

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: 675066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Honey Grove Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 9 of 15 resident rooms on Hall's 2 and 3 (Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9). The facility failed to ensure that Resident room [ROOM NUMBER], #2, #3, #4, #5, #6, #7, #8, and #9 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 12/16/25 at 10:58 AM of Resident room [ROOM NUMBER] reflected thick brownish dirt stains on the floor near a fall mat. The bathroom floor had grayish stains on the floor near the sink and toilet. Back wall and floor in the bathroom had brownish stains. A nightstand in the room had dark stains along the top edge of the stand. An observation on 12/16/25 at 11:06 AM of Resident room [ROOM NUMBER] reflected brownish spotted dirt stains on the floor near a waste basket. An observation on 12/16/25 at 11:10 AM of Resident room [ROOM NUMBER] reflected the inside toilet bowl had a dark stain circling it. The corner of bathroom floor, behind the toilet, had brownish stains. An observation on 12/16/25 at 11:13 AM of Resident room [ROOM NUMBER] reflected the floor tiles, leading into the bathroom, were broken, which was a tripping hazard. The bathroom floor had brownish dirt stains circling the toilet. The room floor, near the door entrance, had dark dirt stains along the corner of the door jams. An observation on 12/16/25 at 11:17 AM of Resident room [ROOM NUMBER] reflected the room floor had broken tiles near the resident's bed. The floor, leading into the bathroom, had gaps separating the room floor and bathroom floor, which was a tripping hazard. An observation on 12/16/25 at 11:20 AM of Resident room [ROOM NUMBER] reflected the door entrance, had dark dirt stains along the corner of the door jams. The bathroom floor had brownish stains circling the toilet. The bathroom floor had dark dirt stains near the wall. An observation on 12/16/25 at 11:29 AM of Resident room [ROOM NUMBER] reflected the bathroom linoleum peeling away from the floor along the entrance and near a wall in the bathroom, which was a tripping hazard. The bathroom floor had brownish dirt stains circling the toilet. An observation on 12/16/25 at 11:30 AM of Resident room [ROOM NUMBER] reflected the room floor near the bed had brownish dirt stains. An observation on 12/16/25 at 11:32 AM of Resident room [ROOM NUMBER] reflected the door entrance, had dark dirt stains along the corner of the door jams. An area of the floor near the wall had a red stain on it. The bathroom floor had grayish stains on the floor near the sink and toilet. In an interview on 12/17/25 at 1:19 AM, the Administrator was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, and #9. She stated she did not see a risk to the residents with the room in the condition observed and it was more an aesthetic issue. She stated her Housekeeping Supervisor did a good job ensuring the resident rooms were cleaned daily. In an interview on 12/18/25 at 11:19 AM, the House Keeping Supervisor was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, and #9. She stated it was her and housekeeping's responsibility to thoroughly clean the rooms. She stated she had gotten with the maintenance director to assist with cleaning the stains (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around the inside of the toilets, and they attempted to clean the stains on the floor around the toilets, but it was hard to get them back to their original state. She stated she had gotten with the maintenance director about replacing the bathroom floors. She stated she did not check all the rooms daily, but she did spot check the rooms for cleanliness. She stated the impact to the residents was the smell could bother them and could result in an infection. In an interview on 12/18/25 at 11:32 AM, Housekeeping B stated she had been at the facility for 3 weeks. She stated they were responsible for cleaning the bathroom, sleeping areas, floors, and from top to bottom. She stated she received training when she started and had housekeeping experience. She was shown photos of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, #7, #8, and #9. She stated she had tried to clean the toilets, but a special cleaner was needed, the floors needed to be stripped and repaired, and the floor around the toilet needed to be redone. She stated the concerns observed could result in the residents having an infection and was a hazard. In an interview on 12/18/25 at 11:45 AM, the Maintenance Supervisor stated he had only been at the facility for 2 months. He was shown concerns with the residents' floors, and he stated they were going to replace the flooring in the residents' bathrooms and was waiting on getting supplies. He stated they also received cleaning supplies to remove the stains on the inside of the toilets on 12/16/25 and would be giving it to housekeeping. Review of the facility's policy for Housekeeping Cleaning & Disinfecting (2021) revealed Purpose: To keep facilities clean and odor free, while providing the residents, their families, and staff with the safest environment possible and projecting a positive image.		

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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 observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. The facility failed to ensure the ice machine in the dining area was thoroughly cleaned. This failure placed residents at risk of exposure to food contamination and illness. Findings include: An observation on 12/16/25 at 9:08 AM revealed an ice machine, located in the dining room, had a thick white substance along the inside walls of the ice machine and on the inside door of the ice machine. In an interview and observation on 12/16/25 at 9:08 AM, the Administrator unlocked and opened the door to the Ice machine and the inside door and upper section of the machine had a thick white substance all over it. The Administrator stated housekeeping, or maintenance was responsible for cleaning the ice machine, but she was not sure. Shen stated she did not know if there was any risk to the residents with the white substance being on the inside of the ice machine. In an interview on 12/17/25 at 12:30 PM the Dietary Manager was advised about the Ice Machine having a thick white substance along the inside walls of the ice machine and on the inside door of the ice machine. She stated it was her and the lead cook's responsibility to clean the ice machine weekly. She stated the ice machine was not cleaned last week. She stated the risk of the ice machine not being cleaned could result in the ice getting contaminated and residents getting ill. Record Review of the Facility's policy on ?Dietary Food Service Personnel Policy and Procedures, undated, revealed It is important that these be followed at all times in order to maintain the efficiency of the department and make this a pleasant place for you and others to work. The resident is the reason that we are here and our job in the resident's care plan is to serve attractive, appetizing, nourishing, and high-quality food to help keep them healthy Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN FOOD		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 (Resident #7) of 6 residents reviewed for dignity. The facility failed to provide a privacy bag for Resident #7's catheter bag (collects urine from the urinary bladder) on 12/16/2025. This failure could place the residents at risk of not having their right to a dignified existence maintained. Findings included: Record review of Resident #7's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old male who admitted on [DATE]. The resident was diagnosed with obstructive and reflux uropathy (blockage that prevents urine from flowing properly). Record review of Resident #7's Comprehensive MDS Assessment, dated 11/04/2025, reflected the resident was cognitively intact with a BIMS score of 13. Section H (Bowel and Bladder) reflected an indwelling urinary catheter. Record review of Resident #7's Comprehensive Care Plan, dated 11/11/2025, reflected an indwelling urinary catheter. One intervention was to Position catheter bag and tubing below the level of the bladder and in a privacy bag. During an observation and interview on 12/16/2025 at 9:25 AM, Resident #7 was lying in bed awake. His catheter bag was hanging on the side of the bed facing the door. It was not in a privacy bag. Resident #7 stated he did not know if it was covered. He stated he did not leave his room very often. In an interview on 12/16/2025 at 9:31 AM, RN D stated she was not sure where the privacy bag was. She stated Resident #7 pulled at it sometimes. She stated it was important to keep the catheter bag covered for his privacy. RN D stated she would get a privacy bag for Resident #7. In an interview on 12/17/2025 at 11:24 AM, the ADON stated Resident #7's catheter bag should have been in a privacy bag. She stated it was important to keep it covered for his dignity. In an interview on 12/17/2025 at 11:29 AM, the DON stated the catheter bag should have been covered. She stated it was important for the resident's dignity. Record review of the facility's policy Resident Rights, undated, reflected A facility must treat each resident with dignity and respect and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of each resident. The right to receive the services and/or items in the plan of care. The facility did not have a policy related to covering catheter bags.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Resident #42) of 16 residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #42's room was in a position that was accessible to the resident on 12/16/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Record review of Resident #42's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with psychomotor deficit (affects how a person moves and thinks) following a nontraumatic subarachnoid hemorrhage (brain bleed). Record review of Resident #42's Comprehensive MDS Assessment, dated 11/28/2025, reflected severe cognitive impairment with a BIMS score of 00. Section GG (Functional Abilities) indicated Resident #42 was dependent on staff for self-care and mobility needs. Record review of Resident #42's Comprehensive Care Plan, dated 11/04/2025, reflected a communication problem related to expressive aphasia (individuals struggle to produce clear and fluent speech). One intervention was to ensure the call light was within reach. An observation on 12/16/2025 at 9:13 AM revealed Resident #42 lying in bed awake. The call light was on the floor behind her bed. It was not within the resident's reach. When asked about her call light, Resident #42 did not answer. During an observation and interview on 12/16/2025 at 9:18 AM, CNA C stated Resident #42's call light should have been placed where she could reach it. She stated Resident #42's call light was attached to a stuffed bear. CNA C stated when she was feeding her breakfast, Resident #42 tried to put the stuffed bear in her mouth. CNA C stated she moved the call light to the side of the bed, and it must have fallen on the floor. CNA C picked up the call light and placed it near Resident #42. She stated it was important for the residents to be able to call staff. During an interview on 12/17/2025 at 11:24 AM, the ADON stated Resident #42's call light should have been in reach. She stated call lights should have been on the residents' beds. She stated all the call light cords had a clip to secure to the bed. She stated it was important to ensure the residents' call lights were in their reach in case they needed help. During an interview on 12/17/2025 at 11:29 AM, the DON stated it was important for Resident #42 and all residents to have their call light. She stated residents should be able to call staff. She stated it was good for staff to be able to reach the call light when needing assistance with a resident. Record review of the facility's policy Resident Rights, undated, reflected The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The right to receive the services and/or items included in the plan of care. The facility did not have a policy related to placement of call lights.		

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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 interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs were identified in the comprehensive assessment for a resident for 1 of 6 residents (Resident #5) reviewed for care plans. The facility failed to ensure Resident #5's care plan was revised upon her return from her hospital stay on 08/28/25 for breathing complications. This failure could place residents at risk of their needs not being met. Findings include: Record review of Resident #5's Face Sheet, dated 12/17/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnosis of COPD. Record review of Resident #5's Quarterly MDS Assessment, dated 11/18/25, reflected Resident #5 had a moderate cognitive impairment response. The Quarterly MDS Assessment reflected the resident had an active diagnosis of COPD. Record review #5's Comprehensive Care Plan, dated 10/22/25, reflected the resident's care plan for Oxygen therapy and swallowing problems was last reviewed on 7/07/25. Record review of #5 progress notes reflected the resident was transferred to the hospital on [DATE] due to a change in respiratory, and the resident returned to the facility on 8/28/25. In an interview on 12/17/25 at 10:35 PM, the DON stated Resident #5 was hospitalized on [DATE] because she had breathing problems. She stated the resident had returned from the hospital on [DATE], and it was recommended she used a straw to drink fluids to reduce the chances of choking, and she had a change in medication. She stated the resident's care plan should have been revised with the updated interventions to ensure the resident had received the required care. She stated it was the DON's responsibility to update the resident's acute care, but she was not at the facility when the resident had returned from the hospital. The DON stated the MDS nurse should have included the intervention during the resident's Quarterly Comprehensive Care plan review on 10/22/25. She stated she was out of the office for a few months and they had Interim DONs while she was out. She stated they also did not have an MDS nurse until 08/16/25 and she was trying to get caught up with updating care plans. She stated she had reviewed the care plan for Resident #5 and noticed it was not updated upon the resident's return from the hospital, and she would be updating it immediately. She stated they have daily meetings with the MDS nurse to discuss medication and treatment changes so the care plan can be updated. In an interview on 12/17/25 at 11:26 AM, the Regional Compliance Nurse was advised of Resident #5's care plan not being revised upon her return from the hospital on [DATE]. She stated she was made aware of this by the DON, and she stated it should have been updated so staff would be aware of her plan of care. In an interview on 12/17/25 at 1:50 PM the Regional MDS Nurse and MDS Nurse stated they were told about Resident #5 not having a revised care plan when she had returned from the hospital on [DATE]. They stated the IDT team, which consisted of the nursing staff, should have revised the resident's care plan to include any changes to the resident's care. The Regional MDS Nurse stated they did not have a DON at the time, and the IDT team did not have consistent staff, and it was overlooked. She stated the MDS nurse should have updated it during the resident's quarterly comprehensive care plan review, but they had just gotten a new MDS nurse at the time. They stated not updating the care plan could impact the resident not receiving appropriate care. Record review of facility's policy, Comprehensive Care Planning, undated, reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident's environment remained as free from accident hazards as possible for 1 (Resident #2) of 5 residents reviewed for environmental hazards. The facility failed to ensure Resident #2's fall mat was properly placed next to his bed on 12/16/2025. This failure could place the residents at risk for injury. Findings included: Review of Resident #2's Face Sheet, dated 12/16/2025, reflected a [AGE] year-old male who admitted on [DATE]. Resident #2 had diagnoses which included Parkinson's disease (brain disorder that can affect body motions) and muscle wasting and atrophy. Resident #2 was on hospice care services. Review of Resident #2's Quarterly Assessment, dated 12/04/2025, reflected severely impaired cognition with a BIMS score of 05. Section J (Health Conditions) reflected Resident #2 had one fall with no injury. Review of Resident #2's Comprehensive Care Plan, dated 12/15/2025, reflected Resident #2 was at risk for falls related to gait/balance problems, unaware of safety needs, and vision/hearing problems. One intervention was to place fall mat at right side of bed. In an interview and observation on 12/16/2025 at 09:08 AM, Resident #2 was lying in bed awake. Resident #2's fall mat consisted of two separate pieces which were the length of the resident when pushed together. One section was on the floor near the upper part of his body. Resident #2's bedside table was next to the fall mat and placed over the bed. The other half of the fall mat was at the end of the bed, approximately two feet past the bedside table. When asked if he had fallen, Resident #2 replied yes. He was unable to provide details. During an observation and interview on 12/16/2025 at 9:18 AM, CNA C entered Resident #2's room and stated the fall mat was not supposed to be placed like that. She stated the section at the end of the bed was supposed to be positioned under the resident's bedside table. She stated the section near the head of the bed was wider and the other was narrower and fit between the legs of the bedside table. She stated it allowed the bedside table to be placed across the resident's bed while having a fall mat next to the bed. CNA C stated the fall mat prevented the resident from hitting the floor hard if he fell. She stated the fall mat could keep him from breaking a bone or having a serious injury. CNA C moved the fall mat under the bedside table, so it was touching the floor mat near the head of the bed. In an interview on 12/16/2025 at 9:31 AM, RN D stated hospice provided Resident #2 an air mattress. She stated it was important for the fall mat to be in place in case he rolled out of the bed. She stated the fall mat did no good if it was not placed where it was supposed to be. She stated the nurses and CNAs monitored fall mat placement during rounds. RN D stated staff may have moved it to provide care and forgot to put it back. She stated if he fell, it could prevent a serious injury. In an interview on 12/17/2025 at 11:24 AM, the ADON stated the fall mat should have been properly placed next to Resident #2's bed. She stated the mat helped protect the resident from injury if he fell. In an interview on 12/17/2025 at 11:29 AM, the DON stated the fall mat should have been placed next to the resident's bed. She stated the mat was used to cushion a fall and help prevent injury to the resident. Record review of the facility's policy Resident Rights, undated, reflected A facility must treat each resident with dignity and respect and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of each resident. The right to receive the services and/or items in the plan of care. The facility did not have a policy related to the placement of fall mats.		