STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675326	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Texas Nursing & Rehabilitation	1800 N Broadway St Ballinger, TX 76821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures for 1 of 3 residents (Resident #1) reviewed for neglect. The facility failed to report an allegation of neglect involving Resident #1 to the State Reporting Agency (HHSC) within 24 hours of CNA D not providing adequate care. This failure could place residents at risk of injury.The findings include: Record review of Resident #1's face sheet, dated 1/16/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: unspecified dementia (significant memory and thinking problems), unspecified convulsions (experiencing sudden, involuntary muscle spasms or full body shaking), chronic obstructive pulmonary disease (progressive lung disease). Resident #1 expired in the facility on 1/3/2026 unrelated to the intake. Record review of Resident #1's Significant Change in Status MDS, dated [DATE], revealed a BIMS score of 00, which indicated severe cognitive impairment. Resident #1 required substantial to maximum assistance of one staff person to move and/or turn and position in bed and extensive assistance of two staff persons to toilet. Section H of MDS revealed resident was always incontinent with bowel and bladder. Record review of Resident #1's Care Plan, initiated on 11/20/2025 and last revised on 12/30/2026, revealed the resident had a terminal prognosis and received hospice services for adult failure to thrive (unexplained decline in physical and functional health) and senile degeneration of the brain (cognitive decline). Resident #1 had an ADL self-care performance deficit and required staff assist for bathing, bed mobility, dressing, and toilet use. An intervention was documented that stated the resident had incontinence and to provide incontinent care every 2 hours. Record review of a witness statement, written by RN Treatment nurse, dated 12/26/2025, revealed at approximately 11:15 AM she was alerted to go to Resident #1's room due to skin concerns. RN Treatment nurse wrote in the witness statement Resident #1 had several raised blister-like areas to right hip, buttock, and redness to coccyx. Resident #1 had soiled sheets, dried BM to bilateral buttocks, shirt with dried yellow urine smell, and large area of dried food to the back of his shirt. RN Treatment Nurse wrote she notified the DON immediately. Record review of a witness statement, written by CNA D, dated 12/26/2025, with no time revealed her and CNA E went to get Resident #1 up for lunch and observed BM dried to his bottom that was difficult to clean. Resident #1's sheets were stained with BM and food. His shirt had dried food on the back. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA D and CNA E also observed wounds that were not present on 12/24/2025 when he had his last shower. Witness statement was provided to Administrator. Record review of witness statement, written by CNA E, dated 12/26/2025, with no time, revealed CNA E and CNA D went to get Resident #1 up and ready for the day. Resident #1 had dried feces on his bottom, sheets were stained with feces and food, shirt had dried food that was stuck. While getting him up they also noticed the wounds. Witness statement was provided to Administrator. Record review of witness statement written by the DON, dated 12/26/2025 with no time, revealed she was asked to go to Resident #1's room and she noticed dried BM on the sheets and dried food on the residents clothing and bed sheets. Witness statement was provided to Administrator.During an interview on 1/15/2026 at 12:00PM, RN Treatment Nurse stated the Hospice CNA notified her on 12/26/2025 at approximately 11:30 AM, that Resident #1 was lying on his right side. His clothing had dried food, dried BM on his buttocks and his back, sheets had dried BM and yellow urine stains. She stated CNA D and CNA E were working and assigned to Resident #1's hall that morning. The RN treatment nurse asked CNA D and CNA E why Resident #1 had not been turned or repositioned and they stated he was sleeping, and they did not want to wake him up. The RN Treatment Nurse reported these findings to the Administrator on 12/26/2025 and the Administrator was given a copy of her witness statement. The RN Treatment Nurse stated the risk of residents not being changed was skin breakdown. The RN Treatment Nurse stated the risk of not following the reporting guidelines was residents experiencing abuse or neglect would not be investigated. During an interview on 1/15/2026 at 4:00 PM, Resident #1's physician stated Resident #1's wounds were unavoidable due to his terminal condition. The risk of not changing was skin breakdown. The Physician stated he did not notice a negative outcome directly from this incident. The risk of not following the facility policy on reporting abuse and neglect allegations could lead to adequate care not being provided. During an interview on 1/15/2024 at 4:30 PM, CNA D stated she was on shift on 12/26/2025 beginning at 6:00AM. She stated it was just her and CNA E who worked the floor that morning. CNA D stated she looked in on Resident #1 that morning but did not change or turn and reposition him. CNA D stated that resident #1 did not like to be woken up in the morning. CNA D stated at approximately 11:00 AM her and CNA E went to get him up for the day. The Hospice Aide was present to shower Resident #1 and that was when the Hospice Aide noticed the wounds. CNA D went to notify the RN Treatment Nurse. She stated Resident #1 had dried food and dried urine on the back of his clothing, dried BM on his bottom and back. CNA D stated this was the first time she had been in Resident #1's room to change him during her shift. She stated the risk of not changing or repositioning residents was skin breakdown. CNA D stated her witness statement was given to the DON and the Administrator. During an interview on 1/15/2026 at 4:45 PM, CNA E stated her shift started at 6:00 AM on 12/26/2025. CNA E stated she looked in on Resident #1 but did not disturb him because he was asleep. CNA E stated during report she was told he was changed right before 6:00 AM. At 11:00 AM, CNA E and CNA D went to get Resident #1 ready for lunch. The Hospice Aide came to give him his shower at this time as well. Resident #1 had dried food on his clothing, yellow stains on his sheets, dried BM on him, and dried BM on the sheets. CNA E stated this was the first time they went to change Resident #1 on this shift. CNA E stated she received education on incontinent care. CNA E stated the risk of this not being done was skin breakdown and infection. CNA E stated her witness statement was provided to the Administrator. During an interview on 1/16/2026 at 11:17AM, the Hospice Aide stated she arrived at the facility at approximately 11:00 AM on 12/26/2025 to give Resident #1 a shower. The Hospice Aide stated when she arrived in the room CNA D and CNA E were already getting Resident #1 out of bed. The Hospice Aide noticed Resident #1 was wearing the same shirt she put on him when he had a shower on 12/24/2025. It was dirty with dried food, dried (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BM, and yellow stains. The Hospice Aide stated CNA D and CNA E were mad about the condition Resident #1 was in. During an interview on 1/16/2026 at 12:47 PM, the DON stated she was called to Resident #1's room on 12/26/2025 to assess his condition. CNA D showed her Resident #1's dirty sheets with urine and dried BM. The DON stated they had been having trouble with CNA F on the night shift completing her rounds and changing residents. The DON stated she did several in-services and write ups with CNA F. After the incident on 12/26/2025 with Resident #1, CNA F was terminated prior to her next scheduled shift for failure to provide adequate care. The DON stated she also saw an issue with CNA D and CNA E not changing Resident #1 on 12/26/2025 from 6:00 AM to 11:00 AM. The DON started an in-service on incontinent care. The DON stated the risk of not doing incontinent care and turning could be skin breakdown. The DON stated Resident #1 did not have a negative outcome related to this incident. The DON stated she reported this to the Administrator on 12/26/2025. The DON stated the risk of not following facility policy on reporting neglect allegations could lead to decreased quality of care. During an interview on 1/16/2026 at 3:05 PM, the Administrator stated he did not watch the cameras or do any further investigation of this incident. The Administrator stated neglect was the failure to provide goods or services to a resident. He stated when he received the witness statements of Resident #1's condition, he was observed, and he did not see it as neglect. He stated CNA F was fired for not doing her job over time. He stated if they had not terminated CNA F, he would have considered it neglect. The Administrator stated their policy on reporting was the same as the HHSC guidelines. The Administrator stated he only reported the incident because someone called the corporate hotline and said multiple residents were having skin issues, but Resident #1 was the only one specifically named in the corporate report. The Administrator stated the failure in reporting neglect allegations could lead to inadequate care. Record review, on 1/16/2025, of Provider Investigation report to HHSC with allegation of neglect involving Resident #1 and the systemic skin concerns in the facility was reported on 12/29/2025. Record review, on 1/16/2025, of CNA F termination letter signed by CNA F, DON and ADON, dated 12/29/2025, revealed CNA F was terminated for failing to meet their job duty/responsibility expectations. It also revealed, on 12/26/2025 it was found that CNA F failed to provide adequate care and rounding on a resident. Record review, on 1/16/2025, of the facility's, undated, policy titled Abuse/Neglect, revealed: .E. Reporting.3. The Facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 2024-14 dated 8/29/24.b. If the allegation does not involve serious bodily injury, the report must be made within 24 hours of the allegation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 3 residents (Resident #1) reviewed for ADL care. The facility failed to ensure Resident #1 was provided with timely incontinent care by facility staff. This failure could place residents at risk for discomfort, skin breakdown, and urinary tract infections.Findings include: Record review of Resident #1 face sheet, dated 1/16/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: unspecified dementia (significant memory and thinking problems), unspecified convulsions (experiencing sudden, involuntary muscle spasms or full body shaking), chronic obstructive pulmonary disease (progressive lung disease). Resident #1 expired in the facility on 1/3/2026. Record review of Resident #1's Significant Change in Status MDS, dated [DATE], revealed a BIMS score of 00, which indicated severe cognitive impairment. Resident #1 required substantial to maximum assistance of one staff person to move and/or turn and position in bed and extensive assistance of two staff persons to toilet. Section H of MDS revealed resident was always incontinent of bowel and bladder. Record review of Resident #1's Care Plan, initiated on 11/20/2025 and last revised on 12/30/2026, revealed the resident had a terminal prognosis and was receiving hospice services for adult failure to thrive (unexplained decline in physical and functional health) and senile degeneration of the brain (cognitive decline). The Care Plan also revealed the resident had an ADL self-care performance deficit and required staff assist for bathing, bed mobility, dressing and toilet use. The Care Plan revealed an intervention that stated resident had incontinence and to provide incontinent care every 2 hours. Record review of a witness statement, written by RN Treatment nurse, dated 12/26/2025, revealed at approximately 11:15 AM, she was alerted to go to Resident #1's room due to skin concerns. The RN Treatment nurse wrote in the witness statement, Resident #1 had several raised blister-like areas to the right hip, buttock, and redness to coccyx. Resident #1 had soiled sheets, dried BM to the bilateral buttocks, shirt had dried yellow urine smell, and large area of dried food to the back of shirt. The RN Treatment Nurse wrote she notified the DON immediately. Record review of witness statement, written by CNA D, dated 12/26/2025, with no time revealed her and CNA E went to get Resident #1 up for lunch and observed BM dried to his bottom that was difficult to clean. Resident #1's sheets were stained with BM and food. His shirt had dried food on the back. CNA D and CNA E also observed wounds that were not present on 12/24/2025 when he had his last shower. Record review of witness statement, written by CNA E, dated 12/26/2025, with no time, revealed CNA E and CNA D went to get Resident #1 up and ready for the day. Resident #1 had dried feces on his bottom, sheets were stained with feces and food, shirt had dried food that was stuck. While getting him up they also noticed the wounds. Record review of witness statement, written by DON, dated 12/26/2025, with no time, revealed she was asked to go to Resident #1's room and she noticed dried BM on the sheets and dried food the on residents clothing and bed sheets. During an interview on 1/15/2026 at 12:00PM, The RN Treatment Nurse stated the Hospice CNA notified her on 12/26/2025 at approximately 11:30 stated Resident #1 was wearing a shirt and a flannel jacket. He was lying on his right side. His clothing had dried food, dried BM on his buttocks and his back, the sheets had dried BM and yellow urine stains. She stated CNA D and CNA E were working and assigned to Resident #1's hall that morning. The RN Treatment Nurse asked CNA D and CNA E why Resident #1 had not been turned or repositioned, and they stated he was sleeping, and they did not want to wake him up. She reported this to the Administrator. The RN Treatment Nurse stated the risk of residents not being changed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was skin breakdown. During an interview on 1/15/2026 at 4:00 PM, Resident #1's physician stated the risk of not changing and turning residents was skin breakdown but in this case the wounds were unavoidable. The Physician stated he did not notice a negative outcome directly from this incident. During an interview on 1/15/2026 at 4:15PM, LVN B stated she was the Nurse in charge of Resident #1 on 12/26/2025. LVN B stated she saw the wounds when the Hospice Aide did. LVN B stated Resident #1 was observed with dried BM on the bedding and his bottom. She stated the risk of not changing a resident at routine intervals could lead to skin breakdown. During an interview on 1/15/2025 at 4:20 PM, RN C stated she was on duty the night of 12/25/2025 and 12/26/2025, and Resident #1 was restless throughout the shift. CNA F was terminated due to this incident and was on shift with RN C that night. RN C stated the risk of not changing residents could be skin breakdown. During an interview on 1/15/2024 at 4:30 PM, CNA D stated she was on shift that day on12/26/2025 beginning at 6:00 AM. She stated it was just her and CNA E working the floor that morning. CNA D stated she looked in on Resident #1 that morning but did not change him. CNA D stated at approximately 11:00 AM her and CNA E went to get him up for the day. She stated Resident #1 had dried food and dried urine on the back of his clothing, dried BM on his bottom and back. CNA D stated this was the first time she had been in Resident #1's room to change him during her shift. CNA D stated she received training on incontinent care. She stated the risk of not changing residents was skin breakdown. During an interview on 1/15/2026 at 4:45 PM, CNA E stated her shift started at 6:00 AM on 12/26/2025. CNA E stated she looked in on Resident #1 but did not disturb him because he was asleep. CNA E stated during report she was told he was changed right before 6:00 AM. At 11:00AM, CNA E and CNA D went to get Resident #1 ready for lunch. The Hospice Aide came to give him his shower at this time as well. Resident #1 had dried food on his clothing, yellow stains on his sheets, dried BM on him, and dried BM on the sheets. CNA E stated this was the first time they went to change Resident #1 on this shift. CNA E stated the Hospice Aide noticed the wounds that were not present on his previous shower day. CNA E stated the risk of this not being done was skin breakdown and infection. During an interview on 1/16/2026 at 11:17 AM, the Hospice Aide stated she arrived at the facility at approximately 11:00 AM on 12/26/2025 to give Resident #1 a shower. The Hospice Aide stated when she arrived in the room CNA D and CNA E were already getting Resident #1 out of bed. The Hospice Aide noticed Resident #1 was wearing the same shirt that she put on him when he had a shower on 12/24/2025. It was dirty with dried food, dried BM, and yellow stains. The Hospice Aide stated CNA D and CNA E were mad about the condition Resident #1 was in. During an interview on 1/16/2026 at 12:47 PM, the DON stated she was called to Resident #1's room on 12/26/2025 to assess his condition. CNA D showed her Resident #1's dirty sheets with urine and dried BM The DON stated they were having trouble with CNA F on the night shift completing her rounds and changing residents. The DON stated she did several in-services and write ups with CNA F. After the incident on 12/26/2025 with Resident #1, CNA F was terminated prior to her next scheduled shift for failure to provide adequate care. The DON stated she also saw an issue with CNA D and CNA E not changing Resident #1 on 12/26/2025 from 6:00 AM to 11:00 AM. The DON started an in-service on incontinent care. The DON stated the risk of not doing incontinent care and turning could be skin breakdown. The DON stated Resident #1 did not have a negative outcome related to this incident. During an interview on 1/16/2026 at 3:05 PM, the Administrator stated he did not watch the cameras or do any further investigation of this incident. He stated CNA F was fired for not doing her job over time. He stated if they had not terminated CNA F he would have considered it neglect. Record review of the facility's in-service on 1/16/2025 at 3:30 PM, dated 12/26/2025, revealed:It is essential that residents be checked and changed as needed and on a schedule. Record review of facility in-service on 1/16/2025 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 4:00PM, dated 12/29/2025, revealed:When rounding on residents, it is to be done on ALL residents every 2 hours at a minimum. Record review on 1/16/2025 of CNA F termination letter, signed by CNA F, DON, and ADON dated 12/29/2025, revealed CNA F was terminated for failing to meet their job duty/responsibility expectations. Termination letter revealed on 12/26/2025 it was found that CNA F failed to provide adequate care and rounding on a resident.