STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhart Oaks Care Center	214 Jones Rd Elkhart, TX 75839

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 6 of 6 resident hallways (Halls #1, #2, #3, #4, #5, and #6) reviewed for sufficient staffing in that:The facility failed to ensure sufficient nursing staff when multiple residents and family members reported slow or no call light response.The facility failed to provide an additional support nurse to assist the charge nurse on 8/4/25, 8/5/25, and 8/6/25.This failure could place all residents who required assistance from staff at risk for loss of dignity, injury, and hospitalization. Findings included: 1.Review of an undated admission Record for Resident #1 indicated she was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of Unspecified Dementia (altered cognition), Macular Degeneration (loss of vision), and muscle wasting. Record review of a significant change MDS dated [DATE] indicated she had moderately impaired cognition with a BIMS score of 12. She required moderate assistance with toileting hygiene; lower body dressing, putting on/taking off footwear, and personal hygiene; she required supervision with oral hygiene; she required setup/cleanup assistance with eating. She was frequently incontinent of bowel and bladder.Record review of a comprehensive care plan dated 11/17/23 indicated Resident #1 had an ADL deficit and required varying assistance with ADLs as needed. Appropriate interventions were in place including do not rush resident, instruct in use of walker/wheelchair, and provide setup cueing assistance for bed mobility, toileting, and eating.Review of an undated admission Record for Resident #2 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of coronary artery disease (heart disease), fracture of left humerus (upper arm bone), repeated falls, and osteoarthritis (loss of bone density). Record review of a significant change MDS dated [DATE] indicated Resident #2 had a BIMS score of 10 which indicated moderate cognitive impairment. She required total assistance for putting on/taking off footwear, toileting hygiene, and lower body dressing; she required maximum assistance with upper body dressing, shower/bathing; she required supervision for oral hygiene; she required setup/cleanup assistance with eating. She was always incontinent of bowel and bladder. Record review of a comprehensive care plan dated 2/12/25 indicated Resident #2 was at high risk for falls related to diagnosis of peripheral vascular disease (affects blood flow to lower extremities), muscle weakness, and lack of coordination. Appropriate interventions were in place including reporting changes in endurance, ambulation, and transfers, monitor frequently, reposition for comfort and safety, encourage call light usage, place call light within reach and answer promptly, assess for medication contributing factors, and assess for proper fitting clothing.Review of an undated admission Record for Resident #3 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of senile degeneration of the brain (age-related cognitive decline), Chronic Kidney Disease, and Metabolic encephalopathy (altered cognition related to metabolic imbalances). Record review of a significant change MDS dated [DATE] indicated Resident #3 had a BIMS score of 3 which indicated severe cognitive impairment. She required total assistance with toileting hygiene and showering/bathing; she required maximum assistance with lower body dressing and taking off/putting on footwear; she required moderate assistance with upper body dressing; she required supervision with oral hygiene and personal hygiene; she required setup/cleanup assistance with eating. She was always incontinent of bowel and bladder. Record review of a comprehensive care plan dated 2/27/24 indicated Resident #3 had an ADL functional deficit related to unsteady gait and confusion. Appropriate interventions were in place including assistance with dressing, grooming, bathing, and bed mobility.During an interview on 8/4/25 at 10:40 a.m., Resident #1's RP said she had concerns about slow call light response times. She said she put a camera in Resident #1's room and saw her on several occasions, dates unknown, banging on the wall to get staff attention because no one was answering her call light. She said she thought the new ADM would resolve the issues.During an observation on 8/4/25 at 10:45 a.m. of a photograph taken from the camera in Resident #1's room Resident #1 appeared to be banging on the wall. The photograph was dated 4/30/25 at 7:43 a.m.During an interview on 8/4/25 at 11:10 a.m., Resident #1 said call lights were always answered slowly. She said she usually did not use her call light because staff never answered it. She said she had to bang on the walls and yell for help on multiple occasions, dates unknown