STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 the resident had the right to be free from abuse for 1 of 5 residents (Resident #1) reviewed for abuse. The facility failed to ensure a safe environment free from physical and verbal abuse for Resident #1 when LVN D grabbed and pulled Resident #1 from behind the nurse's station, and Resident #1 was observed with redness on 07/13/25, and with bruises to both hands and wrists on 07/14/25. During this incident LVN D said to the resident three times that her daddy was dead. The noncompliance was identified as PNC. The IJ began on 07/13/25 and ended on 07/14/25. The facility had corrected the noncompliance before the survey began on 07/15/25. These failures could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. Findings include:Record review of Resident #1's face sheet, dated 07/17/25, revealed an [AGE] year-old-female who was originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia mild, with mood disturbance (cognitive decline with changes in behavior), insomnia (trouble sleeping), anxiety disorder (excessive worry feelings of fear), disorientation (lost sense of direction), glaucoma (vision loss), schizoaffective disorder bipolar type (mental health condition episodes mania and depression), intermittent explosive disorder (physical and/or verbal outburst), lack of coordination (unsteadiness), muscle wasting (decrease in strength), muscle weakness (lack of movement), depression (sadness), difficulty in walking (abnormal walking pattern). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C Brief Interview for Mental Status (BIMS) score revealed a score of 3 which indicated the resident's cognition was impaired. Section E Behavior indicated Resident 1 had potential behavior of psychosis that included hallucinations and delusions. And she exhibited physical behaviors directed towards others every 1 to 3 days, verbal behaviors directed towards others every 4 to 6 days, and wandering behavior that occurred every 4 to 6 days. Record review of Resident #1's care plan, dated 06/25/2025, revealed: Focus: Resident #1 had episodes of verbal/physical aggression. Date initiated 05/10/2024Intervention: Assist me to phone [family member] during episodes of agitation. Give me as many choices as possible about care and activities. Monitor for physical/verbally aggressive q shift. Document observed behavior and attempted interventions in behavior log. Focus: Resident #1 is an elopement risk/wanderer r/t disoriented to place, wander risk score 11. Date initiated 12/27/2024 date revised 06/25/2025. Intervention: Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, I prefer having snacks. Date initiated 12/27/2024 revised date 12/24/2025. Record review of Resident #1's progress notes, dated 07/14/2025 - 07/16/2025 revealed: On 07/14/2025 at 1:03 PM, the DON documented a Late Entry, because she was notified of Resident #1 having bruises to both wrists from an incident that occurred the on 07/13/25. The DON went to assess Resident #1 and found her to have bruising to both wrists. Resident #1 was asked if she was in pain from the bruising and she stated no. Notified the MD and emergency contact. The MD gave an order to get an x-ray to both wrists. Hospice was notified on 07/16/2025 at 3:29 PM, the DON documented spoke with Hospice staff about bruising on [Resident #1's] bilateral wrist. Per Hospice staff, the bruising to her wrists were not there Friday (07/11/2025). Per Hospice staff, she spent about 30 to 40 minutes talking with [Resident #1]. Monday (07-14-2025) Hospice staff did not know about bruising because [Resident #1] had her hands under her head and refused a shower. Noted resident is frequently wearing long sleeves. Record review of the x-ray report dated 07/14/2025 for Resident #1 revealed the right had wrist no acute abnormalities. The left wrist had osteopenia (body doesn't make new bone as quickly as it reabsorbs old bone) and degenerative changes. Record review of Resident #1's physician's progress note dated 07/15/2025 revealed staff reported new onset bruising to bilateral (having or relating to two sides; affecting both sides) FA (forearms). Record review of Resident #1's physician's orders dated 07/17/25 revealed Resident #1 was not prescribed blood thinners at the time of the incident. Observation on 07/15/25 at 7:30 AM indicated the nurses' cart was next to the display case that contained the reporting number for abuse and/or neglect and included the Administrator's phone number. Observation on 07/15/25 at 9:30 am of the facility's video recording dated 07/13/25 at 6:07 PM revealed LVN D was at the medication cart that was next to and in front of the nurse' station, when Resident #1 passed behind her and went into the nurses' station. LVN D said to Resident #1 You can't go back there. and Resident #1 replied I can too. LVN D said You cannot, and Resident #1 replied My daddy own's this place. LVN Dsaid Look lady as she grabbed Resident

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement written policies and procedures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of known source and misappropriation of resident property, were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to other officials (including the State Agency) and the Administrator for 1 of 5 residents (Resident #1) reviewed for abuse. The facility failed to ensure a safe environment free from physical and verbal abuse for Resident #1 when LVN D grabbed and pulled Resident #1 from behind the nurse's station, and Resident #1 was observed with redness on 07/13/25, and with bruises to both hands and wrists on 07/14/25. During this incident LVN D said to the resident three times that her daddy was dead. The noncompliance was identified as PNC. The IT began on 07/13/25 and ended on 07/14/25. The facility had corrected the noncompliance before the survey began on 07/15/25. These failures could affect all residents by placing them at risk of continued abuse, physical harm, pain, mental anguish, emotional distress, and serious harm. Findings include:Record review of Resident #1's face sheet, dated 07/17/25, revealed an [AGE] year-old-female who was originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia mild, with mood disturbance (cognitive decline with changes in behavior), insomnia (trouble sleeping), anxiety disorder (excessive worry feelings of fear), disorientation (lost sense of direction), glaucoma (vision loss), schizoaffective disorder bipolar type (mental health condition episodes mania and depression), intermittent explosive disorder (physical and/or verbal outburst), lack of coordination (unsteadiness), muscle wasting (decrease in strength), muscle weakness (lack of movement), depression (sadness), difficulty in walking (abnormal walking pattern). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C Brief Interview for Mental Status (BIMS) score revealed a score of 3 which indicated the resident's cognition was impaired. Section E Behavior indicated Resident 1 had potential behavior of psychosis that included hallucinations and delusions. And she exhibited physical behaviors directed towards others every 1 to 3 days, verbal behaviors directed towards others every 4 to 6 days, and wandering behavior that occurred every 4 to 6 days. Record review of Resident #1's care plan, dated 06/25/2025, revealed: Focus: Resident #1 had episodes of verbal/physical aggression. Date initiated 05/10/2024Intervention: Assist me to phone [family member] during episodes of agitation. Give me as many choices as possible about care and activities. Monitor for physical/verbally aggressive q shift. Document observed behavior and attempted interventions in behavior log. Focus: Resident #1 is an elopement risk/wanderer r/t disoriented to place, wander risk score 11. Date initiated 12/27/2024 date revised 06/25/2025. Intervention: Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, I prefer having snacks. Date initiated 12/27/2024 revised date 12/24/2025. Record review of Resident #1's progress notes, dated 07/14/2025 - 07/16/2025 revealed: On 07/14/2025 at 1:03 PM, the DON documented a Late Entry, because she was notified of Resident #1 having bruises to both wrists from an incident that occurred the on 07/13/25. The DON went to assess Resident #1 and found her to have bruising to both wrists. Resident #1 was asked if she was in pain from the bruising and she stated no. Notified the MD and emergency contact. The MD gave an order to get an x-ray to both wrists. Hospice was notified 07/16/2025 at 3:29 PM, the DON documented spoke with Hospice staff about bruising on [Resident #1's] bilateral wrist. Per Hospice staff, the bruising to her wrists were not there Friday (07/11/2025). Per Hospice staff, she spent about 30 to 40 minutes talking with [Resident #1]. Monday (07-14-2025) Hospice staff did not know about bruising because [Resident #1] had her hands under her head and refused a shower. Noted resident is frequently wearing long sleeves. Record review of the x-ray report dated 07/14/2025 for Resident #1 revealed the right had wrist no acute abnormalities. The left wrist had osteopenia (body doesn't make new bone as quickly as it reabsorbs old bone) and degenerative changes. Record review of Resident #1's physician's progress note dated 07/15/2025 revealed staff reported new onset bruising to bilateral (having or relating to two sides; affecting both sides) FA (forearms). Record review of Resident #1's physician's orders dated 07/17/25 revealed Resident #1 was not prescribed blood thinners at the time of the incident. Observation on 07/15/25 at 7:30 AM indicated the nurses' cart was next to the display case that contained the reporting number for abuse and/or neglect and included the Administrator's phone number. Observation on 07/15/25 at 9:30 am of the facility's video recording dated 07/13/25 at 6:07 PM revealed LVN D was at the medication cart that was next

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety 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 all alleged violations involving abuse were reported immediately, but not later than 2 hours if the alleged violation involved abuse or neglect and resulted in bodily injury, to the abuse coordinator, the facility Administrator for 2 of 5 residents (Resident #1) reviewed for abuse.The facility failed to ensure a safe environment free from physical and verbal abuse for Resident #1 on 7/13/25 at 6:07 PM when LVN D grabbed and pulled Resident #1 from behind the nurse's station, and Resident #1 was observed with redness on 07/13/25, and with bruises to both hands and wrists on 07/14/25. During this incident LVN D said to the resident three times that her daddy was dead. LVN D remained working at the facility for 6 hours the remainder shift on 7/13/25 after the incident and had direct contact with Resident #1.The noncompliance was identified as PNC. The IJ began on 07/13/25 and ended on 07/14/25. The facility had corrected the noncompliance before the survey began on 07/15/25. These failures could affect all residents by placing them at risk of continued abuse, physical harm, pain, mental anguish, emotional distress, and serious harm.Findings include: Record review of Resident #1's face sheet, dated 07/17/25, revealed an [AGE] year-old-female who was originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia mild, with mood disturbance (cognitive decline with changes in behavior), insomnia (trouble sleeping), anxiety disorder (excessive worry feelings of fear), disorientation (lost sense of direction), glaucoma (vision loss), schizoaffective disorder bipolar type (mental health condition episodes mania and depression), intermittent explosive disorder (physical and/or verbal outburst), lack of coordination (unsteadiness), muscle wasting (decrease in strength), muscle weakness (lack of movement), depression (sadness), difficulty in walking (abnormal walking pattern). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C Brief Interview for Mental Status (BIMS) score revealed a score of 3 which indicated the resident's cognition was impaired. Section E Behavior indicated Resident 1 had potential behavior of psychosis that included hallucinations and delusions. 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