STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675387	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program to include all residents with newly evident or possible serious mental disorder for 1 of 7 residents (Resident #28) reviewed for the PASRR program. The facility failed to ensure Resident #28 was referred for a PASRR (Level II) evaluation when she admitted to the facility on [DATE] with a possible serious mental disorder. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs.The findings included: Record review of the face sheet, dated 08/13/25, reflected Resident #28 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder, bipolar type (chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression). Record review of the PASRR Level 1 Screening form, dated 09/30/24, reflected Resident #28 had no evidence or indicator of a mental illness. No PASRR Level II screening was completed. Record review of the admission MDS assessment, dated 10/10/24, reflected Resident #28 was not considered by the state level II PASRR process to have serious mental illness. The MDS reflected Resident #28 had clear speech, was understood by others, and was able to understand others. Resident #28 had a BIMS score of 15, which indicated no cognitive impairment. Resident #28 had no documented behaviors or refusal of care during the look-back period. The MDS reflected Resident #28 had an active diagnosis of Schizophrenia, which included schizoaffective disorder. Record review of the comprehensive care plan, initiated on 10/07/24, reflected Resident #28 had a mood problem related to a diagnosis of schizoaffective disorder, bipolar type and was taking psychotropic medication. During an interview on 08/13/25 beginning at 5:33 PM, the MDS Coordinator stated she was responsible for obtaining the PL1 from the referring entity, entering the PL1 into the system, and coordinating with the local authority when it was needed. The MDS Coordinator stated she reviewed the PL1 and any diagnoses prior to the residents admitting to the facility. The MDS Coordinator stated if the PL1 was inaccurate and needed to be changed, she normally called the hospital or referring entity and asked them to change it, or she would change it in the system, or a form 1012 could have been completed, as needed. The MDS Coordinator stated some of the diagnoses that she looked for prior to admission were schizophrenia and bipolar disorder. The MDS Coordinator stated the local authority made the determination of eligibility after a positive PL1 was submitted. The MDS Coordinator stated Resident #28's PL1 screening should have been positive for mental illness because of her diagnosis of schizoaffective disorder. The MDS Coordinator stated she was not working full time at the facility during the time period Resident #28 admitted . The MDS Coordinator stated she was going to enter a new PL1 and notify the local authority. During an interview on 08/13/25 beginning at 6:08 PM, the Administrator stated she expected the correct PASRR documentation to have been on file at the facility. The Administrator stated if the PL1 screening was incorrect, it should have been fixed so the local authority could have completed the level II PASRR evaluation. The Administrator stated the MDS coordinator was responsible for coordinating the PASRR services and performed audits on admission. The Administrator stated it was important to ensure PL1 screening was accurate to ensure residents received the correct services at the facility. Record review of the admission Criteria policy, revised March 2019, reflected all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid PASRR process. the facility conducts a Level 1 PASRR screen for all potential admission, regardless of payer source to determine if the individual meets the criteria for a MD, ID, or RD. if the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASRR representative for the Level II (evaluation and determination) screening process .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 2 of 16 residents reviewed for care plans. (Resident #8, Resident #43)1. The facility failed to ensure Resident #8's care plan had interventions to be used for the use of a self-releasing seat belt, on his motorized wheelchair. 2. The facility failed to implement the comprehensive person-centered care plan for Resident #43's low air loss mattress on the correct settings for her current weight. These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings include: 1. Record review of Resident #8’s face sheet dated 8/12/25 indicated Resident #8 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8 had diagnoses including cerebral palsy (is a group of conditions that affect movement and posture), paraplegia (is paralysis that affects your legs, but not your arms), abnormal posture, and contractures (is a type of scarring in your soft tissues that causes them to tighten and stiffen). Record review of Resident #8’s consolidated physician order dated 8/12/25 indicated may use motorized wheelchair for mobility when out of bed. If motorized wheelchair is unable to be used, may use Geri-chair for mobility related to contractures and poor trunk control. Ordered date 5/6/25. Record review of Resident #8’s quarterly MDS assessment dated [DATE] indicated Resident #8 was usually understood and had the ability to understand others. Resident #8 had unclear speech, adequate hearing, and impaired vision with corrective lenses. Resident #8 had a BIMS score of 99 which indicated the resident was unable to complete the interview. Resident #8 had short term memory call problem and moderately impaired cognitive skill for daily decision making. Resident #8 had functional limitation in range of motion to the upper and lower extremities, on both sides of his body. Resident #8 used a wheelchair for mobility. Resident #8 was dependent for ADLs. Resident #8 was not coded for a physical restraint. Record review of Resident #8’s care plan sated 4/24/25 indicated Resident #8 was at risk for falls related to decreased safety awareness, paraplegia, psychoactive drug use, vision/hearing problems, incontinence, cerebral palsy, chronic flexion contractures (is a long-term inability to fully extend a joint, meaning the joint is stuck in a bent position) to upper/lower extremities, muscle spasms, pain and spina bifida (is a condition that occurs when the spine and spinal cord don't form properly). Resident #8 has self-releasing seat belt because Resident stated, he “feels safer with it on.” Resident #8 was able to release upon request. Resident #8’s care plan did not reflect interventions or services that would attain or maintain the resident’s physical well-being for the use of a self-releasing seat belt. During an observation on 8/12/25 at 9:40 a.m., LVN C and CNA F placed Resident #8 in a motorized wheelchair. CNA F buckled Resident #8’s seat belt. CNA F asked Resident #8 to release the seat belt. After CNA F and LVN C asked Resident #8 two more times and CNA F showed him the release button, he successfully pushed the button. (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 8/13/25 at 12:45 p.m., the MDS Coordinator said she was responsible for the initial care plans and care plans after the MDS assessments. She said the DON and ADON were responsible for acute care plans. She said the interventions were important for the monitoring and assessment of the care plan problem. She said the IDT met to discuss the resident’s care plan on admission and quarterly. She said the DON and Regional/Corporate MDS Coordinator were responsible for overseeing the MDS Coordinator. During an interview on 8/13/25 at 2:42 p.m., LVN D said the ADON and DON was responsible for the residents’ care plans. She said Resident #8’s use of the seat belt on his wheelchair should be care planned. She said the interventions were important to assess the safety of the seat belt. She said the staff should make sure Resident #8 was able to release the seat belt and the seat belt was working properly. She said if Resident #8 use of the seat belt was not assessed, it placed the resident at risk for falls. She said Resident #8 could hurt himself. During an interview on 8/13/25 at 3:03 p.m., LVN C said the DON or a RN was responsible for the residents’ care plans. She said Resident #8’s use of the seat belt on his wheelchair should be care planned with interventions. She said the staff should make sure Resident #8 was able to release the seat belt and the seat belt was functioning correctly. She said the care plan was important to let the staff know what interventions were in place, what had been tried, and what to expect from the facility. She said Resident #8’s seat belt not being care planned with intervention was a safety issue. During an interview on 8/13/25 at 3:04 p.m., the DON said the IDT was responsible for the residents’ care plans. She said Resident #8’s wheelchair seat belt needed interventions for monitoring and assessment. She said the interventions were important to know what to monitor to prevent injury. She said the facility did not consider Resident #8’s seat belt as a restraint because he could release it. She said the facility should have still developed a care plan with interventions to ensure it did not become a restraint. She said when the care plan problem did not have interventions, the residents’ needs could not be met. She said the IDT monitored each other to ensure the residents’ care plans were complete. During an interview on 8/13/25 at 5:02 p.m., the ADM said the DON was responsible for developing care plan interventions for Resident #8’s wheelchair seat belt. She said the care plan interventions were important to ensure Resident #8’s seat belt was not a restraint. She said when the resident’s care plan problem did not have interventions, the resident’s needs could not be met. She said the IDT oversaw the care planning process. She said the IDT reviewed the residents’ care plans during the daily “stand up” meetings. 2. Record review of Resident #43’s admission Record indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included contracture of right knee (a condition characterized by the inability to fully extend the knee joint), dementia (a general term for a decline in cognitive function that affects memory, thinking, and social abilities, significantly interfering with daily life), essential hypertension (a form of high blood pressure that occurs when the pressure in your blood vessels is consistently too high), severe protein-calorie malnutrition (serious health condition stemming from an insufficient intake or absorption of protein) and major depression disorder (a mood disorder that cause persistent feelings of sadness and loss of interest). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #43's Annual MDS dated [DATE] revealed that the resident did not have a BIMS score indicating Resident #43 was rarely or never understood. The MDS also revealed, Resident #43 was dependent with all ADL’s such as eating, toileting, bathing, dressing upper and lower body, and transfers. The MDS revealed Resident #43 weighed 104 lbs. Record review of Resident #43's Care Plan revised on 7/22/2025, revealed Resident had Deep tissue injury to Right Distal Lateral foot with interventions for a low air loss mattress for pressure relief. Record review of Resident #43’s weight and vital sign summary dated 8/13/2025 revealed on 5/22/2023 Resident weighed 104.2 lbs. During observation on 8/12/2025 at 1:57 PM, observed Resident #43 lying in bed on her left side with covers pulled up. Resident #43 was nonverbal and unable to communicate. During an observation and interview on 8/12/2025 at 2:33 PM, Resident #43 was lying in bed and wearing pressure relieving boots to bilateral lower extremities. The ADON said Resident #43 was on Hospice care. The ADON said Resident #43 was contracted on her lower extremities and wore the pressure relieving boots to her bilateral lower extremities. The ADON said Resident #43 was followed by a wound care specialist. The ADON said Resident #43 rubs her legs in her bed which she felt contributed to her DTI (deep tissue injury) (a serious condition that affect the underlying layers of skin and soft tissue, often resulting from sustained pressure or shear forces). The ADON said the DTI (deep tissue injury) was closed and she was not required to be on EBP (Enhanced Barrier Precautions) (Infectious control measures designed to reduce the transmission of multidrug-resistant organisms in healthcare settings). The ADON said Resident #43 was unable to position herself and required a Hoyer lift and a Geri-chair (geriatric chair). The ADON said Resident #43 had wounds on her bottom but had healed and the facility left Resident #43 on the low air loss mattress for prevention. The ADON looked at the settings and said it was set on 210. She said the Geri-chair must have bumped the setting and said the setting was not correct. The ADON said more pressure could cause a skin injury. The ADON said she was going to check on Resident #43’s weight and adjust the setting after checking the orders and update the orders if there was not one. During an interview on 8/13/2025 at 12:39 PM, LVN K said Resident #43 had an air loss mattress. She said Resident #43 was to be repositioned every 2 hours and had these wounds in the past stating that the wounds had healed and reopened. LVN K said Resident #43 was terminal and the wounds were unavoidable. LVN said Resident #43 did not have any current wounds to her bottom. LVN K said the staff gets her up in the Geri-chair. LVN K said normally the staff does not touch the settings on the low air loss mattress and said she did not know if the settings were supposed to be on an order. LVN K reviewed Resident #43’s order and said there was not an order. She said the low air loss mattress settings were based on the weight of the resident. She said the low air loss mattress would circulate to ensure the pressure was not in one spot. LVN K said it could cause pressure sores and skin breakdown if not on the correct settings. (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 8/13/2025 at 1:39 PM, the Wound Care Physician said he started seeing Resident #43 a couple of weeks ago. He said she was currently wearing her pressure relieving boots. He said Resident #43 likes to turn on her right side and he said the deep tissue injury was unavoidable due to her contractures. He felt with her wearing the boots, she would be ok. The Wound Care Physician said sometimes people turn up the settings on the low air loss mattress while positioning a resident. He said more air could cause more pressure. He said Resident #43’s wound was scabbed over and not ready to come off yet. He said Resident #43’s wound showed no signs of infection. During an interview on 813/2025 at 4:13 PM, the Administrator said she expected the nurses to check the settings on the low air loss mattress to ensure it was on the proper settings. The Administrator said she thought there should be specific settings on the care plan and orders. The Administrator said a resident could develop pressure ulcers if the low air loss mattress was not on the proper setting. The Administrator said the ADON and DON were responsible for ensuring the orders were on the care plan and the settings were correct. During an interview on 8/13/2025 at 4:36 PM, the DON said she expected the nurses and aides to assess Resident #43 low air loss mattress and for it to be on the proper settings. The DON said she was working on order to make sure they were specific. The DON said the aides could place the settings on static while they are positioning a resident but would need to be placed back on the correct setting. The DON said there was a potential for skin breakdown or if a resident had a current skin issue, it could make a wound worse. The DON said it could be a comfort issue as well. The DON said she had started an in-service with staff and was adding a task for the aides to check as well. Record review of a facility policy revised on December of 2016 titled Care Plans, Comprehensive Person-Centered revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident…the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment…describe 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 16 residents (Resident #6), reviewed for care plans. The facility failed to revise and update Resident #6's care plan after she was coded on the annual MDS assessment dated [DATE] for use of a diuretic and an antiplatelet. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs.Findings included: Record review of Resident #6's face sheet dated 8/12/25 indicated Resident #6 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses including hemiplegia (is paralysis that affects only one side of your body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (is the death of brain tissue due to a blockage of blood flow), other cerebral infarction due to occlusion or stenosis of small artery (a blockage or narrowing of a small blood vessel, which can restrict blood flow and potentially lead to tissue damage) and hypertension (is when the force of blood pushing against your artery walls is consistently too high). Record review of Resident #6's annual MDS assessment dated [DATE] indicated Resident #6 was usually understood and usually had the ability to understand others. Resident #6 had a BIMS score of 14 which indicated intact cognition. Resident #6 had received a diuretic (are medicines that help reduce fluid buildup in the body) and an antiplatelet (are medications that prevent platelets from sticking together and forming blood clots) during the last 7 days. Record review of Resident #6's care plan dated 8/6/24 indicated Resident #6 had hemiplegia and hemiparesis related to previous cerebral infarction. Intervention included give medications as ordered and monitor/document for side effects and effectiveness. Resident #6's care plan did not reflect use of a diuretic and an antiplatelet. Record review of Resident #6's consolidated physician orders dated 8/12/25 indicated:*Aspirin 81mg Oral tablet Delayed Release, give 1 tablet by mouth one time a day related to hemiplegia and hemiparesis following cerebral infarction, other cerebral infarction due to occlusion or stenosis of small artery. Ordered date 3/7/25. *Spironolactone Oral Tablet 25mg, give 25mg by mouth one time a day for edema. Ordered date 2/24/25. Record review of Resident #6's MAR dated 8/1/25-8/31/25 indicated:*Aspirin 81mg Oral tablet Delayed Release, give 1 tablet by mouth one time a day related to hemiplegia and hemiparesis following cerebral infarction, other cerebral infarction due to occlusion or stenosis of small artery. Resident #6 received 12 out of 12 scheduled doses. *Spironolactone Oral Tablet 25mg, give 25mg by mouth one time a day for edema. Resident #6 received 12 out of 12 scheduled doses. During an interview on 8/13/25 at 12:45 p.m., the MDS Coordinator said the resident's care plans were revised with the MDS assessments and changes of condition. She said each department of the IDT were responsible for updating the care plan, after the MDS assessment. She said the resident's care plans were reviewed and updated quarterly. She said Resident #6's use of a diuretic and an antiplatelet should have been care planned. She said she normally only care planned the major antiplatelets on the resident's care plans. She said the resident's medications should be care planned to know which type of medications the resident was on and what to monitor for. She said when a resident's medications were not care planned, the comorbidities it was treating may not be monitored or assessed. She said the DON and Regional/Corporate MDS Coordinator were responsible for overseeing her. During an interview on 8/13/25 at 2:00 p.m., the ADON A said the MDS Coordinator with the assistance of the DON were responsible for revising and updating care plans after the MDS assessment. She said she would expect Resident #6's use of a diuretic and an antiplatelet to be on her care plan. She said it was important for Resident #6's diuretic use to be on the care plan to know what to monitor for fluid control. She said the antiplatelet needed to be care planned to assess and monitor for the side effects. She said if the resident had a fall and would not stop bleeding, the facility needed to know why. She said if the resident's medications were not care planned, it placed the resident at risk for not being assessed or monitored and affected the level of care and needs provided. She said the IDT should review the resident's care plan to ensure it was revised by the MDS Coordinator. During an interview on 8/13/25 at 2:42 p.m., LVN D said the DON, ADON and SS were responsible for updating the resident's care plan. She said it was important to care plan the resident's medications to know the history, diagnosis, and care needs. She said when medications were not care planned, the resident could not get the care they needed. She said the staff could think the resident was urinating too much and had an UTI (is when bacteria gets into your urinary tract- kidneys, bladder, or urethra) but it was from the diuretics. She said

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good nutrition for 1 of 5 residents (Resident #50) reviewed for ADLs. The facility did not ensure Resident #50 received set-up assistance during the lunch meal on 08/11/25. This failure could place residents at risk of decreased quality of life, weight loss, and injury related to choking.The findings included: Record review of the face sheet, dated 08/13/25, reflected Resident #50 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, affecting the right dominant side (right-sided weakness/paralysis from a stroke), history of a stroke, and the need for assistance with personal care. Record review of the admission MDS assessment, dated 06/26/25, reflected Resident #50 had clear speech, was understood by others, and was able to understand others. Resident #50 had a BIMS score of 6, which reflected severely impaired cognition. Resident #50 had no behaviors or refusal of care during the look-back period. The MDS assessment reflected Resident #50 usually required partial/moderate assistance with eating, which indicated the helper did less than half the effort. Record review of the comprehensive care plan, initiated on 06/26/25, reflected Resident #50 had an ADL self-care performance deficit and required partial/moderate assistance as needed with eating. Record review of the ADL flow sheet for eating, dated from 07/31/25 to 08/12/25, reflected Resident #50 required setup or clean-up assistance with eating on 08/01/25, 08/02/25, 08/03/25, 08/06/25, 08/11/25, and 08/12/25. During an observation on 08/11/25 at 12:04 PM, Resident #50 was served her lunch meal tray. Resident #50 was asked if she wanted her plate on or off the serving tray. The tray was placed down in front of her, and the cover was removed. The plastic was taken off the drinks, her utensils were unfolded from her napkin, and then the staff left her with her tray. Resident #50's dinner roll was left in the plastic bag. During an observation on 08/11/25 at 12:07 PM, Resident #50 was eating the plastic bag that her dinner roll was in. Resident #50 would take a bite of the plastic and then spit it out. Resident #50 was unable to remove the dinner roll herself. During an observation on 08/11/25 at 12:18 PM, Resident #50 continued to take bites of the plastic bag and then spit it out on her tray. Surveyor notified CNA G in the dining room. CNA G immediately removed the plastic from her dinner roll. During an interview on 08/13/25 beginning at 3:26 PM, CNA G stated Resident #50 normally required setup help with eating but would not allow staff to assist her with eating. CNA G stated setup help included taking everything off the serving tray and sitting it on the table, taking the plastic off of the food, unwrapping and placing straws in the cups, and putting condiments on the food as needed or requested. CNA G stated Resident #50's dinner roll should have been removed from the plastic bag when she was served. CNA G was unsure why Resident #50's dinner roll was not removed from the bag, but it was usually taken out. CNA G stated she believed Resident #50 had not attempted to eat the plastic around her dinner roll before that incident. CNA G stated it was important to ensure Resident #50 received setup assistance during mealtimes to ensure she did not choke on the plastic. During an interview on 08/13/25 beginning at 3:39 PM, LVN C stated Resident #50 required setup assistance during meals because of a previous stoke that caused right-sided weakness. LVN C stated setup assistance included asking if they wanted their food on or off the serving tray, cutting up any vegetables or meat, taking the plastic wrapper off of all the food, and then asking if they wanted salt/pepper or sweetener. LVN C stated the plastic should have been removed from Resident #50's dinner roll on 08/11/25. LVN C stated she was the nurse in the dining room on 08/11/25 but was unable to remember who served Resident #50. LVN C stated she was unaware until later that Resident #50 was eating the plastic. LVN C stated it was important to ensure Resident #50 received setup assistance during mealtimes to maintain a homelike environment. LVN C stated Resident #50 was unable to remove the plastic herself because of the stroke that caused weakness. During an interview on 08/13/25 beginning at 5:44 PM, the DON stated she expected the nursing staff to ensure residents received setup assistance during mealtimes. The DON stated setup assistance included: opening milks, removing plastic from food, setting up the utensils, or adding salt/pepper. The DON stated the nurse in the dining room was responsible for monitoring to ensure residents received setup assistance in the dining room. The DON stated it was important to ensure residents received setup assistance during mealtimes to ensure adequate nutrition and maintain the resident's safety during meals. During an interview on 08/13/25 beginning at 6:08 PM, the Administrator stated she expected staff to ensure the residents received setup assistance during mealtimes

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	675387	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 2 of 16 residents reviewed for activities. (Resident's #30 and #50) The facility failed to ensure Resident #30, and Resident #50 were offered to participate in activities on 08/11/25 and 08/12/25. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being.The findings included: 1. Record review of the face sheet, dated 08/13/25, reflected Resident #30 was a [AGE] year-old female who initially admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (neurodegenerative disease that causes memory loss). Record review of the annual MDS assessment, dated 04/22/25, reflected Resident #30 had clear speech, was understood by others, and was usually able to understand others. Resident #30 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #30 had delusions, physical and verbal behavior, and refusal of care 1 to 3 days during the look-back period. Resident #30 stated it was very important to participate in her favorite activities and was somewhat important to do things with groups of people. Record review of the comprehensive care plan, revised 04/03/23, reflected Resident #30 was dependent on staff for activities, cognitive stimulation, and social interaction. The goal was Resident #30 will attend/participate in activities of choice 3 -5 times weekly by the next review date. The interventions included: all staff to converse with resident while providing care and invite Resident #30 to scheduled activities. Record review of the Activities - Quarterly/Annual Participation Review assessment, dated 07/08/25, reflected Resident #30 participated in activities of choice, she enjoys the daily chronicles, nail are, and watching/visiting with staff and residents in the dining room. The assessment reflected her favorite activities were the daily chronicles and a hot cup of coffee. 2. Record review of the face sheet, dated 08/13/25, reflected Resident #50 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, affecting the right dominant side (right-sided weakness/paralysis from a stroke). Record review of the admission MDS assessment, dated 06/26/25, reflected Resident #50 had clear speech, was understood by others, and was able to understand others. Resident #50 had a BIMS score of 6, which reflected severely impaired cognition. Resident #50 had no behaviors or refusal of care during the look-back period. The MDS assessment reflected Resident #50 stated it was very important to participate in her favorite activities and somewhat important to do things with groups of people. Record review of the comprehensive care plan, initiated on 07/14/25, reflected Resident #50 was dependent on staff for activities, cognitive stimulation, and social interaction. The goal was Resident #50 will attend/participate in activities of choice 3 to 5 times a week. The interventions included: notify resident daily of daily activities and times, provide assistance as needed with daily activity, and assure activities are compatible with physical and mental capabilities. Record review of the Activities - Initial Review, dated 06/20/25, reflected Resident #50 participated in activities of choice. The assessment reflected Resident #50 participated in weekly bible study. Resident #50 wished to participate in activities while in the home, group activities, and independent activities. Record review of the activity calendar, dated August 2025, reflected the following:08/11/25 - 11 AM Painting08/11/25 - 2 PM Bingo08/12/25 - 8 AM Daily Chronicles08/12/25 - 1 PM Noodle ball During an observation on 08/11/25 beginning at 11:03 AM, the AD was in the dining room. She gathered the supplies for rock painting. The AD sat a small table with 2 residents and began the activity. Resident #30 and Resident #50 were sitting at a table in the dining room. The AD did not offer or encourage Resident #30 or Resident #50 to participate in the activity. During an observation on 08/11/25 beginning at 2:12 PM, the AD was calling bingo numbers in the dining room. Resident #30 and Resident #50 were sitting at the same table in the dining room with no bingo cards in front of them. Resident #30 was sitting up with her head looking down. Resident #50 was staring at the table. Resident #50 asked the surveyor about a funeral and said she did not know what to do. During an observation on 08/11/25 beginning at 3:32 PM, Resident #50 was sitting up in her wheelchair at the same dining room table. During an observation on 08/12/25 beginning at 8:25 AM, Resident #30 was sitting at the same dining room table. There were a stack of daily chronicles sheets in a neat pile. Resident #30 was staring around the room. During an observation on 08/12/25 beginning at 1:18 PM, Resident #30 and Resident #50 were sitting at the same dining room table. Both residents were just looking around the room. There were no activities. During an interview on

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #49) reviewed for accidents and hazards. The facility failed to ensure Resident #49's fall mat was utilized while he was in his bed on 08/11/25 and 08/12/25. This failure could place residents at risk of injury or harm and a decreased quality of care related to falls.The findings included: Record review of the face sheet, dated 08/12/25, reflected Resident #49 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), apraxia (inability to execute purposeful, previously learned motor tasks, despite physical ability and willingness, as a result of brain damage) following a stroke, and paranoid schizophrenia (A serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior.). Record review of the quarterly MDS assessment, dated 07/11/25, reflected Resident #49 had clear speech, was understood by others, and usually able to understand others. The MDS reflected Resident #49 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS reflected Resident #49 had rejection of care 1 - 3 days during the look-back period. The MDS reflected Resident #49 had an impairment on both upper and lower extremities. Resident #49 was dependent on staff assistance with most ADLs. Resident #49 had no falls since the prior assessment. Record review of the comprehensive care plan, revised on 10/16/23, reflected Resident #49 was at risk for falls related to decreased safety awareness, confusion, psychoactive drug use, vision/hearing problems, incontinence, cardiovascular disease, impaired muscle control, and limited range of motion to lower extremities. The interventions included apply mat to bedside while Resident #49 is in bed. Record review of the fall risk assessment, dated 08/08/25, reflected Resident #49 was at high risk for falls. Record review of the order summary report, dated 08/13/25, reflected Resident #49 had an order, which started on 01/15/20, for May have fall mat every shift for fall risk. Record review of the MAR dated August 2025, reflected Resident #49's fall mat was signed off by the nurse daily. During an observation on 08/11/25 beginning at 3:33 PM, Resident #49 was laying in the bed with his eyes closed. Resident #49's bed was in the lowest position and his fall mat was laying long ways, against the wall at the head of his bed. Approximately 6 inches of the fall mat was sticking out on both sides of the bed and the legs of the bed, at the head, were indenting the fall mat. Another fall mat on the right side of his bed was folded in half and laying in the floor between Resident #49's bed and his roommate's bed. During an observation on 08/12/25 beginning at 8:26 AM, Resident #49 was laying in the bed with his eyes closed and covers pulled up to his chin. Resident #49's bed was in the lowest position and his fall mat was laying long ways, against the wall at the head of his bed. Approximately 6 inches of the fall mat was sticking out on both sides of the bed and the legs of the bed, at the head, were indenting the fall mat. Another fall mat on the right side of his bed was folded in half and laying in the floor between Resident #49's bed and his roommate's bed. During an observation on 08/12/25 beginning at 1:38 PM, Resident #49 was laying in the bed with his eyes closed. Resident #49's bed was in the lowest position and his fall mat was laying long ways, against the wall at the head of his bed. Approximately 6 inches of the fall mat was sticking out on both sides of the bed and the legs of the bed, at the head, were indenting the fall mat. Another fall mat on the right side of his bed was folded in half and laying in the floor between Resident #49's bed and his roommate's bed. During an interview on 08/13/25 beginning at 3:26 PM, CNA G stated she was the restorative CNA and has worked at the facility for a while. CNA G stated Resident #49 had not had any falls recently but was at risk for falls. CNA G stated Resident #49 had a low bed and fall mats beside his bed. CNA G stated the fall interventions should have been in place to prevent injuries from falls. CNA G was unsure why Resident #49's fall mats were not in place because she did not work the floor. During an interview on 08/13/25 beginning at 3:34 PM, CNA H stated Resident #49's fall mats were not in place this morning when she arrived at work. CNA H stated she put them down this morning. CNA H stated Resident #49 was at risk for falling and required a low bed and fall mats while in bed. CNA H stated she did not specifically check for fall mat placement when she arrived at work, but if she noticed they were not being utilized she would place them down appropriately. CNA H stated it was important to ensure fall interventions were utilized to protect the resident from injuries related to falls. During an interview on 08/13/25 beginning at 3:54 PM, LVN K stated Resident #49 had fallen in the past but

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practices for 1 of 5 residents (Resident #31) reviewed for respiratory care. The facility failed to ensure Resident # 31's internal filter (the air passes through a series of filters that remove impurities, ensuring that the oxygen delivered to the patient is of high quality) in the oxygen concentrator (take air from your surroundings, extract oxygen and filter it into purified oxygen for you to breathe) was free of white/yellow, fuzzy particles. This failure could place residents at risk for respiratory infections.Findings included: Record review of Resident #31's face sheet dated 8/13/25 indicated Resident #31 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #31 had diagnoses including heart failure (is a condition where the heart can't pump enough blood to meet the body's needs for oxygen and nutrients), chronic obstructive pulmonary disease (is a lung condition that obstructs airflow, making it difficult to breathe) and dependency on supplemental oxygen. Record review of Resident #31's quarterly MDS assessment dated [DATE] indicated Resident #31 was understood and had the ability to understand others. Resident #31 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #31 received oxygen therapy. Record review of Resident #31's care plan dated 6/28/25 indicated Resident #31 had oxygen therapy. Intervention included oxygen settings: oxygen via nasal cannula at 2-3 liters per minute. Record review of Resident #31's consolidated physician order dated 8/13/25 indicated change respiratory tubing, mask, bottled water, and clean filter every 7 days, every night shift, every Sunday. Ordered date 12/27/24. Record review of Resident #31's nurse administration record dated 8/1/25-8/31/25 indicated:*Oxygen at 3 liters per minute via nasal cannula during daytime, with ambulation and while resting and 2.5 liters per minute via nasal cannula at hour of sleep every shift for Chronic Obstructive Pulmonary Disease. *Change respiratory tubing, mask, bottled water, and clean filter every 7 days, every night shift, every Sunday. During an observation on 8/11/25 at 11:23 a.m., Resident #31 was sitting in her recliner with a nasal cannula connected to an oxygen concentrator. Resident #31's internal filter vent had a moderate amount of white/yellow, fuzzy particles. During an observation on 8/12/25 at 7:40 a.m., Resident #31 was sitting in her recliner with a nasal cannula connected to an oxygen concentrator. Resident #31's internal filter vent had a moderate amount of white/yellow, fuzzy particles. During an interview on 8/13/25 at 2:00 p.m., the ADON A said the oxygen company was responsible for the internal filters on the oxygen concentrators. She said the DON and ADON were responsible for notifying the oxygen company. She said the nurses changed the resident's oxygen equipment and cleaned the filters on Sundays. She said having an oxygen concentrator filter with dust was not good because the resident would be breathing it in. She said it could cause respiratory issues. During an interview on 8/13/25 at 2:42 p.m., LVN D said the nurses should notify the DON if they were unable to clean the resident's oxygen concentrator filter. She said the nurses were responsible for the oxygen filter when everything was changed on Sunday nights. She said a dirty oxygen filter affected the air quality. She said a dirty filter placed the resident at risk for a respiratory infection and breathing problems. She said if a resident developed a respiratory infection or experienced breathing problems, they could need antibiotics or hospitalization. During an interview on 8/13/25 at 3:04 p.m., the DON said the nurses were responsible for notifying the maintenance worker and DON when the internal oxygen filter needed to be cleaned. She said it was important to receive clean and the right amount of oxygen. She said if the internal oxygen filter was clogged with dust particles, it placed the resident at risk for not getting the right amount of oxygen. She said this could cause decrease oxygen intake, increase work of breathing and affect the resident's respiratory status. She said maintenance was overall responsible for the oxygen concentrator internal filters. She said maintenance should ensure the cleanliness of the internal filters by rounding. During an interview on 8/13/25 at 5:02 p.m., the ADM said the oxygen company was responsible for the internal oxygen concentrator filters. She said the nurses should check the internal filters every Sunday and notify the DON when it needed to be cleaned. She said an unclean oxygen filter could lead to an infection. She said the resident could then need antibiotics or hospitalization. She said the ADON and DON should ensure the nurses were cleaning and checking the internal and external filters every Sunday by rounding. Record review of a facility's Oxygen Administration policy revised 10/2010 indicated, .the purpose of this procedure is to provide guidelines for safe oxygen administration.report other information in accordance with facility policy and professional standards of practice. Record review of a

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 resident (Resident #6) reviewed for trauma-informed care. The facility failed to ensure Resident #6 had a care plan to address past trauma with a PTSD diagnosis. Resident #6 completed a brief trauma assessment on [DATE] which indicated a positive trauma screen. This failure could place residents at an increased risk for psychological distress due to re-traumatization.Findings included: Record review of Resident #6's face sheet dated [DATE] indicated Resident #6 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had diagnoses including post-traumatic stress disorder (is a mental health condition that can develop after experiencing or witnessing a traumatic event), generalized anxiety disorder (persistent and excessive worry about various everyday events and activities), major depressive disorder (is a serious mental health condition characterized by persistent sadness, loss of interest in activities, and difficulty functioning in daily life), and intermittent explosive disorder (is a behavioral disorder characterized by episodes of impulsive aggression that are disproportionate to the situation). Record review of Resident #6's annual MDS assessment dated [DATE] indicated Resident #6 was usually understood and usually had the ability to understand others. Resident #6 had a BIMS score of 14 which indicated intact cognition. Resident #6 did not have experience psychosis or behavioral symptoms. Resident #6 had an active diagnosis of PTSD. Record review of Resident #6's care plan dated [DATE] indicated Resident #6 had ADL self-care performance deficit related to hemiplegia following cerebral infarction affecting the right side and PTSD. Intervention included praise all efforts at self-care. Resident #6's care plan did not reflect triggers, interventions, and goals related to her PTSD diagnosis. Record review of Resident #6's Brief Trauma Questionnaire dated [DATE] indicated Resident #6 had experienced being made or pressured into some type of unwanted sexual contact and she thought her life was in danger or might be seriously injured. Resident #6 also experienced a close family member or friend who died violently. The Brief Trauma Questionnaire indicated that none of the above questions were answered with a yes. The Brief Trauma Questionnaire did not reflect the date and time an IDT meeting was scheduled regarding interventions and plan of care. Record review of Resident #6's progress note dated [DATE] by the MDS Coordinator indicated, . spoke with resident [Resident #6] about her brief trauma questionnaire and her answers on that form. Resident [#6] stated that her triggers are.1. Too many people talking to her at once.2. No male CNAs. Resident [#6] did state that all that was a long time ago and she has not had any triggers since moving into the facility. During an interview and observation on [DATE] at 10:29 a.m., Resident #6 was heading out of her room. LVN C said Resident #6 was headed out to smoke. Resident #6 looked at the surveyor and appeared anxious. Resident #6 walked to the smoking area, unable to complete interview. LVN C said Resident #6 was an anxious person. During an interview and observation on [DATE] at 11:42 a.m., Resident #6 was heading out of her room. CNA F told Resident #6 the surveyor wanted to talk to her. Resident #6 shook her head and said, no! Unable to complete interview. During an interview on [DATE] at 12:43 p.m., the SS said she had started in [DATE]. She said she did not complete Resident #6's Brief Trauma Questionnaire. She said the MDS Coordinator would be responsible for care planning Resident #6's PTSD diagnosis. During an interview on [DATE] at 12:45 p.m., the MDS Coordinator said she was responsible for the resident's initial care plans. She said the ADON and DON completed the acute care plans. She said the SS, AD, and DM completed their portion of the care plan. She said SS completed the Brief Trauma Questionnaire. She said if the resident triggered for experiencing trauma, then the SS notified the DON. She said the SS would initiate the PTSD care plan in the beginning and everyone else would add to it. She said the PTSD care plan was important to know Resident #6's triggers. She said due to Resident #6 not having a PTSD care plan, the staff would not know her triggers and may have caused some triggers. She said on admission, the IDT met to discuss each resident. She said the IDT also met quarterly to discuss the resident's care plans. She said she did not remember Resident #6 mentioning any triggers during the care plan meetings. During an interview and observation on [DATE] at 1:17 p.m., Resident #6 was lying in her bed. Resident #6 said she was sleeping. Unable to complete interview regarding the PTSD diagnosis. During

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 2 of 16 residents (Resident #31 and Resident #26) reviewed for pharmacy services. The facility failed to ensure Resident #31's Claritin (Loratadine) order had a dosage for administration. The facility failed to ensure RN B documented the medication order change for Resident #26's Folic Acid 400 MCG to 1000MCG on 8/12/25, which resulted in RN B documenting administration of the wrong medication dosage on the MAR. These failures could place residents at risk for inaccurate drug administration.Findings included: 1. Record review of Resident #31's face sheet dated 8/13/25 indicated Resident #31 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #31 had diagnoses including chronic obstructive pulmonary disease (is a lung condition that obstructs airflow, making it difficult to breathe) and dyspnea (shortness of breath). Record review of Resident #31's quarterly MDS assessment dated [DATE] indicated Resident #31 was understood and had the ability to understand others. Resident #31 had a BIMS score of 12 which indicated moderate cognitive impairment. Record review of Resident #31's care plan dated 6/28/25 indicated Resident #31 had oxygen therapy. Intervention included give medications as ordered by physician. Record review of Resident #31's consolidated physician order dated 8/13/25 indicated Claritin Oral Tablet (Loratadine), give 1 tablet by mouth, one time a day for allergies. Ordered date 5/27/25. Resident #31's physician order did not reflect a MG dose of Claritin to administer. Record review of Resident #31's MAR dated 8/1/25-8/31/25 indicated Claritin Oral Tablet (Loratadine; is an antihistamine that prevents and treats allergy symptoms), give 1 tablet by mouth, one time a day for allergies. Resident #31 received 12 out of 13 scheduled doses. 2. Record review of Resident #26's face sheet dated 8/13/25 indicated Resident #26 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #26 had diagnoses including nutritional anemia (is a condition where a lack of essential nutrients in the diet leads to a decrease in red blood cell production or function, causing a deficiency in oxygen delivery to the body) and vitamin deficiency (occurs when the body doesn't receive enough of a vital vitamin). Record review of Resident #26's quarterly MDS assessment dated [DATE] indicated Resident #26 was understood and had the ability to understand others. Resident #26 had a BIMS score of 15 which indicated intact cognition. Record review of Resident #26's care plan dated 8/14/23 indicated Resident #26 had a vitamin/mineral deficiency. Intervention included administer medications as ordered by MD. Record review of Resident #26's consolidated physician order dated 8/13/25 indicated Folic Acid Oral Tablet (is used for preventing and treating low blood levels of folate (folate deficiency)), give 1000 mcg by mouth one time a day for supplement. Ordered date 8/12/25. Start dated 8/13/25. Record review of Resident #26's MAR dated 8/1/25-8/31/25 indicated:*Folic Acid Tablet 400 MCG, give 1 tablet by mouth one time a day related to osteoarthritis (is a common joint disease where cartilage breaks down, leading to pain, stiffness, and swelling in affected joints). Discontinued 8/12/25 at 11:42 a.m. The MAR indicated RN B administered 400 MCG on 8/12/25 at 7:00 a.m. * Folic Acid Oral Tablet, give 1000 mcg by mouth one time a day for supplement. The MAR indicated the first dose was administered on 8/13/25 at 8:00 a.m. During an observation on 8/12/25 at 8:01 a.m., RN B showed a 1000 MCG bottle of Folic Acid and stated she had received a new order from the physician but had not changed the order yet. RN B administered 1 tablet of Folic Acid 1000 MCG to Resident #26. On 8/13/25 at 12:39 p.m., attempted to contact RN B by phone. A voicemail was left for a return call. During an interview on 8/13/25 at 2:00 p.m., the ADON A said the physician order needed the resident and medication name, route, dose, and frequency. She said a medication should not be given without a complete order. She said the wrong dose could be given. She said the resident could be under and over dosed. She said everybody who looked at Resident #31's Claritin order was responsible for getting the dose to administer. She said before administering a medication, the nurses should follow the 6 rights of medication administration. She said the DON, ADON, and Pharmacy consultant were responsible for ensuring the nurses inputted complete physician's orders. She said they monitored this process by doing chart audits. She said RN B should have administered Resident #26's current medication order until the new physician order had been placed in the charting system. She said RN B's documentation of Resident #26 MAR was inaccurate. She said RN B should have documented the dose she administered. She said the resident needed an accurate record of administration. She said when the documentation was inaccurate, the MD would not be able to accurately assess the

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	675387	A. Building B. Wing	08/13/2025

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Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities and to ensure the attending physician documented in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it in response to the pharmacist report for 1 of 5 residents (Resident #35) reviewed for (MRR) Medication Regimen Review. The facility failed to ensure Resident #35's Medication Regimen Review dated 4/30/25, had a specific duration for the extended duration beyond 14 days of PRN Ativan (Lorazepam). This failure could place residents at risk from maintaining their highest practicable level of physical, mental, and psychosocial well-being, and could place them at risk for adverse consequences related to medication therapy. Findings included: Record review of Resident #35's face sheet dated 8/12/25 indicated Resident #35 was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #35 had diagnoses including dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety (repeated episodes of sudden feelings of intense anxiety), and heart failure (is a condition where the heart cannot pump enough blood and oxygen to meet the body's needs). Resident #35 was on a local hospice service. Record review of Resident #35's quarterly MDS assessment dated [DATE] indicated Resident #35 usually understood and usually had the ability to understand others. Resident #35 had clear speech, moderate difficulty hearing and impaired vision. Resident #35's BIMS score was 2 which indicated severely impaired cognition. Resident #35 experienced inattention and disorganized thinking. The MDS assessment did not reflect use of an antianxiety medication during the last 7 days. Resident #35 received hospice care. Record review of Resident #35's care plan dated 6/16/25 indicated Resident #35 had a mood problem related to anxiety disorder. Resident #35 currently taking Lorazepam (is used to treat anxiety disorders). On 6/9/25, per MD regarding end date for Lorazepam: Medication was needed for end-of-life care. DO NOT STOP MED Intervention included administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #35's consolidated physician order dated 8/12/25 indicated Lorazepam Oral Concentrate 2MG/ML, give 0.25 ml by mouth every 4 hours as needed for anxiety related to anxiety disorder. Per MD, Do Not Stop Medication it is needed for End-of-Life Care. Ordered date 6/6/25. Record review of Resident #35's Nurse Administration Record dated 8/1/25-8/31/25 indicated Lorazepam Oral Concentrate 2MG/ML, give 0.25 ml by mouth every 4 hours as needed for anxiety related to anxiety disorder. Per MD, Do Not Stop Medication it is needed for End-of-Life Care. The NAR did not reflect any administration. Record review of Resident #35's Treatment Administration Record dated 8/1/25-8/31/25 indicated Lorazepam antianxiety medication behavior monitoring. The TAR did not reflect Resident #35 experienced anxious/nervous related to terminal illness. Record review of Resident #35's MRR dated 4/30/25 indicated, .this resident [Resident #35] is currently receiving the following psychotropic (Non Antipsychotic) medication on a PRN basis : ATIVAN.per regulatory guidelines, the duration of treatment with such medications on a PRN basis should be limited to 14 days, however, a new order may be written to extend the duration beyond 14 days if the prescriber believes it is appropriate. please evaluate the continued need for this medication. If it is to be extended. please document the rationale for the extended time period in the medical record and indicate a specific duration.CP P. Physician/Prescriber Response.Medication is needed for end-of-life care.Do Not Stop Med.MD O.6/6/25. Record review of Resident #35's progress notes dated 6/1/25-8/12/25 did not reflect Resident #35 had experience anxious/nervous related to terminal illness. During an interview and observation on 8/11/25 at 10:30 a.m., Resident #35 was sitting up in his bed. Resident #35 was watching television and appeared comfortable. Resident #35 displayed inattention and disorganized thinking when interviewed. Resident #35 was pleasant and did not appear anxious. Resident #35 only had questioned related to an investigation about his missing money. During an observation on 8/11/25 at 3:06 p.m., Resident #35 was sitting up in his bed. Resident #35 was watching television and appeared comfortable. During an observation on 8/12/25 at 7:42 a.m. Resident #35 was sitting up in his bed. Resident #35 was eating breakfast and appeared comfortable. During an observation and interview on 8/12/25 at 3:00 p.m., Resident #35 was sitting up in his bed. Resident #35 was watching television and appeared comfortable. Resident #35 was pleasant and did not appear anxious. Resident #35 only had questioned related to an investigation about his missing money. During an interview on 8/13/25 at 2:00 p.m., the ADON A said she had been back at the facility full time for a

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #8) of 16 residents reviewed for infection control. The facility failed to ensure LVN C did not place Resident #8 feeding tubing, in his bed during g-tube medication administration on 8/12/25. This failure could place a resident at risk for an infection. Findings included:Record review of Resident #8's face sheet dated 8/12/25 indicated Resident #8 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8 had diagnoses including cerebral palsy (is a group of conditions that affect movement and posture), paraplegia (is paralysis that affects your legs, but not your arms), abnormal posture, contractures (is a type of scarring in your soft tissues that causes them to tighten and stiffen), and artificial openings of gastrointestinal tract status. Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated Resident #8 was usually understood and had the ability to understand others. Resident #8 had unclear speech, adequate hearing, and impaired vision with corrective lenses. Resident #8 had a BIMS score of 99 which indicate the resident was unable to complete the interview. Resident #8 had short term memory call problem and moderately impaired cognitive skill for daily decision making. Resident #8 was dependent for ADLs. Resident #8 had a feeding tube while a resident and received 51% or more of total calories from tube feeding. Record review of Resident #8's care plan dated 5/9/24 indicated Resident #8 required an alternate method of nourishment due to nothing by mouth status and required use of feeding tube. Intervention included g-tube site (is a feeding tube inserted through the abdomen into the stomach) assessed every shift and notify MD of signs and symptoms of infection. During an observation on 8/12/25 at 9:00 a.m., LVN C disconnected Resident #8 feeding tubing from the g-tube site. LVN C placed the feeding tubing directly on the bed, towards the foot of the bed. LVN C checked Resident #8's residual and g-tube placement. LVN C reattached the feeding tubing to the g-tube. LVN C prepped her medication for administration. LVN C disconnected Resident #8's feeding tubing from the g-tube site. LVN C placed the tubing on the bed, near his chest and arm area. The tip of the feeding tubing was visualized touching the bed sheets. After medication administration, LVN C reconnected the feeding tubing to Resident #8's g-tube site and restarted the enteral feedings. During an interview on 8/12/25 at 2:06 p.m., the DON said the nursing staff should store the feeding tubing, when it was disconnected from the resident, where it could be kept clean. She said the tubing should not be placed on the bed or hanging in the wind. She said the nursing staff could use the cap that came with the feeding syringe to cover it. She said the facility's policy and procedure did not specify, not to lay it on the bed. She said it was best practice to store the tubing in a clean environment. She said if Resident #8's tubing was placed in the bed and reattached to the resident, it needed to be discarded. During an interview on 8/13/25 at 2:00 p.m., the ADON A said the resident's feeding tubing needed to be recapped when it was not in use. She said Resident #8's feeding tubing should not have been placed in his bed. She said the feeding tubing should not have been laid in the bed to prevent infection to the g-tube site. She said if the resident developed an infection, they could require antibiotics, hospitalization, and additional care. She said the ADON and DON were responsible for ensuring the nurses used infection control precautions during medication administration. She said they monitored this process by doing checkoff with the nursing staff. She said checkoffs were done upon hire, annual, and after an event where reeducation was needed. During an interview on 8/13/25 at 3:03 p.m., LVN C said she should have placed Resident #8's feeding tubing in a clean environment on 8/12/25. She said she could have placed the tip of the feeding tubing in the flush bag. She said she should not have placed it on the bed because it was an infection control issue. She said the g-tube that the feeding tube went into, was in the body. She said she did not want to put an infection in the body through the g-tube. She said if the resident developed an infection, they could experience a fever, an increase in white blood cells, and lower their immune system. She said the resident could require antibiotic, probiotics, and hospitalization. She said she had been checked off on g-tube medication administration and infection control. During an interview on 8/13/25 at 3:04 p.m., the DON said a resident's feeding tubing should be stored in a clean environment when disconnected, like previously stated. She said the nurses were responsible for ensuring infection control measures were done during medication administration. She said those measures needed to be followed to decrease the potential for causing an infection. She said if the

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free of water bugs for one (1) common area hallway near secure unit, and for one (room [ROOM NUMBER]) of 5 rooms reviewed for pests.The facility failed to maintain an effective pest free from water bugs for Resident #36 and a dead water bug located in one common hall located near the secured These failures placed residents at risk for the potential spread of infection, cross-contamination, food-borne illness, and decreased quality of life.Findings included:Record review of Resident #36's admission Record indicated she was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included acute respiratory infection (a sudden illness affecting the respiratory system), Chronic obstructive pulmonary disease (a progressive lung disease that makes it hard to breath), Type II Diabetes (a chronic condition that affects the way the body metabolizes sugar leading to high blood sugar levels and various health complications), and major depression disorder (a serious mood disorder characterized by persistent feelings of sadness and loss of interest in activities once enjoyed). Record review of Resident #36's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 15 indicating she was cognitively intact. The MDS also revealed, Resident #36 was dependent with transfers, and required substantial to maximal assistance with eating, toileting, bathing, dressing upper and lower body.Record review of Resident #36's Care Plan revised on 2/13/2025, revealed Resident #36 COPD with interventions to monitor for signs and symptoms of acute respiratory insufficiency and monitor, document and report any signs and symptoms of respiratory infection. During an observation and interview on 8/12/2025 at 8:21 AM, a water bug was located running under Resident #36's bed. Resident #36 said she had noticed bugs in her room. During an interview on 8/13/2025 at 12:39 PM, LVN K said she had seen water bugs on the secured unit. She said most of the time the water bugs were dead. LVN K said she had seen them pretty frequently noticing them every other day. LVN K said she has seen the pest control company come out and spray. LVN K said the building was old and she was not sure where they were coming from. LVN K said they could be getting in from outside door gaps. LVN K said maintenance was responsible for ensuring the pests were controlled.During an interview on 8/13/2025 at 1:00 PM, the Housekeeper N said she had worked at the facility for approximately 1.5 months. She said the water bugs get bad and some days she does not see as many. Housekeeper N said she noticed the water bugs more when there was rainy weather and humidity. Housekeeper N said she has seen them in the bathrooms. Housekeeper N said no one had complained to her about the water bugs and she did not know where they were coming from. During the interview, a water bug was observed dead on the floor at the surveyor's feet in the hallway leading to the secure unit.During an interview on 8/13/2025 at 1:23 PM the CNA E said she had seen water bugs. She said maintenance and a pest control company comes to spray the facility. She said she did not know where they were coming from, and no residents had complained to her about bugs. During an interview on 8/13/2025 at 2:00 PM, the Maintenance Director said he had been at the facility for about 1 year. He said a pest control company comes to the facility to treat for bugs monthly. The Maintenance Director said the pest control company had placed box stations outside to help. He said he had not noticed any water bugs in the facility recently. He said the last treatment was on 7/30/2025. He said the pest control had treated all areas of the facility such as dry storage, dining hall, common areas and cracked areas. The Maintenance Director said he felt the water bugs were coming in from outside and the building was old, and the bugs were under the foundation. He said the water bugs set up where there was moisture, and they run inside. He said the housekeepers and aides were to report to him if bugs were in resident rooms and they were good about letting him know. He said the housekeepers sweep under furniture and in the bathrooms. During an interview on 8/13/2025 at 4:13 PM, the Administrator said she expected the building to be as free as possible for pests. She said if the staff observed an increase in bugs, they should notify maintenance so the pest control company can come to the facility to spray. She said pest or bugs in the building could cause infection to residents.During an interview on 8/13/2025 at 4:36 PM, the DON said she was aware of the big water bugs. She said a pest control company has come out and the facility could get them to come out more frequently. The DON said the facility staff try to keep them out of the building. The DON said Maintenance was responsible for pest control, and it was all their responsibility. The DON said staff was expected to report to Maintenance and then Maintenance contacted the pest control company. She said it would not be good environmentally for the residents and the staff would not want water