| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675076 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Llano Nursing and Rehabilitation Center | 800 W Haynie St<br>Llano, TX 78643 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician and the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 3 of 6 residents (Resident R#1, R#2, R#3) reviewed for notification of changes. The facility failed to ensure R#1's physician and residents' representative were notified on 2/27/26 and on 3/5/26 when resident alleged staff were abusive to her. The facility failed to ensure R#2 and R#3's physician and resident representative were notified on 2/20/26 when R#2 and R#3's were within hearing distance of a staff verbal altercation. These failures could place residents at risk of not receiving appropriate medical treatment, which could result in a decline in health.Findings included: Record review of R#1's face sheet, dated 03/19/26, revealed a [AGE] year old female, admitted [DATE] and re-admitted [DATE], with diagnoses that included hemiplegia and hemiparesis (one-sided paralysis or weakness of the face, arm and leg caused by brain, spinal cord or nerve problems), thrombocytopenia (low blood platelet count), and psychotic disorder with hallucinations (false perceptions of sensory experiences). Record review of a Quarterly MDS assessment, dated 02/13/26, for R#1's Cognitive Patterns were not documented on t02/13/26, R#1's functional abilities indicated she needed partial to moderate assistance with eating and she was dependent on assistance with dressing, showering, and person hygiene. Assessment of R#1's medications documented R#1 received antipsychotics on a routine basis. Record review of R#1's comprehensive care plan, dated 02/13/26, revealed the resident had socially inappropriate behaviors, ie, making false accusations toward staff members, s had difficulty comprehending complex information and making needs or wants known consistently due to dementia. R#1 took an antipsychotic medication due to socially inappropriate/disruptive behaviors, hallucinatory events, and episodes of delusion. During an observation and interview on 03/19/26 at 8:55 a.m., R#1 stated she was sick with a bug but everyone was treating her great. R#1 stated she had no recollection of any employee being rude or rough with her. R#1 stated she was getting showers and there were no concerns related to her medications. She stated she felt safe and was satisfied with her care. During an interview on 3/19/2026 at 1:02 p.m., the R#1's Responsible Party indicated he was not notified of any incidents regarding R#1 on 2/27/26 or 3/5/26. He stated he recalled speaking with a nurse discussing the idea of considering R#1 going on hospice. Record review of R#2's face sheet, dated 03/19/26, revealed an [AGE] year-old female, admitted [DATE], with diagnoses that included unspecified dementia without behavioral disturbance (A group of symptoms that affects memory, thinking and interferes with daily life.), psychotic disturbance (hallucinations), anxiety (feeling of uneasiness or worry) and language disorder (a persistent difficulty in using language, problems understanding). Record review of R#2's comprehensive care plan, dated 01/05/26, revealed R#2 exhibited aggressive responses during care due to increased threat perception as a result of dementia and staff were [NAME] ensure R#2's needs were met. Furthere record review revealed R#2 experienced fidgeting, fearfulness, wide eyes & trembling, staff will establish a trusting relationship with R#2. R#2 was on hospice and staff were to provide comfort measures. Record review of a (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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Quarterly MDS assessment, dated 12/31/25, R#2's cognitive patterns were not documented on t12/31/25 R#2's functional abilities indicated she was dependent on assistance with eating, dressing, showering, toileting hygiene, and personal hygiene. Assessment of Medications documented R#2 received antidepressants and opioids on a routine basis. During an observation and interview on 3/19/26 at 9:08 a.m., R#2 was not able to verbalize answers while being interviewed. R#2 was observed with lifts legs and eyed opened, but did not respond to questions. R#2 was observed clean and dressed appropriately. Record review of R#3's face sheet, dated 03/19/26, revealed a [AGE] year-old female, admitted [DATE], with diagnose including essential hypertension (high blood pressure), major depressive disorder (persistent feelings of sadness), and generalized anxiety disorder (feeling of uneasiness or worry). Record review of R#3's comprehensive care plan, dates 12/09/25, revealed R#3 was on palliative care(Palliative care is designed to relieve symptoms, stress, and emotional burdens associated with serious or chronic illnesses, regardless of a patient's age or stage of disease.) and would experience death with dignity and physical comfort., R#3was at risk for muscle spasticity(disruption in muscle movement patterns that causes certain muscles to contract all at once when you try to move or even at rest.) and R#3 would be as comfortable as possible. Further record review revealed R#3 had impaired decision making related to dementia and would have positive experiences in daily routine without overly demanding tasks and without becoming overly stressed. Record review of a Quarterly MDS assessment, dated 12/31/25, for R#3's cognitive patterns were documented as a BIMS of 3, indicting severe cognitive impairment problems with thinking and memory. R#3's functional abilities indicated she was dependent on staff for assistance with eating, dressing, showering, toileting hygiene, and personal hygiene. Assessment of Medications document that R#3 was receiving antidepressants and anticonvulsants on a routine basis and the resident had not received antipsychotic medication since she was admitted to this facility. During an observation and interview on 3/19/26 at 10:00 a.m., R#3 was incoherent and she was not able to respond to questions. R#3 appeared clean and dressed appropriately. During an interview on 3/19/2026 at 10:15 a.m. the OT said she did not regularly work with R#1. She stated, this morning I assisted with serving breakfast to R#1 and she seemed fine. The OT stated she knew nothing about the incident involving R#1. During an interview on 03/19/2026 at 9:21 a.m., LVN A stated the facility protocol when an incident occurred included a nurse assessment of the residents involved, reporting the incident to ADM, DON, NP and family. When asked why the NP and family's representatives were not called, she stated .was not on duty when the incidents occurred involving R#1 on both 2/27/26 and 3/5/26 and I don't' know why they were not notified. During an interview on 3/19/26 at 10:24 a.m., LVN B stated the facility protocol for any incident was investigate, a nurse completed an assessment of the resident, provide proper care, call the ADM, DON, s\and later we were to call the NP and the residents representative. LVN B stated she was not working here during any of the incidents reported so she did not know why the NP or family representatives were not notified of the events. During an interview on 03/19/2026 at 2:30 p.m., the DON stated that staff were to report any incidents to the AC( ADM) if they suspected abuse. She stated the protocol for reporting any incident was as follows: 1. report to the AC by calling the number posted in the facility lobby, 2. AC reported to the state, 3. nurse assessed the resident(s), 4. call the NP to give notification of the incident, 5. notify the residents' representative, and 6. in-service the staff and do safe surveys by interviewing the residents. The DON stated an investigation of the incident involving R#1 on 2/27/26 was performed. She stated the NP and R#1's representative were not notified because it was not documented in the file. She stated that they missed that after the incident occurred. The DON stated an investigation of the incident on 2/20/2026 involving one CNA being abusive to another CNA. The DON stated R#2 and R#3 were within earshot of the altercation. The DON stated physical assessments were done for both residents and no injuries were noted The DON was not able to confirm that R#2's and R#3's representatives or NPs were notified of this event. The DON stated the abusive employee was suspended and staff were in-serviced on Abuse and Neglect During an interview on 3/19/26 at 12:15 (continued on next page) |

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