STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure CNA A performed safe bed positioning on 4/15/2025 while performing incontinent care on Resident #1 when CNA A did not follow the Kardex (plan of care) which stated Resident #1 was a two person assist with bed positioning, resulting in Resident #1 falling from the elevated bed causing major injury of a left hip fracture (broken bone), lacerations above her left eye, and a hematoma (collection of blood) to her forehead.The noncompliance was identified as PNC. The IJ began on 4/15/25 and ended on 4/16/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of injury.Findings included:Record review of Resident #1's face sheet dated 9/26/25 indicated she was [AGE] years old and admitted to the facility initially on 3/08/22 and re-admitted on [DATE] with diagnoses including a history of psychomotor (mental processes and physical activity) deficit following a nontraumatic subarachnoid hemorrhage (brain bleed), hemiplegia (unable to move or severe weakness on one side of the body), dementia (decline in cognitive function severe enough to interfere with daily life), anxiety (excessive worry, fear, nervousness), bipolar disorder (mental health disorder extreme mood swings between elevated mood and depression-sadness), and left intertrochanter femur fracture (broken top part of the upper leg bone).Record review of Resident #1's quarterly MDS dated [DATE] indicated she had a BIMS score of 1, which indicated she had severe cognitive impairment. Resident #1 had functional limitations in range of motion of all extremities. Resident #1 was dependent on staff for most ADLs but required substantial assistance with rolling side to side in bed.Record review of Resident #1's Care Plan last reviewed on 3/04/25 indicated she had an ADL self-care performance deficit related to impaired balance, limited mobility, and stroke and required total assistance of two staff for bed mobility. Resident #1 had a fall and was at risk for further falls related to dementia, balance and anxiety medication and had interventions for bed in lowest position.Record review of an Event Nurses' Note-Fall dated 4/15/25 indicated LVN B was called to Resident #1's room by CNA (not named) and resident was lying face down on the floor with blood noted on the floor. Resident #1 was repositioned and assessed and was noted to have two lacerations above her left eye and a knot on her forehead and she complained of pain when moved. In the pain section, LVN B indicated Resident #1 had severe pain in the area of her hip and legs. Resident #1 was sent to the emergency room.Record review of Resident #1's hospital records dated 4/16/25 indicated the reason for the visit was left hip fracture. The records indicated Resident #1 fell out of bed landing on her hip and hitting her head at the nursing facility and had a closed left lesser trochanter femur fracture and laceration to left eyelid, which required five sutures. The records indicated the physician had discussed the fracture with Resident #1's RP and it was determined there would not be surgical intervention at that time.On 9/29/25 at 11:26 AM and 12:07 PM, CNA A was called but there was no answer, the voicemail was full and was unable to leave voicemail. On 9/29/25 at 3:06 PM, CNA A was texted a detailed message and requested a return call. On 9/30/25 at 12:10 PM, CNA A was called but there was no answer and was unable to leave a voicemail. CNA A did not return the calls or text message prior to the surveyor exiting the facility.During an interview on 9/29/2025 at 1:45 PM, LVN B said she had worked at the facility for three years on the 6 AM-6 PM shift. LVN B said she was the nurse on duty on the day Resident #1 fell. LVN B said the fall with Resident #1 was horrible. LVN B said CNA A came and told her Resident #1 had fallen from the bed. LVN B said Resident #1 was face down on the floor and was unable to use her arms to catch herself and took a blow to her face. LVN B said the bed was elevated due to CNA A was performing incontinent care. LVN B said CNA A said she had looked for someone to help her perform incontinent care, but CNA A said she thought she could do it alone, even though Resident #1 was a two person assist. LVN B said when CNA A rolled Resident #1 onto her side to put the incontinent brief on, Resident #1 was too close to the edge and Resident #1 rolled off the bed. LVN B said Resident #1 was saying she was hurting. LVN B said she assessed Resident #1 and sent her to the hospital. LVN B said CNA A was a sweet aide and would have never done anything intentionally to hurt Resident #1. LVN B said staff should look at the Kardex to see how much care/assistant a resident needed or required. LVN B said she had received the in-services on bed positioning and ADL assistance, and abuse and neglect During an interview on 9/30/25 at 11:27 AM, the ADON said she had worked at the