STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675065	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass Valley Healthcare Center	103 Teakwood St Centerville, TX 75833

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure a resident was free from verbal and physical abuse by staff for 1 of 4 sample residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse on 03/13/2026 when CNA A physically and verbally abused Resident #1 during care. This failure placed residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's face sheet reflected a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.), diabetes mellites (A condition results from insufficient production of insulin, causing high blood sugar.) dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), and bipolar disorder (A serious mental illness characterized by extreme mood swings.). Review of Resident #1's annual MDS dated [DATE] reflected Resident #1 was assessed to not have a BIMS assessment done indicating the resident was rarely/ never understood and had severe cognitive impairment. Resident #1 was assessed to not have behavior during the assessment period. The MDS reflected Resident #1 had short and long- term memory problems and was severely impaired in daily decision making. The MDS also reflected Resident #1 continuously had inattention, disorganized thinking, was short tempered and easily annoyed. The MDS further reflected Resident #1 was functionally dependent on staff for transfers, bathing, toileting, and all activities of daily living. Review of Resident #1's comprehensive care plan dated 07/12/2024 reflected there was an electronic monitoring device in his room that family has consented to. The Care Plan dated 05/27/2024 reflected Resident #1 had ADL self-care performance deficit related to dementia and ADLs fluctuate related to the disease process. The Care Plan revised 10/21/2024 reflected Resident #1 was resistive to care related to dementia and refuses glucose checks, ADL care, incontinence care, medications, and showers. Interventions included to allow the resident to make decisions in treatment to provide a sense of control; give clear explanations of treatment and if residents resist with ADLS to leave and return 5-10 minutes later and try again. The Care plan revised on 02/11/2025 reflected Resident #1 had the potential to be physically aggressive related to dementia and has hit, push, bite, or slap staff. Interventions included to communicate to alleviate anxiety, give the resident choices about care when resident agitated or distressed, staff is to walk away calmly and approach later. The Care plan on 03/13/26 added interventions for behavior problems that reflected that two person staff to slowly approach the resident when providing care and if escalated reattempt and provide care later. Observation and interview with Resident #1 on 04/21/2026 at 10:40 AM revealed Resident #1 in room in his bed. The bed was low to the floor with fall matt in place. Resident #1 was confused and did not answer questions. Resident #1 was clean and without odors. Review of the video footage recorded on 03/13/2026 at 5:30 AM revealed CNA A was in Resident #1's room interacting with the resident. Resident #1 was in his bed with CNA A attempting to change the resident's incontinence brief. CNA A entered the room, stated moving the bed up, and turned the light on while the resident appeared to be asleep. Resident #1 immediately responded with arms up, and (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nor emotional distress. Further review of the facility investigation revealed provider response Alleged Perpetrator, CNA A, suspended pending investigation. Alleged Perpetrator HR file reviewed. All background checks and training in place. Nursing competencies completed with her on 02/18/2026 with good reviews. Head-to-toe assessment performed on resident. No findings. Emotional assessment performed on resident. No findings. Family notified. Physician notified. Ombudsman notified. Sheriff's office notified. Resident Interviews performed regarding Physical Abuse with no findings. Peer interviews performed regarding Alleged Perpetrator with no findings. Full head-to-toe assessments performed on all residents in the secure unit with no findings. Alleged perpetrator only worked in Secure Unit. Abuse drills started with all staff. Multiple scenarios presented for education purposes. Drills to continue. Monitored victim for 72 hours for any signs and symptoms of abuse/injury. No findings. Upon becoming aware of the allegation, the facility immediately initiated an investigation in accordance with the facility's Abuse Prohibition Policy and Procedures to ensure resident safety and determine the circumstances surrounding the incident. The facility maintains a comprehensive abuse prevention program designed to ensure residents are protected from abuse, neglect, and exploitation. All employees receive education on abuse prevention, appropriate resident interactions, and mandatory reporting requirements during new hire orientation and through ongoing in-service training throughout the course of their employment. Staff are educated on maintaining resident dignity, responding appropriately to behavioral escalations, and utilizing de-escalation techniques when residents become agitated or combative. As part of routine supervisory oversight and competency validation, nursing leadership conducts regular observations of staff providing resident care. The employee involved in this incident had been recently evaluated by the Director of Nursing within the past several weeks regarding patient handling and care delivery. During that evaluation, the employee demonstrated appropriate care techniques and resident interactions, and the Director of Nursing provided positive feedback regarding the employee's handling of residents and delivery of care. The investigation reviewed the circumstances surrounding the resident interaction. Documentation and staff interviews indicated that during the provision of care, the resident became agitated and combative, which can occur with residents experiencing confusion, cognitive impairment, or distress during personal care activities. Staff are trained to respond to these situations using de-escalation techniques such as pausing care, allowing the resident time to calm, speaking calmly, and requesting assistance when necessary. During this interaction, the employee reacted inappropriately to the resident's behavior and engaged in actions that were not consistent with the training, expectations, or abuse prevention policies of the facility. Staff are expected to maintain professional conduct at all times and utilize appropriate behavioral management techniques when residents become combative. As part of the investigation, the facility reviewed available video footage, conducted staff interviews, and reviewed relevant documentation. Based on the review of the video evidence and information obtained during the investigation, the facility confirmed that the employee engaged in inappropriate physical contact with the resident which was not consistent with the facility's abuse prevention policies or staff training. Based on the findings of the investigation, the facility determined that the employee's actions represented a deviation from established policies, procedures, and training, and did not reflect the standards of care or the culture of resident dignity and safety promoted within the facility. Consistent with the facility's zero-tolerance policy for abuse, the employee was immediately removed from resident care and subsequently terminated from employment. Appropriate notifications were made in accordance with regulatory requirements, including reporting the incident to law enforcement. The facility has reinforced staff education related to abuse prevention, appropriate resident approach techniques, and management of combative resident behaviors, and has implemented additional monitoring to ensure continued adherence to resident rights and abuse prevention standards. Based on the investigation findings, the facility determined that the employee's actions were inconsistent with the facility's abuse prohibition policies, staff training, and expectations for resident care. In an interview on 04/21/2026 at 12:09 PM (continued on next page)

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