STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	647 US Hwy 190 W Woodville, TX 75979

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 5 (Resident # 1) residents reviewed for misappropriation of resident property. The facility failed to prevent a drug diversion (misappropriation) of Resident #1's liquid morphine sulfate, a controlled medication. During the narcotic count audit, on 10/17/24, LVN D and LVN F discovered approximately 1 mL of Resident #1's liquid morphine sulfate was missing. The non-compliance was identified as past non-compliance. The noncompliance began on 10/17/24 and ended on 10/17/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for decreased quality of life, increased pain, and misappropriation of property or physician ordered medications. The findings included: Record review of the face sheet, dated 5/19/25, reflected Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (brain disorder that slowly destroys a person's memory and thinking skills), prostate cancer, and fractured (broken) left leg and hip. Record review of the quarterly MDS assessment, dated 09/20/24, reflected Resident #1 had clear speech and was understood by others. Resident #1 was able to understand others. Resident #1 had a BIMS score of 5, which indicated severe cognitive impairment. Resident #1 had no behaviors or refusal of care. Resident #1 received scheduled and PRN pain medications. Resident #1 denied any pain during the 5-day look-back period. Resident #1 received opioid pain medication and had an indication for use. Record review of the comprehensive care plan, last reviewed 08/28/24, reflected Resident #1 was receiving hospice services related to a terminal prognosis. The interventions included: observe closely for signs of pain, administer medication as ordered, and notify doctor immediately for breakthrough pain. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the provider investigation report, dated 10/23/24, reflected during shift change on 10/17/24, it was noticed that 1 mL of morphine was missing from 6 AM cart count all nurses were immediately called in to give statements to DON and Administrator. All nurses were required to provide a urine sample for drug screen. In-services were conducted with all staff. 4 nurses total were terminated and/or suspended pending outcome of investigation . Record review of Resident #1's MAR, dated October 2024, reflected LVN D administered 0.5 mL of morphine sulfate 20 mg/mL by mouth at 11:30 AM on 10/17/25. Record review of the MAR administration note, dated 10/17/24, reflected LVN D administered 0.5 mL of morphine sulfate to Resident #1. The note reflected LVN D was instructed by the hospice nurse to administer the medication. Record review of the DON's witness statement, dated and signed on 10/17/24, reflected she worked the 400 hall nurses' cart on 10/5/25 from 6 AM until about 10 AM until she was relieved by LVN F. She did not administer morphine to Resident #1. Record review of LVN F's witness statement, dated and signed on 10/17/24, reflected she had given Resident #1 morphine sulphate on two occasions. LVN F administered morphine on 08/17/24 and 08/24/24 after a fall when Resident #1 was in severe pain, and it was okay with the responsible party. LVN F stated she had worked the 2 PM to 10 PM shift on 10/16/24. LVN F stated the count was correct for all the narcotics. LVN F stated when she arrived for her shift on 10/17/24, Resident #1's morphine count was short. Record review of LVN K's witness statement, signed and dated 10/17/24, reflected she worked on the 400 hall nurses' cart on 10/6/24 and did not administer any morphine to Resident #1 at any time. Record review of LVN A's witness statement, signed and dated 10/17/24, reflected she had not provided any morphine to Resident #1 because of a family request that he not receive the medication unless the family member was notified. Record review of LVN O's witness statement, signed and dated 10/17/24, reflected she had never administered morphine to Resident #1. Record review of LVN H's witness statement, signed and dated 10/17/24, reflected she had not given Resident #1 morphine at any time since 07/03/24. Record review of LVN P's witness statement, signed and dated 10/17/24, reflected she had not given Resident #1 morphine since 07/03/24. Record review of LVN Q's witness statement, unsigned and undated, reflected LVN Q had never administered morphine to Resident #1. Record review of LVN R's witness statement, signed and dated 10/17/24, reflected she had never given any morphine to Resident #1. LVN R wrote on 06/28/24 she notified hospice that Resident #1 was in severe pain and the nurse came to the facility, notified the family member, and administered the morphine. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN S's witness statement, signed and dated 10/17/24, reflected she had administered 0. 25 mL of morphine at 3:30 PM to Resident #1 on 07/03/24. Record review of LVN T's witness statement, signed and dated 10/17/24, reflected she had never given Resident #1 morphine. Record review of LVN L's witness statement, unsigned and undated, reflected she had not administered morphine to Resident #1. Record review of LVN U's witness statement, signed and dated 10/17/24, reflected she had been working on Hall 100 and had not been on hall 400 nurses' cart to the best of her knowledge. Record review of the ADON's witness statement, signed and dated 10/17/24, reflected she had not given Resident #1 morphine. Record review of LVN V's witness statement, signed and dated 10/17/24, reflected she did not remember giving Resident #1 any morphine since July 2024, but she was not positive. LVN V stated she did not remember any major discrepancies on the morphine sulfate. Record review of LVN W's witness statement, signed and dated 10/17/24, reflected she had worked 10 PM - 6 AM in August of 2024. LVN W stated she did not administer any morphine to the best of her knowledge. Record review of the DON's witness statement, dated 10/21/24, reflected on 10/17/24 at shift change LVN F was the oncoming nurse and approached the DON about the morphine sulphate count being off for Resident #1. The off-going nurse, LVN D, documented giving 0.5 mL of the morphine during her shift on 10/17/24, but the count was still off. The DON contacted the Administrator and the Regional Compliance Nurse, and it was determined to be a drug diversion. The DON initiated the drug diversion protocol. The DON called in all nurses who worked the 400 hall medication cart, since 07/03/24 and had them give statements and take a drug test. LVN D, the off-going nurse, had clocked out and left before calling the drug diversion. LVN D was called and asked to come back to the facility and give her statement and obtain a drug screen. LVN D reported that she had a seizure and was taken to the hospital by an ambulance. The DON informed her she only had 2 hours to come back to the facility or it would be self-termination. LVN D said she would have her husband bring her after she was released from the hospital. LVN D did not show up, so the Administrator and the Human Resources Coordinator called the hospital to see if they could get a consent for a drug screen and it was learned that the employee had left the hospital against medical advice. During an interview on 05/18/25 beginning at 8:58 AM, LVN A stated she had never given Resident #1 any morphine, but Resident #1 was on her scheduled hall. LVN A stated she looked at the narcotic count book during the investigation to make sure the count was accurate. LVN A stated she helped measure out and check the morphine. LVN A stated there was discrepancy of about 1 mL that was missing from what she was able to remember. LVN A stated Resident #1 was on routine pain medication and was followed by hospice services. LVN A stated he frequently had pain because he had metastatic bone cancer. LVN A stated Resident #1 did not have any pain exacerbations related to the discrepancies. LVN A stated the facility drug tested all the nurses' and staff who had access to the 400 hall nurses' medication cart. LVN A stated there was suspicions of what happened but there was never any proof. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 beginning at 11:17 AM, the Administrator stated she had attempted to obtain the police report for Resident #1's self-reported incident, however the person who dealt with the medical record was out sick. During an attempted telephone interview with LVN D on 05/19/25 beginning at 11:22 AM, the following message was received Wireless customer you are trying to reach is unavailable. No message was left, and no return call was obtained upon exit of the facility. During an attempted telephone interview with LVN D on 05/19/25 beginning at 11:23 AM, the following message was received Wireless customer you are trying to reach is unavailable. No message was left, and no return call was obtained upon exit of the facility. During a telephone interview on 05/19/25 beginning at 11:24 AM, LVN E stated on 10/17/24 there was discrepancy with one of the medication carts. She said Resident #1 was short on morphine. LVN E stated she believed they were short approximately 2 mL but was not sure. LVN E stated the next thing she knew; she was requested to take a drug test. LVN E stated she had only worked in the facility PRN as an aide. LVN E stated it had been a while since she had even worked the medication cart. LVN E stated on 10/17/24 when the morphine medication was missing, she had not worked on the cart. LVN E stated she normally counted the narcotics when she came into work and got off work if she was working the medication cart. LVN E stated she had never noticed any discrepancies when she worked. LVN E stated LVN D was suspected of taking the medication. LVN E stated LVN D had been to work several times before the incident acting suspicious. LVN E stated LVN D was sleeping on the job, slurring her words, and acting strange. LVN E stated management staff were aware of the way LVN D was acting. LVN E stated she did not take the morphine. During an interview on 05/19/25 beginning at 11:40 AM, LVN F stated on 10/16/24 she had counted the narcotics when she left her shift at 10 PM. LVN F stated the count was correct and there were no discrepancies. LVN F stated when she arrived back to the facility for her 2 PM to 10 PM shift on 10/17/24, Resident #1's morphine count was off. LVN F stated LVN D had reported she had administered some of the medication to Resident #1 during the shift. LVN F stated she had reported the discrepancy to the DON and LVN D had left the facility before the investigation had been completed. LVN F stated LVN D had not taken a drug test. LVN F stated she had a lot going on in her life around the time of the incident and refused to take the drug test. LVN F stated she did not take the morphine as she was the one that found the discrepancy. LVN F stated she had not noticed a major discrepancy with the narcotic count prior to the incident. LVN F stated LVN D did not exhibit any signs or symptoms of drug use when they counted on 10/17/24. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 beginning at 12:02 PM, the DON stated if discrepancies were reported, then she notified the pharmacist and Administrator. The DON stated an investigation would have been completed. The DON stated an audit would have been performed to determine if any other discrepancies were identified. The DON stated on 10/17/24, LVN F reported that there was a discrepancy with Resident #1's morphine. The DON stated she spoke with the Administrator and Regional Compliance Nurse, and it was determined to initiate the drug diversion protocol. The DON stated a complete audit of all narcotics was conducted by the ADON and herself, with no other discrepancies identified. The DON stated it was decided that drug testing needed to be performed for everyone that worked the 400 hall medication cart for the last 3 months. The DON stated LVN D had already left the facility. The DON stated she attempted to call LVN D to return to the facility to complete a drug screen and her husband stated she had a seizure and was taken to the hospital. The DON stated LVN D had never showed up and had actually left the hospital against medical advice. The DON stated LVN D had attempted to call the facility 3 -4 days after the incident and stated she was ready for the drug screen. The DON informed her that she was unable to complete the drug screen because too much time had passed, and she had self-terminated. The DON reported she had suspected LVN D because she had started administering PRN medications that were not normally given. The DON stated she was never able to prove her suspicions because LVN D documented well. The DON stated several other nurses had refused the drug screen and she had to terminate all of them according to the policy. The DON stated after the incident she temporarily switched from liquid morphine to the morphine tablets. The DON stated if liquid morphine was required, then two nurses had to verify the dosage and sign off on the controlled record form. The DON stated Resident #1 had access to pain medication and suffered no adverse effects or exacerbated pain. The DON stated in-service education was provided to nurses to include counting medication carts, medication administration policy and procedure, and the new process for signatures related to morphine administration. During an interview on 05/19/25 beginning at 2:40 PM, the ADON stated she assisted the DON during the drug diversion investigation. The ADON stated she had helped the DON complete the drug audit with no further discrepancies identified and assisted with the drug screening. During an interview 05/19/25 beginning at 3:18 PM, the Administrator stated her expectations during a drug diversion were to be notified immediately. She expected the nursing staff to contact the doctor, Regional Compliance Nurse, and Area Director of Operations. The Administrator stated an investigation should have been started immediately. The Administrator stated the police should have been notified and drug testing performed on any licensed staff who had access to the drugs. The Administrator stated the facility followed the policy and procedures for the drug diversion that happened on 10/17/24. The Administrator stated Resident #1 suffered no ill effects or exacerbation of pain. The Administrator stated the incident was reported to HHSC. The Administrator stated LVN D who was suspected of the diversion was called in for a drug screen and her husband said she was at the hospital for seizures. The Administrator stated she had called the hospital to request a drug screen be conducted and she was told that LVN D had left against medical advice. The Administrator stated she attempted to contact LVN D numerous times, but she never came in for the drug screen. The Administrator stated her refusal was an automatic termination. The Administrator stated several other staff members had refused and another staff member tested positive for a different drug. The Administrator stated none of the staff members had tested positive for morphine. The Administrator stated no referrals had been made to the board of nursing related to a lack of evidence. The Administrator stated the DON completed in-service education with the nurses, and the process was reviewed monthly in QAPI. The Administrator stated the Medical Director was aware and there have been no further incidents. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had corrected the non-compliance on 10/17/24 by the following: 1. Record review of a statement, signed and dated on 10/17/24, by the Administrator reflected she had called the hospital at 7:14 PM, the ask if LVN D was still there and if so, could they obtain a drug test. The Administrator was informed that LVN D had refused to give the hospital a drug screen and left against medical advice. 2. Record review of the Employee Disciplinary Report Action Request, signed and dated 10/17/24, reflected LVN E refused to take a drug screen related to the drug diversion and was terminated. 3. Record review of the Employee Disciplinary Report Action Request, signed and dated 10/17/24, reflected LVN F refused to take a drug screening related to the drug diversion and was terminated. 4. Record review of the Payroll Input/Personnel Action Form, dated 10/17/24, reflected LVN D was self-terminated for refusal of drug screen. 5. Record review of the drug screens, dated 10/17/24, reflected LVN W, the ADON, LVN U, LVN L, LVN T, LVN S, LVN R, LVN Q, LVN P, LVN H, LVN O, LVN A, LVN K, and the DON were negative for all drugs. 6. Record review of the Ad Hoc QAPI sign in sheet, dated 10/17/24, reflected the Administrator, DON, ADON, Medical Director, Social Services, Dietary Manger, Activity Director, BOM, and 6 other people were in attendance. 7. Record review of the In-service Training Attendance Roster, dated 10/17/24, reflected nurses were provided education on medication administration procedure. There were 12 nurses' signatures. 8. Record review of the In-service Training Attendance Roster, dated 10/17/24, reflected nurses were provided education on drug diversion, morphine sulphate count, and requiring 2 nurses' signatures to verify the dosage given. There were 10 nurses' signatures. 9. Record review of the In-service Training Attendance Roster, dated 10/17/24, reflected nurses' were provided education on pain management. There were 13 nurse signatures. 10. Record review of the Drug Destruction Monitoring Forms, revealed the following: 1. On 10/17/24 and 10/18/24 all medications awaiting drug destruction were logged and placed under double lock until destruction by the pharmacist and DON. 2. On 10/21/24 through 10/25/24 all medications awaiting drug destruction were logged and placed under double lock until destruction by the pharmacist and DON. 3. On 10/28/24 through 11/01/24 all medications awaiting drug destruction were logged and placed under double lock until destruction by the pharmacist and DON. 4. On 11/04/24 through 11/08/24 all medications awaiting drug destruction were logged and placed under double lock until destruction by the pharmacist and DON. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. During an observation and interview on 05/19/25 beginning at 9:36 AM, a narcotic audit count of the liquid morphine was completed with LVN A on the 100/300/unit nurses' medication cart. Resident #3, Resident #5, Resident #6, Resident #7, and Resident #8's morphine bottles matched the amount on the Individual Patient's Controlled Substance Record. Resident #6 had received 0.25 mL of liquid morphine on 05/10/25 and two nurse signatures had signed off. There were no discrepancies observed. LVN A stated she counted the narcotic on the medication cart when he arrived for her shift and when she left her shift. LVN A stated when liquid morphine was administered it required 2 nurses' signatures to verify the dosage administered. LVN A stated if the narcotic medication count was off or did not match, she would try to investigate to see if the math was off, or if the medication was not signed out. LVN A stated if she was unable to determine the cause, then she would have notified the DON. 12. During interview conducted on 05/19/25 between 12:02 PM and 2:21 PM, reflected LVN A, LVN G, LVN H, LVN K, LVN L, RN M, LVN O, the ADON, the MDS Coordinator, and the DON had been provided education on medication administration procedures, misappropriation of property or drug diversion and reporting immediately, and two nurses verifying the dosage of liquid morphine and signing off on the narcotic count record. Record review of the Abuse/Neglect policy, revised 3/29/18, reflected The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation .misappropriation of property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent . The noncompliance was identified as PNC. The noncompliance began on 10/17/24 and ended on 10/17/24. The facility had corrected the noncompliance before the survey began.

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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** 47006 Based on observation, interviews, and record review, the facility failed to develop or implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 2 of 4 residents reviewed for comprehensive care plans related to behaviors. (Resident #2 and Resident #3) 1. The facility failed to ensure Resident #2's comprehensive care plan for physical aggression was personalized and person-centered. 2. The facility failed to develop a person-centered care plan for Resident #2's verbal and other (verbal/vocal symptoms like screaming, disruptive sounds) behaviors. 3. The facility failed to develop a person-centered care plan for Resident #3's verbal behaviors. These failures could place residents at risk of not having individual needs met and a decreased quality of life. The findings included: 1. Record review of the face sheet, dated 05/18/25, reflected Resident #2 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses Alzheimer's disease (brain disorder that slowly destroys a person's memory and thinking skills), generalized anxiety disorder (mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), and cancer of the colon and anus. Record review of the annual MDS assessment, dated 01/01/25, reflected Resident #2 had clear speech and was usually understood by others. Resident #2 was usually able to understand others. Resident #2 had a BIMS score of 2, which indicated severe cognitive impairment. Resident #2 had inattention and disorganized thinking continuously present and did not fluctuate. The MDS reflected Resident #2 had other behavioral symptoms not directed toward others, which included examples such as . verbal/vocal symptoms like screaming, disruptive sound . daily during the 7 day look-back period. Record review of the quarterly MDS assessment, dated 02/21/25, reflected Resident #2 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #2 had physical behavioral symptoms directed toward others 1 - 3 days during the 7 day look-back period. Record review of the care plan conference form, dated 03/19/25, reflected Resident #2's behaviors were not documented as discussed. Record review of Resident #2's weekly nursing summary report, reflected the following: 1. On 3/21/25 Resident #2 had verbal behaviors 1 to 3 days. The description included: has increased agitation at times, preaches to staff and other resident's in raised voice, will clap hands together at staff and other residents when preaching. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 03/28/25 Resident #2 had verbal behaviors 1 to 3 days. There was no description documented. 3. On 04/04/25 Resident #2 had verbal behaviors 1 to 3 days. There was no description documented. 4. On 04/11/25 Resident #2 had verbal and physical behaviors that occurred 4 to 6 days. The description included: has increased agitation at times, preaches to staff and other residents in a raised voice, will clap hands together at staff and other residents when preaching. 5. On 04/19/25 Resident #2 had verbal and physical behaviors that occurred 1 to 3 days. There was no description documented. 6. On 04/26/25 Resident #2 had verbal behaviors that occurred 1 to 3 days. The description included: has increased agitation at times, preaches to staff and other residents in a raised voice, will clap hands together at staff and other residents when preaching. 7. On 05/03/25 Resident #2 had verbal behaviors that occurred 1 to 3 days. The description included: has increased agitation at times, preaches to staff and other residents in a raised voice, will clap hands together at staff and other residents when preaching. 8. On 05/10/25 Resident #2 had verbal behaviors that occurred 1 to 3 days. There was no description documented. Record review of the comprehensive care plan, initiated 04/11/25, reflected Resident #2 was physically aggressive toward another resident. The goal was determine the cause of residents physical aggression. The interventions included resident moved to another room and secure care consult. The care plan did not address any verbal or other behaviors. Record review of the event nurses' note for behavior, dated 04/11/25, reflected Resident #2 was physically aggressive towards another resident. Resident #2 walked up to another resident and slapped her on the left side of her face . Interventions included: interval monitoring, redirection, and lab work. Record review of Resident #2's follow-up behavior nurses notes, reflected the following: 1. On 04/11/25 at 3:22 PM Patient is unaware of the situation that occurred earlier in then day with Resident #4. She was kept mostly separated from Resident #4 this shift. Aggressive behavior not shown. Interventions included: one-on-one monitoring, every 15 minute monitoring, and directed the resident to room to decrease stimulation. 2. On 04/11/25 at 11:22 PM resident in bed asleep, no behaviors noted or reported. Interventions included: scheduled monitoring per protocol. 3. On 04/12/25 at 9:06 AM Resident sitting in common room watching television. CNA reported that resident ate in the dining room without incident. No behaviors noted at this time. Resident is unaware of being physically aggressive towards another resident. Interventions included: scheduled monitoring and lab work collected, and results were pending. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 04/12/25 at 11:05 PM Resident in bed, no behaviors noted. Interventions included: scheduled monitoring per protocol. 5. On 04/13/25 at 7:24 AM Resident awake and alert, sitting in common room watching television. CNA reports no negative behaviors at this time, will continue to monitor. Interventions included: scheduled monitoring and lab results pending. 6. On 04/13/25 at 4:33 PM No behaviors noted this shift. Interventions included: scheduled monitoring per protocol. 7. On 04/13/25 at 11:45 PM Resident asleep, no behaviors noted or reported. Interventions included: monitored per protocol. 8 On 04/14/25 at 11:01 AM ambulating in unit no distress noted at this time. Interventions included: scheduled monitoring per protocol. Record review of the behavior task documentation for CNAs dated between 04/24/25 and 05/18/25, reflected Resident #2 had physical, verbal, and other behaviors documented on 04/24/25, 04/26/25, 04/30/25, 05/02/25, 05/03/25, 05/04/25, and 05/12/25. 2. Record review of the face sheet, dated 05/18/25, reflected Resident #3 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of senile degeneration of brain (range of neurological disorders characterized by a progressive decline in cognitive function, impacting memory, reasoning, and the ability to perform everyday activities) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). Record review of the quarterly MDS assessment, dated 03/11/25, reflected Resident #3 had clear speech and was understood by others. Resident #3 was able to understand others. Resident #3 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #3 had verbal behaviors that occurred 1 to 3 days during the 7 day look-back period. Record review of Resident #3's comprehensive care plan, last reviewed on 03/12/25, did not address behaviors. Record review of the care plan conference form, dated 03/19/25, reflected Resident #3's behaviors were not documented as discussed. Record review of Resident #3's weekly nursing summary report, reflected the following: 1. On 04/05/25 Resident #3 had verbal behaviors that occurred 1 to 3 days. There was no description documented. 2. On 05/10/25 Resident #3 had verbal behaviors that occurred 1 to 3 days. There was no description documented. Record review of the nursing progress note, dated 04/29/25, reflected Resident #3 had increased agitation, pacing through the secure unit, anger directed towards other resident, stated 'she needs to leave, i already called the police' . (continued on next page)

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	675152	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	647 US Hwy 190 W Woodville, TX 75979

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the nursing progress note, dated 05/12/25, reflected Resident #3 was trying to kick all the other residents out of his house multiple attempts to redirect unsuccessful. Record review of the behavior task documentation for CNAs dated between 04/24/25 and 05/18/25, reflected Resident #3 had physical, verbal, and other behaviors documented on 04/28/25 and 04/29/25. During an observation on 05/18/25 beginning at 9:27 AM, Resident #2 was sitting up in the dining room around the dining room table with 5 other residents, including Resident #3. The television was off and there was no music, or other activity going on during the observation. No staff members were in the dining room, which was a resident room that had been converted to a dining room. CNA B was sitting in the living area directly across the hallway, which was another resident room that had been converted. CNA B was looking down and writing in a binder. She had one resident sitting in the wheelchair beside her. Resident #2 was ranting and cussing God knows what I do .only God knows . I don't give a shit . Resident #3 became agitated and told Resident #2 Why don't you just shut up? Resident #2 then repeated to Resident #3 Why don't you shut up? CNA B was unable to hear the exchange and the state surveyor stepped out into the hallway from the doorway to alert CNA B. CNA B was entering the dining room when Resident #3 swung his hand at Resident #2 without making contact. CNA B immediately separated Resident #2 and Resident #3. CNA B called LVN A with the facility phone. LVN A arrived on the secured unit to assist CNA B. During an interview on 05/18/25 beginning at 11:52 AM, CNA B stated there was normally one staff member on the secured unit at all times. CNA B stated the nurse assisted on the secured unit as it was needed. CNA B stated Resident #2 and Resident #3's behaviors were normal. CNA B stated Resident #2's behaviors included verbal and physical. CNA B stated Resident #2 was hyper focused on religion. CNA B stated Resident #3 only exhibited behaviors in response to Resident #2 starting up. CNA B stated starting up meant ranting or preaching out loud. CNA B stated she normally redirected the residents, took them for a walk, or distracted them with music if they exhibited behaviors. CNA B stated she was able to see into the dining room from her position in the living room. CNA B stated she was unable to hear anything going on but would have gotten up to investigate when she saw a commotion or movement. CNA B stated the residents normally sit in the dining room after breakfast with no problems. CNA B stated Resident #2 and Resident #3's behaviors should have been included on a care plan. CNA B stated the purpose of a care plan was to provide interventions to use if the residents had behaviors. CNA B stated it was important to ensure behaviors were included on the care plan to help the staff provide interventions that worked for the residents and to prevent escalation of behaviors. During an interview on 05/19/25 beginning at 1:47 PM, LVN A stated the care plan process included identified problems or concerns happening with the residents, notifying the DON and possibly talking with the MDS Coordinator. LVN A stated the purpose of a care plan was to see a snapshot of the resident. LVN A stated a care plan could have given an idea of the residents' day to day care and services they should have been receiving at the facility. LVN A stated Resident #2 talked aimlessly and randomly. LVN A stated Resident #2 had random conversations with herself, which often have to do with religion. LVN A stated Resident #2 preaches at staff and residents. LVN A stated Resident #3 did not have behaviors often. LVN A stated Resident #3 does have sundowning behaviors and becomes confused. LVN A stated behaviors should have been included on a care plan. LVN A stated it was important to ensure behaviors were included on the care plan and interventions were resident specific to ensure staff were aware of the interventions that worked to deescalate and calm the residents down. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 beginning at 2:11 PM, the MDS Coordinator stated care plans were developed as part of an IDT. The MDS Coordinator stated care plans were developed on admission and then reviewed and updated quarterly. The MDS Coordinator stated only behaviors that effected the plan of care should have been included on the care plan. The MDS Coordinator stated comprehensive care plans should have been person-centered and resident specific. The MDS Coordinator stated Resident #2 and Resident #3's behaviors should have been care planned. The MDS Coordinator stated Resident #2's care plan for physical behaviors should have been resident specific. The MDS Coordinator was unsure why the behaviors were not included on the care plan. The MDS Coordinator stated it was important to ensure behaviors were included in the care plan and interventions were specific to the resident because it effects how the staff respond and care for the residents. During an interview on 05/19/25 beginning at 2:21 PM, the Social Worker stated she had only worked at the facility for a few weeks. The Social Worker stated it was important for the staff to be aware of any behaviors the residents could have. The Social Worker stated the purpose of the care plan was to create an individual care map of the resident. The Social Worker stated it was important to ensure staff were aware of residents' behaviors, so staff were aware of how to care for them. During an interview on 05/19/25 beginning at 2:48 PM, the DON stated when she identified issues or concerns with the residents' she initiated a care plan. The DON stated behaviors should have been included on the care plan. The DON stated if a care plan interventions or goals specified to determine then the care plan should have been updated to reflected resident specific goals or interventions. The DON stated she was unsure why Resident #2 and Resident #3's behaviors were not included in the care plan. The DON stated she was unsure why Resident #2's care plan was not updated to reflect a resident specific goal. The DON stated the purpose of the care plan was to ensure all staff were on the same page and knew how to care for the resident. During an interview on 05/19/25 beginning at 3:18 PM, the Administrator stated she expected behaviors to be included on the care plan. The Administrator stated the IDT was responsible for monitoring to ensure behaviors were included on the care plan. The Administrator stated it was important to ensure behaviors were included on the care plan to monitor the resident's progress, determine the root cause of the behaviors, and prevent or manage escalation of behaviors. Record review of the Comprehensive Care Planning policy, undated, reflected The facility will develop and implement a comprehensive person-centered 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 .the comprehensive care plan will describe the following the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47006 Based on interview and record review the facility failed to provide pharmaceutical services that determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 2 nurses' medication carts (100/300/unit nurses' medication cart) reviewed for pharmacy services. The facility failed to ensure the 100/300/unit nurses' medication cart Controlled Drugs Audit Record was signed off before and after each shift for October 2024, November 2024, December 2024, January 2025, February 2025, March 2025, and April 2025. The Audit Record had a total of 28 missing nurse signatures. These failures could place residents at risk for medication errors and loss of medications through drug diversion. The findings included: Record review of the 100/300/Unit nurses' medication cart Controlled Drugs Audit Record dated October 2024, reflected 2 missing nurse's signatures. On 10/24/24, the nurse on under 6 AM - 2 PM shift and the nurse off under 2 PM - 10 PM shift were not signed. Record review of the 100/300/unit nurses' medication cart Controlled Drugs Audit Record dated November 2024, reflected 6 missing nurse's signatures. The missing signatures were as follows: 1. On 11/04/24 the nurse on under 6 AM - 2 PM shift and the nurse off under 2 PM - 10 PM shift were not signed. 2. On 11/24/24 the nurse on under 6 AM - 2 PM shift and the nurse off under 2 PM - 10 PM shift were not signed. 3. On 11/25/24 the nurse on under 6 AM - 2 PM shift and the nurse off under the 2 PM - 10 PM shift were not signed. Record review of the 100/300/unit nurses' medication cart Controlled Drugs Audit Record dated December 2024, reflected 4 missing nurse's signatures. The missing signatures were as follows: 1. On 12/13/24 the nurse on under 10 PM - 6 AM shift was not signed. 2. On 12/14/24 the nurse off under 6 AM - 2 PM shift was not signed. 3. On 12/24/24 the nurse off under 2 PM - 10 PM and the nurse on under 10 PM - 6 PM were not signed. Record review of the 100/300/unit nurses' medication cart Controlled Drugs Audit Record dated January 2025, reflected 3 missing nurse's signatures. The missing signatures were as follows: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 01/01/25 the nurse off under 10 PM - 6 AM shift was not signed. 2. On 01/08/25 the nurse off under 2 PM - 10 PM shift was not signed. 3. On 01/09/25 the nurse off under 2 PM - 10 PM shift was not signed. Record review of the 100/300/unit nurses' medication cart Controlled Drugs Audit Record dated February 2025, reflected 1 missing nurse's signature. On 02/28/25 the nurse on under 10 PM - 6 AM shift was not signed. Record review of the 100/300/unit nurses' medication cart Controlled Drugs Audit Record dated March 2025, reflected 8 missing nurse's signatures. The missing signatures were as follows: 1. On 03/01/25 the nurse off under 6 AM - 2 PM shift, the nurse on under 6 AM - 2 PM shift, and the nurse off under the 2 PM - 10 PM shift were not signed. 2. On 03/20/25 the nurse on under the 2 PM - 10 PM shift, the nurse off under 10 PM - 6 AM, and the nurse on under the 10 PM - 6 AM were not signed. 3. On 03/21/25 the nurse off under the 6 AM - 2 PM shift was not signed. 4. On 03/31/25 the nurse on under the 10 PM - 6 AM shift was not signed. Record review of the 100/300/unit nurses' medication cart Controlled Drugs Audit Record dated April 2025, reflected 4 missing nurse's signatures. The missing signatures were as follows: 1. On 04/15/25 the nurse on under the 10 PM - 6 AM shift was not signed. 2. On 04/16/25 the nurse off under the 6 AM - 2 PM shift was not signed. 3. On 04/25/25 the nurse on under the 10 PM - 6 AM shift was not signed. 4. On 04/26/25 the nurse off under the 6 AM - 2 PM shift was not signed. During an interview on 05/19/25 beginning at 1:47 PM, LVN A stated the 100/300/unit nurses' medication cart was counted for accuracy of controlled medications when she started her shift and when she left her shift. LVN A stated the medication carts were counted with the on-coming nurse and off-going nurse. LVN A stated part of counting the nurses' medication carts were signing the Controlled Drugs Audit Record sheet. LVN A stated the missing signatures could have happened related to forgetting to sign or getting interrupted while counting the nurses' medication carts. LVN A stated it was important to ensure the nurses' medication carts were counted and signed each shift to verify a count was completed and prevent a potential drug diversion. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/19/25 beginning at 2:48 PM, the DON stated she expected the nurses to sign the Controlled Drugs Audit Record after the medication carts were counted. The DON stated she expected the nurses' medication carts to be counted before their shift and after their shift. The DON stated she monitored the nurses to ensure they were counting the controlled medication on the medication carts by visual rounds. The DON was unsure if the Controlled Drugs Audit Record was monitored to ensure signatures were completed. The DON stated it was important to ensure the nurses' medication carts were counted and signed each shift to ensure no medications were missing, to ensure everything was counted, and to verify the person responsible for that medication cart. During an interview on 05/19/25 beginning at 3:18 PM, the Administrator stated she expected the nursing staff to ensure the Controlled Drugs Audit Record had no missing signatures. The Administrator stated the DON was responsible for monitoring to ensure the record had no missing signatures. The Administrator stated it was important to ensure the Controlled Drugs Audit Record had all the required signatures to prevent drug diversion or missing medications. The Administrator stated it was important to provide the best care to ensure their quality of life. Record review of the Controlled Medications - Administration policy, year dated 2025, reflected . At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA .or equivalent as allowed by your State regulatory agency and is documented on an audit record .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review the facility failed to maintain an effective pest control program so that facility was free of pests and rodents for 1 of 7 residents (Resident #4) on the secured unit reviewed for pests. The facility failed to ensure Resident #4's room was free of ants, which resulted in 10 ant bites to her left arm, 2 ant bites for her right arm, and 2 ant bites to her left clavicle. The bites were identified on 12/18/24. These findings could place residents at risk for an injury or infection related to ant bites, an unsanitary environment, and a decreased quality of life. The findings included: Record review of the face sheet, dated 05/18/25, reflected Resident #4 was an [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (brain disorder that slowly destroys a person's memory and thinking skills). Record review of the quarterly MDS assessment, dated 05/10/25, reflected Resident #4 had clear speech and was usually understood by others. Resident #4 was usually able to understand others. Resident #4 had a BIMS score of 5, which indicated severe cognitive impairment. Resident #4 had inattention and disorganized think continuously present with no fluctuation. Resident #4 required assistance with ADLs that fluctuated from supervision to partial/moderate assistance to substantial/maximal assistance. Record review of the comprehensive care plan, initiated 08/02/23, reflected Resident #4 had an ADL self-care performance deficit. Resident #4 required supervision and one staff assistance with most ADLs. Record review of the pest control work order created on 12/14/24 by CNA B, reflected ants around the baseboards and roaches. The 4 rooms listed were on the secured unit. The notes section obtained the following: 1. On 12/14/24 found black ants around base boards eating food crumbs. Had housekeeping to deep clean rooms. 2. On 12/17/24 found 2 black ants and more food crumbs against baseboard. Housekeeping deep cleaned rooms again. 3. On 12/18/24 found more food crumbs and about 6 black ants. Housekeeping deep cleaned rooms. Contacted pest control for appointment. 4. On 12/19/24 Pest control arrived and put out bait for black ants. 5 On 12/20/24 no signs of black ants or food crumbs located in rooms. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the event note, dated 12/18/24, reflected Resident #4 had multiple pustules (small blister or pimple that contains pus) noted to left upper arm and chest/neck area. The nursing description of the event included Reported to DON that resident had multiple pustules that appear to be ant bites to left upper arm and chest/neck area. Resident room was assessed, and 4 ants were found around the bottom of the nightstand. No ants found on resident or in her bed. The resident and roommate were removed from the room and deep clean was performed and residents were returned to room. The event note reflected Resident #4 had no pain and treatment was not required. Record review of the Weekly Skin Assessment, dated 12/18/24, reflected Resident #4 had other skin findings not described above. The description was Ant bites noted to left arm x 10, left clavicle x 2, and right arm x 2. Denies any pain or discomfort. Resident stated she was unaware that she had any bites on her during head-to-toe skin assessment . Record review of Resident #4's Other Event Nurses' Note, reflected the following: 1. On 12/18/24 at 7:20 PM - No new ant bites noted, no signs or symptoms of infection noted to previous bites. 2. On 12/18/24 at 11:36 PM - No signs or symptoms of infection or discomfort noted from ant bites. 3. On 12/19/24 at 7:13 AM - Healing ant bites to bilateral upper extremities and left clavicle area. Resident denies any pain or itching to areas. 4. On 12/19/24 at 4:24 PM - No new ant bites noted. No signs or symptoms of infection noted to previous bites. 5. On 12/19/24 at 11:53 PM - No signs or symptoms of infection or discomfort from ant bites noted. 6. On 12/20/24 at 8:21 AM - No signs or symptoms of infection or discomfort from ant bites noted. 7. On 12/20/24 at 6:38 PM - No signs or symptoms of infection or discomfort from ant bites noted. 8. On 12/20/24 at 11:23 PM - No signs or symptoms of infection or discomfort from ant bites noted. Record review of the Inservice Training Attendance Roster, dated 12/18/24, reflected the Maintenance Supervisor was provided education on ant treatment. The training reflected The Maintenance Supervisor will be in-serviced to monitor the facility grounds and to treat any new or active ant mounds with an insecticide, once treated he will mark the area with green spray pain. Also, in-service the Maintenance Supervisor to monitor the outside perimeter for ants entering the facility. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the pest control inspection report, dated 12/19/24, reflected . on site for monthly service. On arrival I spoke with the Maintenance Supervisor who noted issues of nuisance ants throughout the facility. I began the service with an interior inspection and cracking crevice liquid residual application to common areas, entryways, and potential harborage sites the Maintenance Supervisor guided me to room [ROOM NUMBER] and 213 (on the secured unit). During my inspection of these rooms, live activity was present in both, and a bait application was performed to aid in control and elimination of nuisance ants. Monitors were replaced in residual perimeter application to aid in control of occasional invaders. Fire ant beds were treated with a bait application to eliminate the present colonies .reported nuisance ants throughout building. Moved service up to accommodate . Record review of the Ant Monitoring form, dated the week of 12/19/24, reflected no staff had reported seeing any ants. The form reflected no residents had evidence of ant bites on their skin assessments. The form reflected no open food was found on or around the residents during daily rounds. Record review of the Ant Monitoring form, dated the week of 12/26/24, reflected no staff had reported seeing any ants. The form reflected no residents had evidence of ant bites on their skin assessments. The form reflected no open food was found on or around the residents during daily rounds. Record review of the pest control inspection report, dated 01/24/25, reflected . I also treated for little black ants in bathroom of 212 (on the secured unit) by applying a gel bait application in cracks and crevices of the bathroom . Record review of the pest control inspection report, dated 02/26/25, reflected . I walked the exterior perimeter and applied a granule ant bait on the lawn and 4-5 ant mounds . Record review of the pest control inspection report, dated 03/28/25, did not indicate any interventions completed regarding ants. Record review of the pest control inspection report, dated 04/25/25, reflected .I applied a non-repellant liquid repellent application on the exterior perimeter/foundation, cracks and crevices to prevent ants and other unwanted pest from entering the facility and applied a granular ant bait on 6-8 ant mounds on the exterior grounds . Record review of the system created work orders, dated 03/05/25, 03/12/25, 03/19/25, 03/26/25, 04/04/25, 04/09/25, 04/16/25, 04/23/25, 04/30/25, 05/07/25, and 05/14/25, reflected ant mound inspections were completed. There were no notes to indicate amount of ant piles observed or treatment notes. During an observation and interview on 05/18/25 beginning at 9:16 AM, Resident #4 was sitting up in her wheelchair beside her family member. The family member was feeding Resident #4. The meal tray was sitting on the bedside table in front of Resident #4. The family member stated Resident #4 did have some ant bites a few months ago and the facility provided education on leaving food in the drawers. The family member stated food was brought from outside the facility and the family member assisted Resident #4 with eating most of the time. The family member stated Resident #4 had no significant issues related to the ant bites and they healed pretty quickly. There were no evidence of food crumbs, or ants along the walls, floors, bed, or furniture inside the room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/18/25 beginning at 9:27 AM, the secured unit had no evidence of food crumbs, or ants along the walls, baseboards, floors, or furniture inside the dining room, living room areas, and hallways. During an interview on 05/18/25 beginning at 11:52 AM, CNA B stated she worked on the secured unit when Resident #4 obtained ant bites. CNA B stated she remembered seeing ants beside Resident #4's bed and on the walls during the month of December 2024. CNA B stated the ant bites were on her chest and upper body. CNA B stated she was the one who noticed the bites and immediately reported them to her charge nurse. CNA B was unable to remember who the charge nurse was. CNA B was unsure if treatment was initiated but there were no issues or discomfort for Resident #4 because of the ant bites. CNA B stated no other residents on the secured unit had ant bites during that time or since the incident. CNA B stated she reported the incident to the Maintenance Supervisor and pest control came to the facility and sprayed or treated for ants. CNA B stated there were no further issues regarding ants on the secured unit. During an observation on 05/18/25 beginning at 5:05 PM, the facility grounds had approximately 6 - 8 ant mounds within approximately 10 - 20 feet of the building. The ant mounds had numerous black and red ants on and around the mounds. There was no evidence of green spray paint to indicate the ant mounds had been treated. During an interview on 05/19/25 beginning at 10:22 AM, CNA C stated she had not noticed any ants in the facility. CNA C stated there was a pest log in the computer where she documented and reported any ant activity or observations. CNA C stated any pest activity or observations should have been reported to the management staff or Administrator. During an interview on 05/19/25 beginning at 1:47 PM, LVN A stated if pest activity was noted or observed, then she was supposed to ensure the resident was safe, clean the area, and notify the Maintenance Supervisor. LVN A stated the Maintenance Supervisor was responsible for ensuring the pest control company was notified. LVN A stated she had not seen any evidence of pest activity. LVN A stated Resident #4 had several ant bites in December 2024. LVN A stated she worked at the facility during that time. LVN A stated she personally cleaned the nightstand and floor when ants were observed in Resident #4's room. LVN A stated there was no food or ants seen in the bed but there were ants and open food found in the nightstand. LVN A stated the Maintenance Supervisor and DON were notified. LVN A stated she assessed Resident #4 and small pustules were identified, which resembled ant bites. LVN A stated Resident #4 had no pain, discomfort, or itching related to the ant bites. LVN A stated Resident #4 had not even realized she had ant bites on her skin. LVN A stated Resident #4 developed no signs or symptoms of infection and the bites cleared up pretty fast. LVN A stated she educated Resident #4's family member regarding open food and sugar packets because he normally assisted Resident #4 with eating. LVN A stated no other residents have present with potential ant bites and she had not seen any evidence of ant activity since the incident. LVN A stated in-service education was provided about making sure the room and dining areas were cleaned and free of food debris. In-service education was also provided on notifying the Maintenance Supervisor and Administrator of any pest activity so pest control could be maintained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	647 US Hwy 190 W Woodville, TX 75979

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 beginning at 2:28 PM, the Maintenance Supervisor stated as part of the pest control maintenance program, the pest control company provided pest services to the facility every month. The Maintenance Supervisor stated if something comes up between visits then he would provide treatment onsite. The Maintenance Supervisor stated he had never seen fire ants inside the facility but has found black ants on several occasions. The Maintenance Supervisor stated he completed daily rounds around the building which included checking for evidence of pests. The Maintenance Supervisor stated during December 2024 he was making daily rounds. The Maintenance Supervisor stated he had not noticed any evidence of ant activity during that timeframe until it was reported by a staff member. The Maintenance Supervisor stated ant activity was reported on 12/14/25 and it took approximately 5 days to ensure the ants were killed off. The Maintenance Supervisor stated Resident #4's family member was always bringing her food and sugar packets. The Maintenance Supervisor stated the family member was provided education about making sure food was not left in open packets in the room. The Maintenance Supervisor stated when ant activity was reported, the first step was to ensure the housekeeping staff performed a deep clean of the room or area where the activity occurred. The Maintenance Supervisor stated after the area was cleaned, he placed ant bait around the baseboards. The Maintenance Supervisor stated the ants would have taken the bait back to the mound and killed it off. The Maintenance Supervisor stated it could have taken a few days for the bait to become effective. The Maintenance Supervisor stated he was provided in-service education on the process for identifying and treating ant mounds around the facility. The Maintenance Supervisor stated he believed he had identified all the ant mounds around the facility. The Maintenance Supervisor stated he normally only identifies 1 or 2 fire ant mounds. He said when the pest control company treats the mounds, he sprays them with green spray paint. The Maintenance Supervisor stated he thought he had identified all the ant piles. The Maintenance Supervisor stated it was important to maintain an effective pest control program to maintain the safety of the residents. During an interview on 05/19/25 beginning at 2:48 PM, the DON stated she expected the facility staff to report any pest observations to the Maintenance Supervisor and ensure the residents were safe. The DON stated the pest control company provided services to the facility every month. The DON stated in December 2024 it was reported Resident #4 had ant bites. The DON stated Resident #4's family member brought a bunch of outside food that included sugar packets. The DON stated Resident #4 was often taken outside as well. The DON stated it was important to ensure an effective pest control program was maintained to ensure the safety of the residents and make sure they were free of insect bites. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	05/19/2025

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 beginning at 3:18 PM, the Administrator stated the pest control company provided services to the facility every month. The Administrator stated the Maintenance Supervisor had a member of corporate office make rounds at the facility once a quarter. The Administrator stated the Maintenance Supervisor was required to ensure ant piles were treated and marking them with spray paint once they were treated. The Administrator stated when the weather started to change, black sugar ants were more likely to been seen around the facility. The Administrator stated pest activity was monitored daily during champion rounds. The Administrator stated deep cleans were performed daily and each area of the facility received a deep clean monthly. The Administrator stated no ant or pest activity had been observed in the last few months. The Administrator stated it was reported that Resident #4 had received ant bites. She said a head to toe skin assessment was completed by the facility staff. The Administrator stated Resident #4's family member was provided education regarding snacks and food, making sure it did not sit or was not left open. The Administrator stated the Maintenance Supervisor provided initial on-site treatment. The Administrator stated the pest control company was notified and provided services the day after the incident. The Administrator stated the incident was reported to HHSC. The Administrator stated she rounded with housekeeping and staff to ensure no further pest activity was identified. The Administrator stated to her knowledge, Resident #4 had no pain, discomfort, or itching as a result of the ant bites. The Administrator stated it was important to maintain an effect pest control program to prevent residents from being bitten and to preserve the resident's quality of life. Record review of the Insect and Rodent Control policy, year dated 2012, reflected The facility will maintain an effect pest control program in order to provide an insect and vermin free food service department . sanitation of the facility will be maintained per other stated sanitation policies to prevent food sources, breeding places, etc. for insect or rodents