STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675098	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farwell Care and Rehabilitation Center	305 Fifth St Farwell, TX 79325

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. report an allegation of abuse to the State Survey Agency within 2 hours of the allegation for 2 of 5 residents (Resident #1 and Resident #2).The facility failed to report an incident of abuse, dated 03/27/2026, between Resident #1 and Resident #2.This deficient practice could place residents at risk of continued and/or unrecognized abuse, neglect, or exploitation.Findings Included:Resident #1Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility originally on 07/18/2025 with a readmission of 04/10/2026. Diagnoses included but are not limited to dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance (decline in cognitive function with behaviors), weakness (lacking strength), reduced mobility (decreased ability to move freely), and major depressive disorder (mood disorder with persistent feelings of sadness). Record review of Resident #1's discharge MDS assessment, dated 03/30/2026, did not reveal a BIMS score.Record review of Resident #1's care plan, dated 01/30/2026, revealed Resident #1's focused goals of Resident exhibits behavior or trying to assist other residents such as pushing another resident in their wheelchair.Resident exhibits physically aggressive behaviors such as hitting, pushing, or kicking, or throwing things typically in response to perceived threats, confusion, or frustration.Resident exhibits verbal outbursts characterized by yelling, cursing, or aggressive speech, often in response to perceived frustration, confusion, or unmet needs.Resident receives cognitive-enhancing medication for dementia.Record review of Resident #1's progress note, dated 03/27/2026 at 11:45 AM, revealed a report regarding resident behavior grabbing the arm of another resident and causing a bruise.Resident #2Record review of Resident #2's face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses include but are not limited to chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe), anxiety disorder (feelings of panic, fear, dread, restlessness, irritability, and difficulty concentrating), hypertensive heart disease with heart failure (heart is unable to pump enough blood to meet the body's needs), and muscle weakness (muscle unable to exert force or perform normal movements). Resident #2 is on hospice.Record review of Resident #2 MDS, dated [DATE], revealed a BIMS score of 11, indicating moderate impairment in thinking and memory.Record review of Resident #2 care plan, dated 03/24/2026, revealed focused goals of Resident experiences excessive worry, nervousness, or unease, which may interfere with daily functioning and quality of life.Resident is prescribed antianxiety medication for management of anxiety, placing them at risk for sedation, falls, cognitive (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675098	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farwell Care and Rehabilitation Center	305 Fifth St Farwell, TX 79325

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes, and medication side effects.The resident has impaired cognitive function and impaired thought processes.Record review of Resident #2's progress notes on 04/22/2026 did not reveal documentation related to the incident on 03/27/2026. In an interview and observation on 04/22/2026 at 2:37 PM, the ADM displayed the footage on her computer of the altercation on 03/27/2026 between Resident #1 and Resident #2. The footage revealed that Resident #2 was seated in her wheelchair on the north side of the entrance door, and Resident #2 was seated in a chair on the south side of the lobby. The video timestamp revealed the incident happened at 11:49 AM. An unknown individual approached the door and pulled the door handle. The individual was unable to enter the facility. Resident #1 stood from the chair and walked to where Resident #2 was located and placed both hands on Resident #2's wheelchair handles. Resident #1 moved Resident #2 backwards, away from the door. Resident #2 attempted to push Resident #1 away from her wheelchair with her left arm. The video timestamp of 11:50:45 AM showed Resident #2 reaching back, in a hitting motion with her right forearm, and contacting Resident #1's right forearm 3 times. The video timestamp at 11:51 AM showed Resident #1 letting go of Resident #1's wheelchair in the lobby and returning to the chair on the south side of the lobby. The ADM stated she did not witness the incident between Resident #1 and Resident #2, but it was reported to her by Resident #2. The ADM stated based on the information that Resident #2 provided, she felt it wasn't reportable. In an interview 04/22/2026 at 2:06 PM, the ADON stated she documented the incident of Resident #1 grabbing Resident #2's arm when trying to move her away from the front door on 03/27/2026 in Resident #1's progress notes. The ADON stated the incident happened at the front entrance of the facility. The ADON reported that she did not feel the incident was reportable because it wasn't intentional.In an interview on 04/22/2026 at 2:25 PM, the DON stated she did not witness the altercation between Resident #1 and Resident #2 on 03/27/2026. The altercation was reported to her; however, she could not recall who reported the altercation to her. The DON stated she felt the facility should have reported the incident. The DON stated that a negative outcome of not reporting would be residents wouldn't feel safe. She stated they should be able to feel they are well taken care of. In a follow up interview on 04/22/2026 at 4:23 PM, the ADON stated that she did not watch the video, and was not told what was on the video. The ADON stated that a resident hitting another resident was a reportable incident. In an interview on 04/22/2026 at 4:29 PM, the MA stated that he viewed the video and confirmed he observed Resident #2 strike Resident #1. The MA confirmed he documented what he observed in the video on 03/27/2026 and provided it to the ADM. The MA stated he emailed the video to the ADM on 03/30/2026. The MA stated that a negative outcome of not reporting abuse or neglect could be an injury that was overlooked.In an interview on 04/22/2026 at 4:38 PM, the ADM stated that a resident hitting another resident was reportable. The ADM stated the incident should be reported within 2 hours. The ADM stated a negative outcome was Resident #1 could try to hit someone else. The ADM stated an incident involving a resident hitting another resident would be considered reportable and should be reported within two hours. The ADM also stated a negative outcome for failing to report such incidents could be residents engaging in additional altercations. Record review of the facility's policy of Abuse, Neglect, and Exploitation, dated 2024, revealed under subheading Definitions revealed, Abuse means the willful and infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated, and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Under heading of The components of the facility abuse prohibition plan are discussed herein:, under [NAME] numeral VII- Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: A. Immediately, but not later that 2 hours (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675098	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Farwell Care and Rehabilitation Center	305 Fifth St Farwell, TX 79325

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.