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	11/24/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for 2 (Resident #5 and Resident #18) of 6 residents reviewed for comprehensive care plans. The facility failed to update Resident #5's and Resident #18's care plan to reflect current activity needs for in-room activities. This failure could place residents at risk of not receiving necessary services or having important needs identified and met. Findings included:1.Record review of Resident # 5's face sheet, dated 09/25/2025, reflected a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #5 had diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms (a mood disorder that causes a persistent feeling of sadness and loss of interest and seeing or hearing things that are not real or false beliefs), anxiety disorder, unspecified (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), other lack of coordination (the body's movements are not smooth, controlled, or precise resulting in unsteadiness, and difficulty with everyday tasks) and unspecified dementia, unspecified moderate, with behavioral disturbance (a condition where individuals experience cognitive decline consistent memory loss, and impaired thinking, with behaviors). Record review of Resident #5's annual MDS Assessment, dated 05/19/2025, reflected Resident #5 had a BIMS score of 1, indicating severely impaired cognition. Resident #5 indicated the following activities was somewhat important: participating in religious services or practices, doing favorite activity, and doing things with groups of people. Record review of Resident #5's Quarterly MDS Assessment, dated 08/18/2025, reflected Resident #5 had a BIMS score of 2, indicating severely impaired cognition. He had disorganized thinking (rambling or irrelevant conversation). Record review of Resident #5's Comprehensive Care Plan, with completion date of 09/18/2025, reflected no revisions of activity preferences and needs assessed in June 2025. Resident #5 had a problem identified in June 2025 as needing in room activities 3 times per week related to a decline in attending group activities. No interventions in place regarding in-room activities.Record review of Activity in Room Resident List, not dated, on 09/22/2025 reflected Resident #5's name was on the list to receive in room activities.2.Record review of Resident # 18's face sheet, dated 09/25/2025, reflected an [AGE] year-old female, admitted on [DATE]. Resident #18 had diagnoses which included unspecified dementia, unspecified severity, with behavioral disturbance (a condition where individuals experience cognitive decline consistent memory loss, and impaired thinking, with behaviors), generalized anxiety disorder (a persistent mental health condition characterized by excessive and difficult-to-control worry interfering with daily life), and cognitive communication deficit (problems or weaknesses in mental functions such as thinking, memory, attention, language, and problem-solving). Record review of Resident # 18's Annual MDS Assessment, dated 03/09/2025, reflected Resident #18 had a BIMS score of 4, which indicated her cognition was severely impaired. Further review reflected Resident #18 indicated keeping up with the news, being with group of people, doing favorite activity, going outside to get fresh air and, participating in religious services or practices was somewhat important to Resident #18.Record review of Resident#18's Quarterly MDS Assessment, dated 09/07/2025, reflected Resident #18 had a BIMS score of 3, which indicated his cognition was severely impaired. Resident #18 had disorganized thinking (rambling or irrelevant conversation, unclear flow of ideas, unpredictable switching from subject to subject).Record review of Resident #18's Comprehensive Care Plan, reflected Resident #18 (date initiated on 11/03/2023) was a wanderer risk related to decreased in safety awareness. Intervention: Resident #18 will be engaged in diversional activities as needed. Encourage Resident #18 to participate in activities of her preference. (Problem and Interventions dated initiated 09/23/2025) Resident #18 will attend activities of choice in order to meet emotional, intellectual, physical, and social needs. Interventions: Assist with arranging community activities. Arrange transportation. Invite Resident #18 to scheduled activities. Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility.Record review of Resident #18's Participation Record, dated September 2025, reflected Resident #18's did not receive in room activities from 09/01/2025 thru 09/21/2025. Interview on 09/25/2025 at 8:30 AM, the Activity Director stated Resident # 5's and Resident #18's care plans were not revised from June 2025 thru September 2025 to reflect their changes in activity needs such as being provided in room activities. She stated anytime a resident's activity preference or activity abilities changed; the residents care plan was expected to be revised to reflect these changes. She stated if a resident was having behaviors or was depressed and staff reviewed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two of eight residents (Resident # 5, and Resident #18) reviewed for activities. The facility failed to provide Resident #5, and Resident #18 in room activities on the dates of 09/01/2025 thru 09/21/2025. This failure could place residents at risk for boredom, depression, and a diminished quality of life. Findings included:1.Record review of Resident # 5's face sheet, dated 09/25/2025, reflected a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #5 had diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms (a mood disorder that causes a persistent feeling of sadness and loss of interest and seeing or hearing things that are not real or false beliefs), anxiety disorder, unspecified (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), other lack of coordination (the body's movements are not smooth, controlled, or precise resulting in unsteadiness, and difficulty with everyday tasks) and unspecified dementia, unspecified moderate, with behavioral disturbance (a condition where individuals experience cognitive decline consistent memory loss, and impaired thinking, with behaviors). Record review of Resident #5's annual MDS Assessment, dated 05/19/2025, reflected Resident #5 had a BIMS score of 1, indicating severely impaired cognition. Resident #5 indicated the following activities was somewhat important: participating in religious services or practices, doing favorite activity, and do things with groups of people. Record review of Resident #5's Quarterly MDS Assessment, dated 08/18/2025, reflected Resident #5 had a BIMS score of 2, indicating severely impaired cognition. He had disorganized thinking (rambling or irrelevant conversation).Record review of Resident #5's Comprehensive Care Plan, with completion date of 09/18/2025, reflected Resident #5 had little or no activity involvement related to he wishes not to participate (Problem, Goal and Intervention- Resident initiated on 07/11/2024). Goal Resident # 5 will participate in activities of choice (1-3) times per week. Intervention: Remind Resident #5 he may leave activities at any time and was not required to stay for entire activity. Resident #5 needed a variety of activity types and locations to maintain interests. Resident # 5 required assistance to activity functions. (Problem and intervention initiated on 05/27/2024) Resident #5 was an elopement risk related to dementia. Intervention: Resident #5 will be provided memory boxes. Record review of Resident #5's Participation Record, dated September 2025, reflected Resident # 5 did not receive in room activities from 09/01/2025 thru 09/21/2025. Observation and interview on 09/23/2025 at 11:05 AM Resident #5 were lying in bed. He did not respond to questions asked about his activities or about his care. During an interview on 09/23/2025 at 11:45 AM, the Activity Director stated Resident #5 did not want to attend very many group activities and changed his activity program during the month of July 2025 to receive in room activities 3 times per week. The Activity Director stated she was expected to ensure all residents received activities based on their preferences and their physical abilities. She stated if residents were not coming out of their room, the residents were to be provided in room activities. The Activity Director stated she provided in room activities at least three times a week. She stated there was no excuse why Resident #5 did not receive in room visits. The Activity Director stated if a resident was not receiving activities on a consistent basis there was a potential a resident may become bored, depressed, or have a decline in their quality of life. She also stated Resident #5 did not have a memory box. 2.Record review of Resident # 18's face sheet, dated 09/25/2025, reflected an [AGE] year-old female, admitted on [DATE]. Resident #18 had diagnoses which included unspecified dementia, unspecified severity, with behavioral disturbance (a condition where individuals experience cognitive decline consistent memory loss, and impaired thinking, with behaviors), generalized anxiety disorder (a persistent mental health condition characterized by excessive and difficult-to-control worry interfering with daily life), and cognitive communication deficit (problems or weaknesses in mental functions such as thinking, memory, attention, language, and problem-solving). Record review of Resident # 18's Annual MDS Assessment, dated 03/09/2025, reflected Resident #18 had a BIMS score of 4, which indicated her cognition was severely impaired. Further review reflected Resident #18 indicated keeping up with the news, being with group of people, doing favorite activity, going outside to get fresh air and

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for 1 (Resident # 5) of 30 residents reviewed for medication storage and labeling The facility failed to ensure medication for Resident # 5 was stored and labeled as it was received. The facility failed to ensure that expired medication package was destroyed or sent back to the pharmacy. These failures could place the residents at risk for receiving the wrong medication or not receiving the therapeutic effect of the prescribed medication.Findings include: In observation of medication room refrigerator on [DATE] at 1400 with LVN A present, revealed a zip lock plastic bag with a prescription sticker label for Resident #5 for Lispro100 units/ML Pen from Pharmacy A with expiration date of [DATE]. The medication that was on the prescription sticker label on the zip lock bag for Lispro 100 units/ML Pen was not present in the zip lock bag. Inside the zip lock plastic bag was a box with a prescription label for Novolog flex pen (insulin aspart)100 U/ML INJ from Pharmacy B with use by date [DATE] on the prescription sticker for Resident #5. Medication packaging indicates that medication does not expire until the year 2026. In record review of Resident #5's physician orders revealed HumaLOG KwikPen (Insulin Lispro)100 UNIT/ML. Further review revealed Resident #5 was not prescribed Novolog (insulin aspart) while living in the facility. In an interview with LVN A on [DATE]at 1419 she stated she has worked in the facility for 2 years. She stated she was in-serviced frequently on abuse, neglect, exploitation, medication administration, and medication storage and labeling. LVN A stated that medication boxes should only be placed in packages they were received in. LVN A states that Resident #5 was on HumaLOG not Novolog. LVN A stated they have HumaLOG for his sliding scale. LVN A stated the medication was in the incorrect bag and it all should have been removed as the Resident was not on Novolog insulin and it was not from the facilities pharmacy. LVN A stated the medications are both rapid acting insulins, they have different absorption rates. LVN A stated she would need an order from the provider to give the alternate medication. LVN A stated it was not okay to place a medication box for one medication in the packaging for another medication. LVN A stated the medication being placed in the incorrect packaging could have led to a medication error. She stated medication errors can potentially harm the Residents. LVN A stated that all nurses are responsible for ensuring medication that is expired or discontinued are removed. In an interview with DON on [DATE] at 1426 she stated they frequently Inservice the staff on abuse, neglect, exploitation, medication administration, and medication labeling and storage. She stated medication should not be placed in packaging supplied for any other medication. They stated it was their expectation that all nurses who have access to the medication room and the medication carts to ensure all expired or discontinued medication are removed to prevent medication errors. The DON stated if medication such as insulin was put into a zip lock plastic bag labeled for a different insulin that was expired the medication could be given and cause harm to the Resident. The DON states t the medication discussed should have been placed in the destruction box and not left in the refrigerator. In an interview with the Administrator on [DATE] at 1430 she stated all staff are in-serviced frequently on abuse, neglect and exploitation. She stated the DON frequently in-serviced nurses on medication administration and medication storage and labeling. She states the nurses are responsible for following the Storage of medication policy. Record Review of facility policy titled Storage of medication last reviewed [DATE] reflected the following: The Facility stores all drugs and biologicals in a safe, secure and orderly manner. 2. Drugs and biologicals used in the facility are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 4 Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute food under sanitary conditions in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure Dietary [NAME] changed her gloves during food preparation after wiping her nose with her fingers on her left hand. This failure could place residents who ate food from the kitchen at risk for foodborne illness.Findings include:Observation on 09/24/2025 at 11:40 AM, Dietary [NAME] was wearing gloves when she was pureeing biscuits. She wiped the left side of her nose with the forefinger and middle finger on her left hand. She did not change her gloves and continued to prepare puree biscuits and put her left hand on the spatula she was using to pour the puree biscuits into a silver container, while standing over the puree biscuits on the food prep table. In an interview on 09/24/2025 at 11:49 AM, Dietary [NAME] B stated at one time during preparation of pureed biscuits, she was wearing gloves when she wiped her nose with her left hand. Dietary [NAME] B stated she continued to puree the biscuits and pour the biscuits in the silver container without changing her gloves or washing her hands. She stated there was a possibility she did touch the biscuits with her left hand. Dietary [NAME] B stated her gloves was considered contaminated and if a resident ate the biscuits with bacteria on the biscuits there was a possibility the resident may become sick and have diarrhea or upset stomach. She stated she had been in-service on hand hygiene; however, she was unable to recall the date of the in-service. In an interview on09/25/2025 at 11:45 AM The Administrator stated the dietary staff was expected to change their gloves if they touched anything considered contaminated. She stated touching their nose would be considered contaminating the gloves. The Administrator stated there was a possibility a resident may become physically ill with stomach issues if they ingested some type of food with bacteria in the food. She stated a resident may become nauseated and possibility have diarrhea. The Administrator stated the Dietary Manager was responsible for monitoring the kitchen. The Administrator stated she was responsible to monitor the Dietary Manager. In an interview on 09/25/2025 at 12:40 PM the Dietary Manager stated she expected all staff to change gloves and wash hands in between tasks and when the staff touched their clothes, nose, or anything considered contaminated. She stated she had in serviced all dietary staff on hand hygiene. The Dietary Manager stated she could not recall the date of the in-service. She stated Dietary [NAME] B was expected to change her gloves and wash her hands if she touched anything when she prepared pureed biscuits. She stated a resident could become ill if a resident ate any contaminated food. She stated the resident may develop stomach issues such as vomiting and diarrhea. The Dietary Manager stated she was responsible to ensure all the staff in the kitchen followed hand hygiene protocol. Record review of the facility's policy on Handwashing-Hand Hygiene, dated 2020, reflected The facility considers hand hygiene the primary means to prevent the spread of infections.