STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675117	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Runningwater Draw Care Center Inc	800 W 13th St Olton, TX 79064

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the professional standards for food service safety for 1 of 1 kitchen (Kitchen #1) reviewed for kitchen sanitation. The facility failed to ensure refrigerated, freezer and pantry food items were properly stored, labeled, and dated. The facility failed to ensure refrigerator and freezer temperatures were monitored and logged per their policy.These failures place residents at risk for food borne illness.Findings included:During an observation of the refrigerator on 05/05/2026 at 9:44 AM, revealed the following:Five small glasses with orange colored liquid, open to air and had no label.One plate with two pancakes, open to air; the tinfoil covering was off the plate.During an observation of the pantry area on 05/05/2026 at 9:49 AM, revealed the following:One bag of small marshmallows opened to air; several marshmallows had hardened.One bag of crisp cereal, 1/4 empty, sealed, but had no open date.One clear plastic bag of crackers not labeled or dated.Two pitcher type containers with white cream were not labeled or dated.One container of red sauce had no label or date.Observation of the walk-in freezer located outside the pantry area on 05/05/2026 at 9:50 AM, revealed the following:One clear plastic bag of pancakes, removed from the original packaging, was not labeled.One clear plastic bag of crumbled meat was not labeled.During an observation of the preparation area on 05/05/202 at 9:55 AM, revealed the following:One bag of tortilla chips, not labeled, or dated.During an observation of the temperature log binder for refrigerator and freezers on 05/05/2026 9:56 AM, revealed the May 2026 temperature documentation sheet lacked documented refrigerator and freezer temperature checks for the morning and lunch shifts on 05/04/2026. Only the dinner temperature check had been documented. During an interview on 05/06/2026 at 9:26 AM, DA A stated it was everyone's responsibility to label and date food and if it were not done, residents could get sick. DA A stated the DM was responsible for ensuring staff complied with labeling, dating, and monitoring and documenting refrigerators and freezers temperatures.During an interview on 05/06/2026 at 9:33 AM, the DM stated it was the responsibility of all dietary staff to ensure food items were labeled, dated, and stored properly. The DM stated the food could spoil and residents could become ill if spoiled food was served. The DM further stated she was responsible for ensuring refrigerator and freezer temperatures were monitored and logged daily to verify safe food storage temperatures and for ensuring staff complied with labeling and dating requirements. During an interview on 05/07/2026 at 8:37 AM, [NAME] E stated it was everyone's responsibility to ensure food items were labeled, dated, and covered. [NAME] E stated the DM was responsible for ensuring staff were labeling, dating, and documenting refrigerator and freezer temperatures. [NAME] E stated a possible negative outcome would be residents receiving spoiled food and becoming ill. Record review of facility policy, titled, Food Receiving and Storage, dated 11/2022, reflected the following: Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use .Dry food that are stored or removed from original packaging, labeled and dated (use by date). Refrigerated/Frozen Storage.All foods stored in the refrigerator or freezer are covered, labeled and dated.Functioning of the refrigeration and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and documented according to state specific requirements.Refrigerated foods are labeled, dated and monitored so they are used by their use-by 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 2 (Resident #35 and #43) of 17 residents reviewed for advanced directives. Resident #35 had a DNR in her record that had no date of when the notary witnessed Resident #35 sign the document. Resident #43 had a DNR in her record that had no information for the physician. This failure could place residents at risk for not receiving healthcare as per their or their legal representatives' wishes.Findings included: Resident #35: Record review of Resident #35's face sheet printed [DATE] revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include cerebral aneurysm (a ballooning or weakening area of an artery in the brain), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), congestive heart failure (a chronic condition in which the heart dose not pump blood as well as it should), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes or deficiency of calcium of vitamin D), and history of malignant neoplasm (a fast-growing cancer). Record review of Resident #35's MDS was a quarterly printed [DATE] and completed [DATE] listing her with a BIMS of 11 indicating she was moderately cognitively impaired, and she had a functionality of requiring partial/moderate assistance with most of her activities of daily living. Record review of Resident #35's care plan printed [DATE] with admission date of [DATE] revealed the following: Focus:-Advanced Directives: DNRDate initiated [DATE]. Record review of the clinical record for Resident #35 revealed an Order Summary printed [DATE] with the following order: -DNR (Do Not Resuscitate) Active [DATE] Record review of the clinical record for Resident #35 revealed a DNR dated [DATE] (signed by Resident #35's adult child) with the following:Section - Two Witnesses: Notary in the State of Texas. -there was no date of when the notary witnessed the adult child-qualified relative sign the DNR form. Resident #43: Record review of Resident #43's face sheet printed [DATE] revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interfere with daily functioning), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), and Wegener's Granulomatosis without renal involvement (a from of autoimmune necrotizing vasculitis that affects small and medium-sized vessels, restricted primarily to the upper and lower respiratory tracts without kidney involvement). Resident #43's last MDS was an annual assessment printed [DATE] and completed [DATE] listed her with a BIMS of 05 indicating she was severely cognitively impaired, and she had a functionality of being dependent on staff for most of her activities of daily living. Record review of Resident #43's care plan printed [DATE] with admission date of [DATE] revealed the following: Focus:-Advanced Directives: Code Status DNR. Date Initiated: [DATE]. Record review of the clinical record for Resident #43 revealed an Order Summary printed [DATE] with the following order: -DNR (Do Not Resuscitate) Active [DATE] Record review of the clinical record for Resident #43 revealed a DNR dated [DATE] (signed by Resident #43) with the following:Section - Physician's Statement: -there was no information for the physician. No date, no signature, no printed name, and no license number. During a group interview on [DATE] at 8:59 AM LVN C (the nurse responsible for Resident #35 and Resident #43 this shift) and LVN D reported Resident #35 and Resident #43 were both currently DNR status. They reported if either resident was reported as not having a heart rate or breathing, they would verify the resident's condition, not start CPR, and notify the ADON or DON. They reviewed Resident #43's DNR in her electronic record and both verified no physician information was on the form therefore the DNR form was not valid. They reviewed Resident #35's DNR in her electronic record and it did not have a date when the notary signed the DNR form therefore it was not valid. Both (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported if one of these residents coded during this shift, they would have to start CPR. LVN C and LVN D reported the facility not ensuring the DNR forms were filled out correctly could result in staff having to perform CPR on a resident who did not wish to have CPR, staff could upset family, and the staff would not be following the residents' wishes. During an interview and record review on [DATE] at 9:11 AM the BOM reported she was the notary for the facility, and she was the one who completed Resident #35's DNR form. The BOM reviewed the DNR to include the original copy and reported she missed dating her signature. When asked if the form was valid, the BOM stated, I don't know. I don't do medical. I just do the notary part. During an interview and record review on [DATE] at 9:16 AM the DON reviewed the electronic chart for Resident #35 and Resident #43 and reported both residents were currently listed as DNR's. The DON reported if either resident was found to be without a heart rate or breathing then they would let them pass. The DON reviewed Resident #43's DNR form in her electronic record and reported the physician did not sign the form, so this one was not valid. The DON review Resident #35's DNR form and reported the notary did not sign the form, and it was not valid either. The DON reported they reviewed the DNR's during each care plan meeting and recently did a full audit of all DNR's and had to correct a few. The DON reported we just missed these. The DON reported if the DNR was not correct then the staff were put in a position where they were legally supposed to code the residents, and the residents' wishes would not be fulfilled. During an interview on [DATE] at 10:26 AM the MDS/LVN reported she did assist with auditing residents DNR forms for completion and accuracy. She was made aware Resident #35 and Resident #43 had invalid DNR's and they were just missed. The MDS/LVN reported if the DNR form was not correct then it was not valid and the facility would not honor the residents wishes. Record review of the facility provided policy titled Code Status Guidelines undated, revealed no information for completing a DNR accurately. Record review of the facility provided policy titled Do Not Resuscitate Order undated, revealed the following: 2. A Do Not Resuscitate (DNR) order form must be complete and singed by the attending physician.6. The interdisciplinary care planning team will review advanced directives with the resident during quarterly care planning sessions. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following:-The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that an assessment accurately reflected a resident's status for 1 (Resident #2) of 17 residents reviewed for accuracy of assessments. The facility failed to accurately assess Resident #2 for the use of a restraint. This failure could place residents at risk not receiving appropriate care and services. Findings included: Record review of Resident #2's face sheet, printed 05/06/26, revealed a [AGE] year-old female admitted [DATE], with diagnoses including, but not limited to, dislocation of left shoulder joint, chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe due to airways and air sacs in the lungs are damaged and narrowed), anxiety disorder (worry, fear, or nervousness becomes so strong it affects everyday life), and edema (swelling caused by too much fluid collecting in the body's tissues). Record review of Resident #2's most recent quarterly MDS assessment, dated 02/13/26, revealed a BIMS score of 06, indicating severe cognitive impairment. Section P0100, Physical Restraints, indicated Resident #2 used limb restraint less than daily. Record review of Resident #2's care plan dated 05/19/25 revealed the following:Resident has limited physical mobility r/t history of falls and dislocation of left shoulder joint Monitor, document, report any signs or symptoms of immobility including contractures forming or skin breakdown. Provided supportive care, assistance with mobility as needed. No documentation of restraint. Record review of Resident #2's Order Summary Report, dated 05/06/26, revealed there was no order for limb restraint. During an observation of Resident #2 on 05/05/26 at 10:19 AM revealed no restraints on her body. During an interview and observation on 05/06/26 at 11:00 AM, observation revealed no restraint on Resident #2's body. A family member of Resident #2 stated that the resident was admitted to the facility with a sling for her arm because she dislocated her shoulder. The family member stated they were not aware of any limb restraints. During an interview on 05/06/26 at 1:20 PM, the MDS LVN stated she was the MDS Coordinator for the facility and used the RAI manual policy as guidance. She stated a limb restraint should not have been coded on Resident #2's MDS assessment would be corrected. The MDS LVN further stated inaccurate MDS coding could result in incorrect care planning and impact reimbursement. During an interview on 05/07/26 at 8:47 AM, the DON stated she was not aware that a limb restraint was inaccurately coded on an MDS for Resident #2. She stated the MDS LVN was responsible for MDS assessments, but that the DON reviewed them before they were signed and submitted. The DON stated that if MDS assessments were miscoded, that resident's needs and individual care could not be met and also affect funding. During an interview on 05/07/26 at 9:02 AM, the ADM stated the MDS LVN was responsible for completing MDS assessments and the DON checked them before they were signed and submitted, but ultimately the ADM stated she was responsible for them since she was the ADM. She stated that if an MDS was miscoded, it could affect funding and care. During an interview on 05/07/26 at 10:18 AM, the ADON stated the MDS LVN was responsible for ensuring MDS assessments were accurate and submitted. She stated inaccurate MDS assessments could impact reimbursement. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025 revealed the following: SECTION P: RESTRAINTS AND ALARMSP0100. Physical RestraintsPhysical Restraints are many manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Enter Codes in BoxesUsed in Bed-A. Bed rail-B. Trunk restraint-C. Limb restraint-D. Other

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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 observation, interview and record review, the facility failed to implement a comprehensive care plan for each resident 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 and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #30 and #42) of 17 residents reviewed for comprehensive care plans. -The facility failed to address the use of halo bedrails in Resident #30 and Resident #42's care plans. This failure could result in residents not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being.Findings included: Resident #30: Record review of Resident #30's face sheet dated 05/05/2026 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interfere with daily functioning), aortic aneurysm (a ballooning or weakening area of an artery), pain, weakness, need for assistance, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath). Record review of Resident #30's quarterly MDS printed 05/05/26 and completed 04/14/26 listed her with a BIMS of 11 indicating she was moderately cognitively impaired, and she had a functionality of requiring partial/moderate assistance when lying to sitting on the side of the bed. Record review of Resident #30's order summary with Active Orders as of: 05/06/26 revealed no orders to address the use of halo rails on the resident's bed. Record review of Resident #30's care plan printed 05/05/26 with date of admission [DATE] revealed no care plan for the use of halo bedrails or any bed rails. Record review of Resident #30's clinical record revealed a Halo Positioning Bar Consent listing the benefits and risk of using a bed rail signed by Resident #30 on 10/04/21. During an observation and interview on 05/05/2026 at 09:54 AM Resident #30 was in her room sitting in her recliners. Resident #30 had a halo bedrail on the right side of her bed that was up and locked in place. Resident #30 reported she uses her halo bedrail to move around in her bed, and she was trained on its use. Resident #42: Record review of Resident #42's face sheet dated 05/05/26 revealed an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interfere with daily functioning), pain, muscle weakness (a lack of muscle strength), myocardial infarction (heart attack), and acquired absence of the left leg below the knee. Record review of Resident #42's annual MDS printed 05/05/26 and completed 02/13/26 listed him with a BIMS of 03 indicating he was severely cognitively impaired, and he had a functionality of requiring substantial/maximal assistance with lying to sitting on the side of the bed. Record review of Resident #42's order summary report with Active Orders as of: 05/06/26 revealed no orders for the use of halo rails. Record review of Resident #42's care plan printed 05/05/26 with date of admission [DATE] revealed no care plan for the use of halo rails or any bed bedrails. Record review of Resident #42's clinical record revealed a Halo Positioning Bar Consent listing the benefits and risk of using a bed rail signed by Resident #42's legal representative on 02/14/23. During an observation on 05/05/2026 at 09:41 AM Resident #42 was in his room in his recliner asleep. He did not wake to knocking or introduction. Observation revealed his bilateral halo bedrails that were up and locked in place on both sides of his bed. During a group interview on 05/07/2026 at 9:09 AM LVN C and LVN D reported a resident's halo bedrail should be care planned so they could be evaluated regularly and if they were not care planned then the halo bedrail may not be used correctly, and the resident could hurt themselves. During an interview and record revew on 05/07/2026 at 9:22 AM the DON reported all residents with a halo bedrail were required to sign a consent, have an assessment for the halo bedrail, and the halo bedrail was to be care planned for ongoing monitoring. The DON reported she signs off on all care plans to ensure they are completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON reviewed the care plans for both Resident #30 and Resident #42 and reported neither of the residents had their halo bedrails included in the care plans. The DON stated, From what I'm seeing, no they are not care planned. The DON reported if the halo bedrails were not addressed in the care plans it would not affect the residents directly but the care plan would not be an accurate reflection of the residents' care. During an interview and record review on 05/07/2026 at 10:28 AM the MDS/LVN reported halo bedrails were supposed to be care planned. The MDS/LVN reviewed both Resident #30 and Resident #42 care plans and reported both care plans did not address the residents' use of halo bedrails. The MDS/LVN reported the facility uses the residents' care plans for ongoing monitoring and if the halo bedrail was not in the care plan the staff might not know if the resident had a halo bedrail. She reported she would get the halo bedrails in both Resident #30 and Resident #42 care plans right now. Record review of the facility provided policy titled Bed Rail Policy undated, revealed the following: -Be Care-Planned regarding the request for Halo Bar. Care Plan evaluations and ongoing assessment will consider the use of the Halo Bar.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #16) of 4 residents observed for infection control. -Resident #16 had her catheter bag on the floor for 3 hours. This failure could place residents at risk for the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene.Findings included: Record review of Resident #16's face sheet printed 05/06/2026 revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions) and calculus of kidney with calculus of ureter (the presence of solid, crystal-like deposits within the kidney that have moved into and become lodged in the ureter). Record review of Resident #16's MDS printed 05/06/2026 was a quarterly completed 04/15/2026 with a BIMS that was not completed because of memory issues, and she had a functional status of being dependent on staff for all her activities of daily living. Resident #16 was not listed as having an indwelling catheter. Record review of Resident #16's care plan printed 05/06/2026 with admission date of 02/06/2027 revealed the following: Focus:Resident has an foley catheter d/t renal calculi w/ stents. Dated initiated: 05/01/2026.Interventions:-Enhanced Barrier Precautions due to indwelling foley catheter, bilateral urethral stents. Date initiated: 05/01/2026. Record review of Resident #16 Order Summary Report printed 05/06/2026 with Active Orders as of: 05/06/2026 revealed the following order:- Enhanced Barrier Precautions due to indwelling foley catheter, bilateral ureteral stents. Active 05/01/2026. During an observation on 05/05/2026 at 10:09 AM Resident #16 was lying in bed with the bed in the lowest position and appeared to be sleeping. Resident #16's catheter bag was observed on the right side of the bed and attached to the lower portion of the bed frame; however, due to the bed being in the lowest position, the catheter bag was resting on the floor. No privacy bag was in place over the catheter bag. The catheter bag was observed to be approximately one quarter full of urine. During an observation on 05/05/2026 at 10:36 AM Resident #16 was observed in her bed with her catheter bag hanging from the foot of her bed with the bottom half of the catheter bag in contact with the floor. Noted the drain mechanism of the catheter bag was in direct contact with the floor. During an observation on 05/05/2026 at 11:06 AM Resident #16 catheter bag was still hanging from the foot of her bed with the bottom half to include the drain mechanism on the floor. There was no barrier between the catheter bag and the floor. During an observation on 05/05/2026 at 11:11 AM CNA B was observed taking Resident #16's catheter bag off the floor, putting it in a privacy bag, then securing the catheter bag to the right side of Resident #16's bed. During an interview on 05/05/2026 at 11:24 AM CNA B reported he was told that Resident #16's catheter was on the floor, so he went to correct the issue. CNA B reported he and another staff member put Resident #16 to bed shortly after breakfast approximately after 8 AM with the use of a Hoyler lift and that was when the catheter bag was in contact with the floor. CNA B reported the catheter bag on the floor was an issue for infection control. CNA B when in CNA training he was taught to always have a barrier between the catheter bag and the floor to prevent bodily fluids from contacting the floor surface. During a group interview on 05/07/2026 at 9:08 AM LVN C and LVN D reported that a catheter bag should not touch the facility floor. That if the catheter bag touches the floor, it can be a dignity issue and an infection control issue. They both reported that a catheter bag should always have a barrier between the bag and any surface. During an interview on 05/07/2026 at 9:14 AM the DON reported a catheter bag should be stored off the floor and in a privacy bag. The DON reported if a residents' catheter bag was allowed to touch the floor then there was a risk of dislodging the catheter, infection control, and dignity through exposure. Record review of the facility provided policy titled Urinary Catheter Bag Storage undated, revealed the following: Purpose:To ensure proper stoae (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and handling of urinary catheter drainage bags to reduce the risk of infection, maintain residents' dignity, and comply with Texas LTC regulation and infection control standards.Policy Statement:The facility will ensure that all urinary catheter bags are stored in a manner that:-Prevents contamination.Policy Guidelines:General Storage Requirements-Bags must never touch the floor.