following: Change in regulation; change in interpretative guidance, case by case review. 3.6. Working with medical practitioners: The facility works closely with its affiliated hospitals and community-based service providers to ensure adequate medical practitioners (including physicians and nurse practitioners) who are trained and knowledgeable in the care of the facility's resident population. The facility is affiliated with the following hospitals: N/A. A list of actively credentialed physicians is maintained and available for print on demand. 3.7. Expectations of medical staff: The facility follows and provides medical practitioners (attending physicians, consultant physicians and other licensed independent practitioners) with federal guidelines and regulations on resident visits, frequency, documentation, and communication with clinical staff. Record review of the staff list provided by the facility with no date reflected no staff member titled Staff Development Coordinator. The facility did not provide a policy that specifically required staff to be trained on behavioral health.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Homeplace Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SW Ave F Hamlin, TX 79520	
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 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, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan with measurable objectives to meet resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #10 and Resident #15) of 12 residents reviewed for comprehensive person-centered care plans. 1. The facility failed to develop care plans based on the assessed needs with measurable objectives and timeframes in area of hospice services for Resident #10. 2. The facility failed to develop care plans based on the assessed needs with measurable objectives and timeframes in area of insulin and diabetes for Resident #15. This failure could place the residents at risk for decreased quality of life and not having their needs met. Findings include: Resident #10 Review of Resident #10's electronic face sheet accessed on 12/18/2025, revealed an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses to include: Alzheimer's disease, fracture of vertebra, adjustment disorder. Review of Resident #10's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 06 which indicated severe cognitive impairment. Review of Section O revealed Resident #10 was on hospice care. Review of Resident #10's Comprehensive Care Plan last revised 12/15/2025, revealed no evidence of Resident #10 being on hospice services and no evidence of code status. Review of Resident #10's electronic Physicians Orders revealed: Admit to hospice services, dated 09/11/2025. Resident #15 Review of Resident #15's electronic face sheet accessed on 12/18/2025, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: dementia, anxiety, and depression. Review of Resident #15's Quarterly MDS dated [DATE], revealed a BIMS score of 13 which indicated intact cognition. Review of Section I: revealed Resident #15 had a diagnosis of Diabetes. Review of Section N: revealed Resident #15 received insulin injections. Review of Resident #15's Comprehensive Care Plan last revised 10/23/2025, revealed no evidence of Resident #15 having diabetes or receiving insulin. Review of Resident #15's electronic Physicians Orders revealed: Basaglar Kwik Pen Subcutaneous Solution Pen-injector 100 Unit/ML (Insulin Glargine) inject 30 unit subcutaneously one time a day related to Type 2 Diabetes, dated 03/05/2025. During an interview on 12/18/2025 at 3:00 pm, the RCN stated hospice services, diabetes, and insulin should have been on the care plan. He stated that he was responsible for ensuring that care plans were current and accurate. He stated he did not know why the failure occurred. He stated that he did not see a negative outcome for residents. Review of facility's policy titled Comprehensive Care Plans, revised 01/01/2024 revealed in part: Policy: it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident's, consistent with resident rights, that includes measurable objectives and time frames to meet a residence medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy explanation and compliance guidelines. 3. The comprehensive care plan will describe, at a minimum, the following: a. the services that are to be furnished to attain or maintain the resident's highest practical people, and mental, and psychosocial well-being.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Homeplace Manor Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 425 SW Ave F Hamlin, TX 79520	
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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on interviews and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a therapeutic recreation specialist or an activity professional for 1 of 1 activity director (AD) reviewed for qualifications. The facility failed to ensure the AD, hired on 9/29/2025, was a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. Findings included Record review of the AD's employee file revealed the AD was hired on 9/29/2025, as the activity director. Further review revealed no evidence of certification or training as a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. During an interview on 12/15/2025 at 8:14 a.m., the RDO stated he expected all staff to have appropriate education and certification for their roles. He stated he expected for the activities director to have required experience or certification to offer an effective activities program to the residents. He stated he had worked for the company for two months, and knew there was improvement to be made. He stated the failure occurred due to change in management and did not know what had been discussed between the AD and the previous ADMIN. During an interview on 12/18/2025 at 9:55 a.m., the AD stated she was a CNA prior to being an activities director. She stated she was hired as an activities assistant, and the facility did not have an activities director. She stated, the previous ADMIN stated he was going to get her in the appropriate training course but then he no longer at the facility. She stated she had experience owning her own daycare service and did activities with those children. She stated she was willing to get what was needed to keep her position, but she did not know what that was. During an interview on 12/18/2025 at 9:38 a.m., the AIT stated the AD was not certified, but was working on that certification. She stated she would provide a job description of the AD position. She stated the AD was hired before she started working at the facility and she did not know what was done by the previous ADMIN to ensure the AD had appropriate certification. Record review of the facility's unsigned AD Job Description reflected The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who: ^ Is licensed or registered, (preferred) if applicable, by the state in which practicing and ^ Is: o Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; oro Has completed a training course approved by the State.		