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	01/14/2026

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. **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 A, CNA B and CNA C forced Resident #1 to leave the dining room and go to bed when they dragged Resident #1 with a blanket to her room.LVN A, CNA B and CNA C made verbal comments about Resident #1 on front of and to Resident #1 mind your own business, calling to find another place for her to live, why haven't they made her move yet.The noncompliance was identified as PNC. The IJ began on 12/19/25 and ended on 01/07/2026. The facility had corrected the noncompliance before the survey began on 01/12/2026.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 1/13/26 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (memory loss), paranoid schizophrenia (delusions), muscle weakness, difficulty in walking, generalized anxiety (worrying), conversion disorder with seizures and convulsions (jerking, limb shaking), insomnia (sleep disorder), schizoaffective disorder, bipolar type (hallucinations with mood swings), intermittent explosive disorder (sudden aggressive outburst).Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C BIMS summary score revealed a score of 6 which indicated severe cognitive impairment. Section E Behavior indicated Resident #1 had had potential behavior of psychosis that included hallucinations and delusions. Resident #1 rejected care and this type of behavior occurred daily. Section GG Mobility devices indicated Resident #1 used a wheelchair.Record review of Resident #1's care plan dated 12/14/25 revealed:Focus: I made an allegation that I was abused verbally and physically by staff on 12/19/25.Interventions: Monitor me for signs of fear, crying, increased agitation and notify MD if indicated. Date initiated 12/22/25Focus: Resident #1 had potential for physical/verbal aggressive secondary to Alzheimer's disease and schizoaffective disorder.Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated 05/02/22Focus: I have potential for delirium and am at risk for an acute confusional episode r/t inattention and disorganized thinking.Interventions: Communication: Use my preferred name. Identify yourself at each interaction.Face me when speaking and make eye contact. Reduce any distractions- turn off TV,radio, close door etc. I understand consistent, simple, directive sentences. Provide me with necessary cues- stop and return if agitated. Date initiated 05/02/22Focus - I have a mood problem r/t depression/anxiety AEB pacing, sitting in floor, aggressive behaviors. I take medication to help me feel less anxious and happier. Intrventions - Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, (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

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	01/14/2026

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	refusing toeat or drink, refusing med or therapies, sense of hopelessness or helplessness,impaired judgment or safety awareness. Date initiated 05/02/22Record review of progress notes for Resident #1 revealed on 12/22/25 at 9:46 AM, the ADON documented Resident #1 voiced that she had been dragged down the hall on a blanket when she refused to go to bed at an early time. She wanted to watch TV in the dining room and the night shift would not let her they turned it off and forced her. Stated that they dumped her out of her wheelchair and then dragged her down the hall on a blanket. Issue reported to ADM, Medical Director, and family.Record review of skin assessment for Resident #1 dated 12/22/25, completed by ADON revealed: Bruising to lower forearm.Record review of Resident #1's physician orders dated 1/13/26 indicated Resident #1 was not prescribed blood thinners at the time of the incident.Record review on 1/12/26 at 3:23 PM, of the facility's video recording dated 12/19/23 revealed Resident #1 was observed sitting in her wheelchair in the dining room with a book in her hand. She was the only resident in the dining room. There was a conversation with staff LVN A and CNA B, and Resident #1 told staff to stop talking about someone. Staff told Resident #1 to mind her business. The conversation goes back and forth with Resident #1 repeating what staff said to her. LVN A observed as she walked past Resident #1 and stated, I am fixing to wheel her to her room CNA B was overheard but not seen and said, it's not your business. Resident #1 stated oh shut up. LVN A was heard but not seen and she stated, why haven't they made her move yet. LVN A observed walking past Resident #1 and stated, I am going to find her a new place to live, she can't stay here. CNA B stated, I wish. LVN A walked towards Resident #1 and stated, I think we should call around and see who would take her. Resident #1 stated something back to staff, but it is inaudible. LVN A continued to tell Resident #1 mind your business Resident #1 stated oh be quiet, mind your business, stop talking about me. LVN A walked over to Resident #1 and stated, you are in our business. Resident #1 stated you are talking about me, LVN A stated, your husband said for you to and makes with her mouth (Brrrtrt sound sticking her tongue out and blowing air) and a hand gesture moving her hand across her neck. Resident #1 stated for you too. CNA B is heard but not see and stated, for you to go to bed. Resident #1 stated you need to shut up, mind your own business. CNA B stated, you need to go to bed. Resident #1 stated you don't need to tell me what to do. CNA B repeated to Resident #1 you need to go to bed. Resident #1 stated you are not my mother to tell me what to do. CNA B stated to Resident #1 I don't want to be your momma. There was something said by staff and Resident #1 but it was inaudible. CNA B was seen walking over to Resident #1 and asked her you don't want to go to bed, why don't you want to go to bed. Resident #1 stated oh don't tell me what to do. CNA B looked up at the two ceiling fans, moved a chair over, stood in the chair and turned both lights off on Resident #1. CNA B stated, but why don't you want to go to bed. Resident #1 stated I don't want you here. CNA B stated, its nighttime, come on Resident #1 come to bed. Resident #1 stated something to staff, but it was inaudible. Resident #1 moved to the TV room and continued reading her book. CNA B walked to the TV room and stated, Resident #1 you need to go lay down already, there is nobody here you need to go lay down. Resident #1 stated you do not pay for it as CNA B turned the light off in the TV room. CNA B stated, it's bedtime. Resident #1 stated It's not bedtime. Resident #1 observed going towards the light switch and stated, you need to turn the light on. CNA B stated, it's bedtime Resident #1. Resident #1 stated move CNA B stated, you want to tell me why you don't want to go to bed. Resident #1 stated you got bedtime. CNAB stated can you tell me why you don't want to go to bed. Resident #1 stated something, but it was inaudible. CNA B stated, can you tell me why you don't want to go to bed you used to always go to bed. Resident #1 stated no I don't have to go to bed. CNA B was observed pushing the wheelchair with Resident #1 sitting in the wheelchair and Resident #1 was pushing her feet towards the ground (continued on next page)

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	01/14/2026

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	and stated, stop it. LVN A was heard but not seen say it's her fault. Resident #1 was observed reaching her right hand for an overbed table as CNA B pushed her down the hall and Resident #1 was observed going forward out of the wheelchair. Staff pushed the wheelchair seat over Resident #1's legs and the seat against her left side. LVN A stated, ok leave her there. Resident #1 stated stop it. LVN stated leave her there. Resident #1 stated stop it, CNA B stated, hitting and swinging. Resident #1 stated you stop it don't tell me what to do. CNA B stated, get up LVN A stated, Resident #1 stop, stop. Resident #1 stated no you stop. LVN A stated, you can just stay right there. Resident #1 stated mind your own business, you're not my mother. CNA C was observed walking towards and Resident #1 took her right hand and moved it towards her left arm and stated to CNA C you stay away from me. LVN A stated stop CNA C stated, nobody's doing nothing to you Resident #1. Resident #1 stated yes you are. CNA C stated, what are we doing LVN A stated, stop punching them Resident #1 stated you to stop punching. LVN A and CNA B and Resident #1 all spoke at the same time, and it was inaudible. CNA C stated, hey everybody just separate. LVN A stated y'all just walk away. Observation made of Resident #1 sitting on the floor and CNA B was standing to her left side with the wheelchair, and CNA B was standing to her right. CNA B pushed the wheelchair to go in front of Resident #1, and the front right wheel was pushed up against Resident #1's left foot. Resident #1 stated go,go,go,go and Resident #1 was turned by that motion more towards the right facing towards the hall. LVN A walked around Resident #1 on Resident #1's right side, Resident #1 stated stop and Resident #1 used her right hand to hit LVN A on her right leg. LVN A stated, stop it Resident #1 stated stop it you stop it. LVN A walked down the hall towards the nurse's station. CNA B was observed standing in front of Resident #1 and leaned down towards Resident #1 and stated, stop hitting her. CNA C reached out her right hand towards the wheelchair to move it. Resident #1 attempted to speak, and CNA B stated no, you stop hitting. Resident #1 stated you stop and CNA B stated stop hitting. Resident #1 observed leaning to her left side then on her back. LVN A stated walk away from her. Resident #1 observed hitting LVN A on the back of her left leg. LVN A pointed her index finger at Resident #1 and stated, Resident #1 stop, stop Resident #1 stated you stop, LVN A pointed her index finger at Resident #1 and stated, that's enough, Resident #1 stated you stop. CNA B stated, should we get a blanket and take her to her room and LVN A stated probably. CNA C stated something in Spanish and LVN A laughed. Resident #1 observed laying on the floor on her back with her legs bent at the knees. LVN A observed walking behind the nurse's station and CNA C turned and walked down the hall. LVN A stated, god dang she can hit girl. CNA B was observed walking down the hall towards Resident #1 with a blanket. LVN A walked out from behind the nurse's station and stated, this is crazy Resident #1 stated something inaudible. LVN A stated, they need to send her out, CNA B stated, they do need to send her out. Resident #1 attempted to grab the blanket as CNA B and LVN A attempted to cover Resident #1. Resident #1 attempted to kick CNA B and LVN A stated, don't let her kick you girl, CNAB stated she's not hurting me. CNA B placed the blanket over Resident #1 and Resident #1 attempted to hit CNA B and CNA B reached for Resident #1's right arm and grabbed her forearm and stared to drag Resident #1 down the hall holding on to the blanket and Resident #1's arm. LVN A walked down the hall at Resident #1's feet and CNA C grabbed the blanket at Resident #1's feet and assisted with CNA B drag Resident #1 down the hall. CNA B was heard not seen and stated y'all watch out she's heavy as explicit. Observation made of CNA B walking backwards dragging Resident #1 and LVN A on the right side of Resident #1 at with CNA C on the left side of Resident #1, then staff turned and dragged Resident #1 into her room.During an interview on 1/12/26 at 11:30 AM, the DON stated Resident #1 was sitting in the dining room reading her Bible and watching tv. LVN A and CNA B, decided she needed to go to bed at 7:00 PM. CNA B turned the lights out (continued on next page)

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	01/14/2026

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	on her and turned the tv off. Stated, then Resident #1 tried to turn the lights back on and CNA B and LVN A started cussing and yelling at her. Resident #1 started off calm but began to get upset the more CNA B, and LVN A did to her. CNA B physically stood in front of the light switch so Resident #1 could not turn the lights back on. CNA B stood on a chair and turned the lights off on the ceiling fans. Resident #1 was yelling and telling staff she was not ready to go to bed then staff started pushing her in her wheelchair out of the dining room and Resident #1 ended up on the floor. Either she put herself on the floor or they dumped her on the floor. CNA B got a blanket and LVN A, CNA B, CNA C got her on the blanket and they dragged her with the blanket on the floor all the way down the hall to her room which is at the end of the hall. She stated she was told that staff said y'all know she has not been taking her meds. She stated that has nothing to do with it, if someone is sitting in the dining room reading their Bible, she is fine. Stated then LVN A was observed on the camera footage making threats to Resident #1 to get her kicked out of the facility. Stated, to her knowledge there were no injuries to Resident #1. Stated that after the incident all 3 staff continued to work because no one reported the incident. Resident #1 mentioned the incident to the ADON and the ADON asked the BOM to review the camera and she reported to the ADON the findings and the ADON and ADM returned to the facility and staff were terminated immediately. Stated the time of the incident was 7:00 PM on Friday 12/19/25 and staff worked until 6:00 AM with Resident #1 no other incidents that shift. She stated then the next day 12/20/25 they worked their shift with Resident #1, On Sunday 12/21/25 they started their shift and then it was discovered and they were terminated. LVN A, CNA B, and CNA C were the only staff on shift and none of them reported the incident because they didn't think they had done anything wrong because Resident #1 was not taking her medication. She stated staff should have left her alone, she was not doing anything wrong.During an interview on 1/12/26 at 12:30 PM, the NP stated she came to the facility for her regular visits on Monday and staff notified her of the incident with Resident #1 and staff. That Resident #1 was fine a little down but no bad thoughts and was still eating and sleeping and didn't recall what really happened but did tell her something about watching tv. Stated Resident #1 did not require any changes to her medication or any additional treatment over the incident. Stated Resident #1 is very resilient and at times will put herself on the floor and say she is going to die and will slide out of the wheelchair However, it was inappropriate for staff to have dragged her on the floor.During an interview on 1/12/26 at 2:00 PM, the ADM stated that the incident with Resident #1 that he had video of all of that and it was bad. He stated LVN A, CNA B and CNA C verbally abused Resident #1 and it was on video. They forced her down the hall in her wheelchair and they pushed the wheelchair so hard they dumped her on the floor. They wrapped her in a sheet and forced her to her room and to bed. The bad thing is all 3 staff were implicated and didn't report it. Resident #1 reported it to ADON two days later on Sunday. It happened on a Friday. Stated that Resident #1 told ADON they dragged me down the hall last night. The ADON was at work when Resident #1 told her and the ADON told the BOM and asked her to review the camera footage. Once it was found on the video footage the BOM reported to him what happened and him, the ADON, and BOM came to the facility. They fired the staff, and they worked the floor for about two hours, and called in additional staff to work. He stated he watched the video, and staff went in the dining room and Resident #1 was in the dining room reading her Bible not bothering anyone. Staff told Resident #1 it was bedtime, and she said something back to them. Then staff turned the lights out on Resident #1 in the dining room and said something else to her. Then staff proceeded to force her to go down the hall in the wheelchair. He fired LVN A and CNA B first then fired CNA C and explained to her she hadn't done anything wrong until she grabbed the sheet and helped them pull Resident #1 down the (continued on next page)

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	01/14/2026

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	hall then didn't report the incident. He stated 1 staff member was pushing the wheelchair and Resident #1 was fighting it and then the CNA B was pushing the wheelchair so hard Resident #1 comes out of the chair and she goes down on one side. She didn't get hurt thank god. Resident #1 got upset and at that point it was fight or flight and so Resident #1 was hitting staff telling them to leave her alone and to quit. CNA B got the sheet with CNA B and then CNA B tells the CNA C to help and that is when they dragged her down the hall using the sheet to her room and forced her to bed. They dragged her from the nurse's station down the hall to her room [ROOM NUMBER] feet. He stated Resident #1 was telling them to stop and the staff didn't. Staff forced her to her room and put her to bed. He stated that staff worked the rest of their shift, since no one reported it. Staff worked 6PM-6 AM. He stated staff worked Saturday 6PM-6AM with Resident #1 and it still was not reported. They were the only staff in the building, and they were all guilty. Then Sunday came around and ADON was working and Resident #1 reports they dragged me down the hall but didn't say who dragged her. ADON told Resident #1 she would investigate and that was when she asked BOM to review the cameras. He stated ADON left the facility and roughly 2 hours later BOM found the camera footage and that is when she reported it to him and ADON and that is when they went to the facility contacted the police and terminated the staff. Then he made rounds and passed medication, and it was about 2 hours before he was able to report it to HHSC. He stated it was a lot, and he could not believe it happened. He stated he spoke to each staff individually with the police and staff tried to justify their actions. He stated we expect our residents to be free from abuse or neglect and any excuses they gave him were not good ones and he fired them. He stated he fired them for abuse and for failure to report. He stated LVN A, the nurse tried to make excuses for her actions, CNA B the same thing and CNA C said she didn't do anything, and he played the video back and showed her right here where you grab the sheet and help drag her down the hall is abuse and you didn't report the incident. Then CNA C said the nurse told her to grab the sheet, and she did what she was told but didn't report it.The staff involved stated the night before Resident #1 stayed up all night and they were tired of these residents staying up all night. Resident #1 had stayed up all night the night before and slept all day and so they forced her to bed because they were tired of residents staying up all night.He stated there were no injuries to Resident #1. He stated the ADON assessed her.He stated he did talk to Resident #1 and she said, they did drag her down the hall. He stated he called and notified the family, and they were not too happy; he told them it would never happen again because he fired them.He stated they have in-serviced staff on ANE reporting ANE, reminded them there are cameras and they will review camera footage from each shift, they discussed QAPI and will discuss over three months then they had the NP for psych services to see her and make sure she was ok. He stated they in-serviced staff on resident rights and let staff know that residents can stay up all night if they want. He stated they completed safe surveys, and they will continue to do safe surveys weekly and as needed for three months.He stated he contacted the Medical Director and he had them assess the resident report to the family and make sure she is ok.He stated he spoke with Corporate Nurse, and she stated to fire them all that were involved.During an interview on 1/12/26 at 2:46 PM, the BOM stated that the ADON called her on that Sunday when she left work around 6PM. She stated the ADON told her that Resident #1 said the girls were mean to her, and they dragged her with a sheet. The ADON asked her to please review the video. She was looking and started with Sunday and then went back to Saturday and then Friday and found it. Resident #1 was in the dining room and Resident #1 thought staff were talking about staff and they told her to mind her own business. Then Resident #1 says something again and LVN A went over to Resident #1 and tells her to mind her own business and then tell CNA B that Resident #1 needs to get out of (continued on next page)

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	01/14/2026

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	this facility. Then time passed and Resident #1 was doing a crossword puzzle or reading her Bible and CNA B went in and stood on the chair and turned the lights off. She stated we never turn off the lights in the dining room or tv area. The CNA B stood on a chair and turned off the lights while Resident #1 was reading or doing her puzzle. Then CNA B moved the chair over and turned off other lights. Then Resident #1 moves herself with her wheelchair and went over by the tv and turned the lights on. Then CNA B realized the lights are on and told Resident #1 you need to go to sleep. Resident #1 said I don't want to go to sleep. Resident #1 told CNA B you don't pay the bills. LVN A told Resident #1 you better stop, or I am going to call the cops. Staff upset her when they turned the lights off. Then staff pushed her in the wheelchair and Resident #1 fell out of the chair. LVN A stated, just leave her there and CNA B said she would get a sheet. Staff had the sheet and Resident #1 was fighting them and they get the sheet over her and pulled her down the hall. CNA C helped pull the sheet but didn't report the incident. Stated she found the video footage around 7:33 PM and she sent it to the group ADM text and Corporate Nurse told her to fire them and she would not tolerate that. At that point they all went to the facility ADM, ADON and herself and they took over care and had two CNA's go in and help. CNA L and CNA J came in and helped from about and the ADON stayed and worked as a nurse.She stated the ADM, and she arrived back at the facility within 10-15 minutes and notified the local police department and they came to the facility. Local Law Enforcement took their ID's, DOB and opened a case with the videos and would see if they could press charges. She stated they interviewed staff involved and due to the incident with Resident #1 they no longer needed them as employees. That what happened was verbal abuse and the way they pulled her with the sheets would not be tolerated. Stated CNA B said well y'all are not here 12 hours like we are and that had to put up with all these behaviors. She stated she let staff know this was facility with behaviors and not every day will be a good day for a resident, but they were there to take care of them. That CNA B said well y'all are just in our offices. LVN A said well y'all already saw it and I am not telling y'all anything. She told the Local Law Enforcement they already saw it and I am not saying anything.CNA C said she didn't do anything, but it was explained to her that yes she did when she put her hand on that sheet and pulled Resident #1, she was involved, and she didn't call and report the incident. Staff said that Resident #1 had stayed up all night and had not slept, and they wanted her to go to bed. She stated but Resident #1 was not bothering anybody. Resident #1 does stay up all night, but she does put herself to bed when she wanted. She stated Resident #1 had the right to stay up all night this was her home.During an interview on 1/12/26 at 3:58 PM, the ADM stated that after the incident with the three staff and Resident #1 they changed the codes to all the access gates/doors.During an interview on 01/12/26 at 3:59 PM, Medication Aide (MA) said she did not witness the incident involving Resident #1 being dragged to her room. MA said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse that included taking a test and was in-serviced on resident rights.Review of the facility's Inservice Training Report dated 01/07/26 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated MA signed these in-services on 01/07/2026.During an interview on 01/12/26 at 4:38 PM, CNA G said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and (continued on next page)

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	01/14/2026

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	neglect, reporting abuse which included taking a test and was in-serviced on resident rights. CNA G, said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA G signed these in-services on 12/21/25.During an interview on 1/12/26 at 4:43 PM, LVN A stated she worked at the facility a little over a year. She stated there were several things with Resident #1. It was every night thing with Resident #1 because she went over a month refusing her meds and her behaviors increased. She stated she did not remember if the lights were turned off. She stated she was at the nurse's station talking to one of the CNAs about another resident and Resident #1 kept interrupting. She would move and try again, and Resident #1 continued to talk so she told staff they would talk about it later. That Resident #1 said y'all don't need to be talking about that resident. She stated Resident #1 followed them around and told them not to talk about the other resident. Resident #1 stayed up every night going into rooms and her behavior was way off because she refused her medication. Resident #1 escalated the situation. She stated Resident #1 had pulled CNA B hair pulled from behind, she didn't see that happen, but she heard Resident #1 and CNA and told staff let's just get her to her room. That this escalated to the point where she told staff let's just stop all this. Resident #1 was combative, and she told CNA B to get a blanket She stated it had never been policy to not do that and whatever is safest for her staff and resident she will do. They rolled her on the blanket and carried her to her room and placed her in bed. That Resident #1 punched her in the stomach and kicked her behind her knee. The administrative staff doesn't understand this goes on all the time. Resident #1 hits hard and gets agitated and she had been up all night and all day and since she had gone a month and a half without her meds. That she did what she thought was the safest thing for all involved that night. That in no way did anyone abuse Resident #1 that night. That her pride was really hurt because there was no way she would hurt anyone. She would never cause harm and the safest way was to use a sheet or blanket because you can't always use a mechanical lift to move them to get a blanket and carry a resident was safer that using the mechanical lift. That resident's had the right to stay up all night but Resident #1 did not have the right to go into other resident's rooms. Stated they rolled her, put the sheet under her and rolled her back and then the two CNAs had the ends of the sheet, then they lifted her up and carried her in the sheet to her room. Stated she could not remember if it was a blanket or a sheet. She stated the CNAs took her to her room she didn't go to her room she walked halfway down the hall. Resident #1 didn't get back up that night. She needed her in her room and in bed so she could take care of other residents. That Resident #1 was fighting staff while they were trying to push her in the wheelchair and then Resident #1 slid herself in the floor like she always does. She did not recall saying she would call the police on Resident #1 that night or saying she will find someplace else for her to live. She said she might have said they would find someplace else for her to live. She knew she was upset that night and she thought about calling the police that night because it was out of hand. She stated the facility has trained her on ANE and put papers out. She stated she was trained over resident rights. There was so (continued on next page)

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	01/14/2026

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	many different behaviors that she did not know how to explain it but it was very, very hard. She stated she was the night nurse, and she knew it was up to her to take care of the residents. She stated she felt that night she made the best decision for everyone so no one got hurt. She stated she did not remember everything that happened. She stated if staff did turn off the lights, then it would be a violation against resident rights. That they have the right to sit up all night if they want that is their home. She stated she did not know if dragging her on the bed sheet was abuse because she was heavy and there was no way she could have been hurt on the sheet because each staff had each end of the sheet, she would not get hurt. She stated that it was normal for Resident #1 to put herself on the floor that she did that for attention.During an interview on 01/12/26 at 5:00 PM, CNA E said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-serviced on resident rights. CNA E, said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA E signed these in-services on 12/21/25.During an interview on 1/12/26 at 5:40 PM, ADON stated she worked on Sunday, and when she left for the day staff told her Resident #1 reported that they dragged her down the hall on a blanket. She called BOM and asked her to look at the videos. Stated she didn't know when it happened that Resident #1 didn't say when it happened just that she was down the hall. She got home showered and then got information on her phone about the videos and text with BOM Corporate Nurse and ADM, Corporate Nurse told them to get to the facility and get the staff out she wanted them gone. Stated when she got there she met BOM, ADM and Law Enforcement Officer outside. They interviewed LVN A in the office and

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	01/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure of 5 of 8 residents (Residents #2, #3, #4, #5, and #6) were free from misappropriation of personal property.The facility did not prevent RN D from taking residents #2, #3, #4, #5 and #6's personal property. This failure could place residents at risk for decreased quality of life and distrust for the staff.Findings include:Record review of Resident #2's face sheet, dated 01/14/2026, revealed a [AGE] year-old female who was admitted to facility on 01/13/25 with diagnosis that included bilateral hearing loss (reduction of hearing ability to both ears), paraplegia (paralysis affecting the lower half of the body), major depressive disorder (persistent sadness, loss of interest in daily activities), anxiety disorder (mental health condition characterized by persistent, excessive fear and worry), age-related cataract of the left eye (clouding of the eye's natural lens), and bilateral optic atrophy (damage to the visual pathway).Record review of Resident #2's Annual Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 13, which indicated resident's cognition was intact. MDS Section GG-Functional Abilities revealed Resident #2 required setup or clean-up assistance with eating and oral hygiene, and was dependent on staff for toileting, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, and personal hygiene.During an interview 01/12/26 at 3:00 PM, Resident #2 said somebody had taken her wine bottle with flowers and faux water, signs with saying, a container with dry colorful flowers, container with markers, and her unopened container of Revitalift by Loreal face cream. Resident #2 said she liked these items and wanted them returned to her.Record review of Resident #3's face sheet, dated 01/14/2026, revealed a [AGE] year-old male who was admitted to facility on 07/20/23 with diagnosis that included age-related cataract of the left eye (clouding of the eye's natural lens), optic atrophy (damage to the visual pathway), mood disorder (emotional state like deep sadness (depression) or intense highs (manic/hypomania), depressive episodes (sadness, loss of interest in daily activities), and anxiety disorder (mental health condition characterized by persistent excessive fear and worry).Record review of Resident #3's Quarterly MDS, dated [DATE], revealed Resident #3 had a BIMS of 14, which indicated resident's cognition was intact. MDS's Section GG-Functional Abilities revealed Resident #3 required setup or clean-up assistance with eating, and was dependent on staff for oral hygiene, toileting, shower/bathe self, upper and lower body dressing, putting on/takin off footwear, and personal hygiene.During an interview 01/13/26 at 3:25 PM, Resident #3 said as far as he knew, he did not have any personal items missing from his room.Record review of Resident #4's face sheet, dated 01/14/2026, revealed a [AGE] year-old male who was admitted to facility on 10/08/25 with diagnosis that included squamous blepharitis of the right and left eye (seasonal allergies), bilateral age-related cataract of the left eye (clouding of the eye's natural lens), depression (sadness, loss of interest in daily activities), and delusional disorders (fixed false beliefs that aren't rooted in reality). Record review of Resident #4's MDS, dated [DATE], revealed Resident #4 had a BIMS of 11, which indicated resident's cognition was moderately impaired. Resident #4's Care Plan review date 10/16/25 revealed his Activities of Daily Living required setup or clean-up assistance with eating, and was dependent on staff for oral hygiene, toileting, shower/bathe self, upper and lower body dressing, putting on/off footwear, and personal hygiene.Resident #4 was not interviewed because he had been discharged from the facility on 12/12/25.During an interview on 01/13/26 at 12:20 pm the Family Member (DON) was interviewed and verified her dad Resident #4 did not know any of his items were missing and she only became aware of these missing items when they were given to her to return to Resident #4.Record review of Resident #5's face sheet, dated 01/16/2025, revealed a [AGE] (continued on next page)

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	01/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old male who was admitted to facility on 09/26/25 with diagnosis that included Alzheimer's Disease (progressive brain disorder that slowly destroys memory and thinking skills), Schizoaffective Disorder (brain disorder affecting though, emotion, and behavior, causing hallucinations, delusions, disorganized speech and impaired functioning), bilateral age-related nuclear cataract (clouding of the eye's natural lens), and depression (sadness, loss of interest in daily activities). Record review of Resident #5's Quarterly MDS, dated [DATE], revealed Resident #5 had a BIMS of 4, which indicated resident's cognition was severely impaired. MDS's Section GG-Functional Abilities revealed Resident #5 was independent with eating, required substantial/maximal assistance with oral hygiene, and was dependent on staff for toileting, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.During an interview on 01/13/26 at 3:22 PM, Resident #5 moved his head sideways to indicate no, when he was asked if anybody had taken his personal items.Record review of Resident #6's face sheet, dated 01/14/2025, revealed a [AGE] year-old male who was admitted to facility on 03/02/45 with diagnosis that included Alzheimer's Disease (progressive brain disorder that slowly destroys memory and thinking skills), Impulse Disorder (persistent inability to resist strong urges or impulses, leading to repetitive behaviors that often harm oneself or others), retinal hemorrhage of left eye (bleeding in the retina), and depressed episodes (persistent feelings of sadness, emptiness, or loss of interest in nearly all activities). Record review of Resident #6's Quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS of 1, which indicated resident's cognition was severely impaired. Resident #6's Care Plan dated 11/06/25 revealed he was independent with eating and oral hygiene; however, he was dependent on staff for personal hygiene, toileting, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene.During an interview on 01/13/26 at 3:40 PM, Resident #6 said as far as he was aware, nobody had taken his personal items.Record review on 01/12/26 at 3:23 PM of the facility's video footage revealed RN D used a code to unlock and enter the gate on the side of the facility and place a bag in a wheelchair. Then he walked around to the other side of the building with a bag in his hand and exited through the gate. RN D re-entered through the gate carrying bags in his hand and walked to the side of the building. RN D was observed stepping out of a car at the front gate of the facility where he hung something on this front gate, then drove off.During an interview on 01/12/26 at 12:03 PM, the Director of Nurses (DON) stated Registered Nurse (RN D) stole several things from the residents and the facility, then over a few days, he returned these items to the facility by leaving trash bags of stuff outside of the facility near the gates. A search of these bags revealed there was clothing and various items that belonged to residents. The DON said the facility did not know these items were missing until RN D returned them to the facility. Residents did not report this information as they did not know their items were missing and did not report them missing. The only resident that reported anything missing was, Resident #2, who said her wallet and ID were missing. The facility did attempt to locate the wallet and ID and assisted Resident #2 with getting a new ID and bank card and verified there was not any money missing from Resident #2's bank account. They did not know the wallet was stolen until RN D returned it. The facility did contact the police and made a self-report once the items were returned and that was when they realized all the items were stolen. There is an intake number for this and a complainant made a report after the facility contacted her to let her know items were stolen and returned.During an interview on 01/12/26 at 2:00 PM, the ADM indicated RN D worked the night shift (6 PM to 6 AM) and that was how he was able to take items out of the building one backpack at a time he always brought his backpack to work. The ADM said RN D worked at the facility for about 2 months. Then the AD reported seeing large bags outside of the her office. The ADM asked why these large (continued on next page)

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	01/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bags were outside, and the AD said RN D had dropped them off. He stated well we need to go through them and see what's in the bags. The ADM stated that RN D had apparently dropped off bags at the facility that morning and then was pulled over for speeding by DPS. RN D eventually informed DPS that he borrowed items from the residents but had returned them. Afterwards, the ADM stated his staff searched the bags and found jewelry, cell phones, laptops, clothes, CD's, random items, money, and a wallet with an ID that belonged to Resident #2. The interviews with staff said they did not know the items were missing and residents had not reported them missing. ADM stated that he texted RN D to let him know that due to the residents' missing items being in his possession, he was terminating his employment with the facility. ADM stated his staff were able to return the items promptly to the residents, and then anything that was left over and not identified as belonging to the residents was turned over to the police for evidence. The ADM said the facility is pressing charges against RN D and to his knowledge all missing items were replaced. ADM said he was informed Resident #2 had a cell phone missing; however, it was returned to her. He stated he is unaware as to why RN D took these items, because he was trained over ANE that includes misappropriation. ADM said RN D should not have taken items belonging to the residents, because it could mess with their psyche diagnosis, and because they are limited to personal items. The ADM said his expectations of staff was to prevent them from exploiting residents by taking and borrowing their personal items. The ADM stated the facility had counselors come to the facility and evaluate them for their psyche issues. Since this incident, the ADM had his staff trained over ANE to prevent this from happening again, and staff will not be allowed to bring big bags to work.During an interview on 01/12/26 at 2:46 PM, the Business Office Manager (BOM) stated the incident involving RN D was recorded on the facility's cameras 12/16/25. The BOM said she reviewed the camera footage on 12/19/25 revealing RN D carried trash bags to the facility and placed these bags on wheelchairs that were outside of the facility. Then RN D moved around to the other side of the facility, returned and put items into the bags. The BOM said on 12/15/25 the AD informed her that she heard someone outside of her office, and it was RN D leaving bags near her office. The BOM said the facility received a call from DPS, who wanted to know if RN D had worked at the facility and they reported yes, but he was currently not working because he was off duty. DPS reported that RN D had a lot of property in his car. Afterwards, the Maintenance Supervisor (MS) did a walkthrough of the facility's exterior area and found bags placed around the facility. The bags included food, clothes, perfume, cologne, amazon items, Hey [NAME] shoes, phones, iPad, rings, jewelry, cash app card, and a Social Security card and debit card that belonged to Resident #2. This card was reviewed and it had the correct balance, indicating RN D had not taken take any money. BOM said Resident #2 had reported that her wallet was missing, but the facility's staff were unable to find it. Resident #2's wallet was found but, but it didn't include her DL or SS card. The BOM said Resident #2 had reported the wallet missing but no one else had reported items missing. BOM stated RN D called and spoke with her, and she asked him why he took the residents' property and he stated, he loves those residents and would never do anything to then. Afterwards, BOM said RN D asked her if he could apply for the DON position, and she replied no.During an interview on 01/12/26 at 3:59 PM, Medication Aide (MA) on 12/16/25 indicated Resident #2 reported to her that her purse and wallet were missing. MA said she assisted with searching for these items, when the Maintenance Supervisor (MS) asked MA if she knew anything about the envelope with Resident #2's drivers' license. MA directed MS to report finding Resident #2's purse on 12/16/25 in the trash bag. MA said this bag had items labeled with names of people that had not lived at this facility. MA said she had never witnessed RN D taking items that belonged to a resident, if she had she would have reported this to the ADM. During an (continued on next page)

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	01/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 01/12/26 at 5:00 PM, CNA E said during Resident #2's shower on unknow date, Resident #2 asked CNA E to help search for her personal items, wallet, perfume, and credit card that were missing. CNA E searched for Resident 2's missing items; however, she did not find these items in her room. CNA E said she reported Resident #2's missing items to the DON and ADON, who said they would talk to Resident #1.Record review of the facility's inventory list indicated the following items were discovered in the trash bags left at the facility on 12/16/25 by the RN D as follows: Resident #2'sElizabeth [NAME] Red Door Perfume,Neutrogena Retinol,[NAME] reversal day cream,[NAME] Hills MD sculpting cream,Neutrogena retinol moisturizer night cream,Youth Dew Parfum spray,White Diamonds spray,Cash App Card,ID card,SS card,iPad,Phone,Wallet-brown.Resident #3'sBlack Texas Tech cup.Resident #4'sBlack Hey Dudes-size 11,2-green short sleeve (shirt)Plaid long sleeve blue shirt.Resident #5's1 small plaid red/white short sleeve (shirt),1 pair of brown [NAME] shoes,1 large Texas flag button shirt,1 SS button blue shirt1 van (shoes)1 ls gray button shirt.Resident #6'sPhillips Norelco Razor with guards and bag.The following items were sent to the police department:Gold chain,Wedding ring band, diamond,Diamond wedding ban,Gold band,Silver band,Men's silver band,Inseego power bank,2-Unifi cameras,3-aluminum flashlights,Duracell pack AAA batteries,Thermometer,1 left brace.During an interview on 01/14/25 at 11:58 PM with Officer from the sheriff's department, stated he responded to the incident involving possession of stolen property by RN D. The officer said RN D was in possession of stolen property and in possession of ID of an elderly. He stated RN D will be charged with 5 counts of theft and a felony for having the identification of an elderly.Record review of RN D's personnel file revealed he had received training for Resident's Rights on 10/27/2025, and he signed on that date. And he received training on Abuse Prohibition Policy and Procedures and signed on 10/27/2025. The employee file revealed the facility completed a background check on RN D and RN D was eligible for employment. The employee file revealed he was terminated on 12/16/25.Record review of the facility's Freedom from Abuse, Neglect, Exploitation that was undated, included Purpose: Ensure each resident's right to be free from abuse, neglect, and corporal punishment of any type by anyone. This policy defined Misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Examples of misappropriation of resident property included, but are not limited to:Identity theft,Theft of money from bank accounts,Unauthorized or coerced purchases on a resident's credit card,Unauthorized or coerced purchases from residents' funds, etc.Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, included Resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to facility staff, etc.During an interview on 01/12/26 at 3:59 pm, Medication Aide (MA) said she had received training on resident rights: Ma Said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take resident's personal items. During an interview on 01/12/26 at 4:38 PM CNA G said she had received training on resident rights. CNA G said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take residents' personal items.During an interview on 01/12/26 at 5 PM CNA E said she had received training on resident rights. CNA E said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take residents' personal items.During an interview on 01/12/26 at 6:01 PM, CNA I said he had received training on resident rights. CNA I said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take residents' personal items.During an interview on (continued on next page)

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	01/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/12/26 at 6:17 PM, CNA J said she had received training on resident rights. CNA J said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take residents' personal items.During an interview on 01/12/26 at 6:33 PM, LVN K said she had received training on resident rights. LVN K said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take residents' personal items.During an interview on 01/13/26 at 10:45 AM, AD said she had received training on resident rights. AD said a resident is not supposed to be forced to do anything against their will, and staff should not borrow, use, or take residents' personal items.Record Review of the facility's Safe Surveys for residents were completed 12/16/25, 12/21/25, 01/06/26 and 1/12/26. The Safe Survey indicated the residents were asked the following questions:1. Do you feel safe?2.Do you have any concerns that you would like to report?3. Are you afraid or fearful of any staff member: If yes, who?There were no negative findings reported by the facility's residents on these reports.Record review of the facility's in-service dated 12/16/25 staff were in-serviced on Abuse and Neglect, which included Exploitation and Misappropriation.

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	01/14/2026

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 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. **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 8 residents (Resident #1) reviewed for abuse. The facility failed to follow their policy for abuse and neglect when LVN A, CNA B and CNA C failed to report an incident with Resident #1 for 2 days and the ADON and BOM failed to immediately report Resident #1's allegation of abuse to the ADM prior to investigation. The noncompliance was identified as PNC. The IJ began on 12/19/25 and ended on 01/07/2026. The facility had corrected the noncompliance before the survey began on 01/12/2026.These failures could affect all residents by placing them at risk of abuse, physical harm, pain, mental anguish, emotional distress, and serious harm.Findings included:Record review of Resident #1's face sheet, dated 1/13/26 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (memory loss), paranoid schizophrenia (delusions), muscle weakness, difficulty in walking, generalized anxiety (worrying), conversion disorder with seizures and convulsions (jerking, limb shaking), insomnia (sleep disorder), schizoaffective disorder, bipolar type (hallucinations with mood swings), intermittent explosive disorder (sudden aggressive outburst).Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C BIMS summary score revealed a score of 6 which indicated sever impairment. Section E Behavior indicated Resident #1 had potential behavior of psychosis that included hallucinations and delusions. Resident #1 rejected care and this type of behavior occurred daily. Section GG Mobility devices indicated Resident #1 used a wheelchair.Record review of Resident #1's care plan dated 12/14/25 revealed:Focus: I made an allegation that I was abused verbally and physically by staff on 12/19/25.Interventions: Monitor me for signs of fear, crying, increased agitation and notify MD if indicated. Date initiated 12/22/25.Focus: Resident #1 had potential for physical/verbal aggressive secondary to Alzheimer's disease and schizoaffective disorder.Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated 05/02/22.Focus: I have potential for delirium and am at risk for an acute confusional episode r/t inattention and disorganized thinking.Interventions: Communication: Use my preferred name. Identify yourself at each interaction.Face me when speaking and make eye contact. Reduce any distractions- turn off TV,radio, close door etc. I understand consistent, simple, directive sentences. Provide me with necessary cues- stop and return if agitated. Date initiated 05/02/22.Focus - I have a mood problem r/t depression/anxiety AEB pacing, sitting in floor, aggressive behaviors. I take medication to help me feel less anxious and happier. Interventions - Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing toeat or drink, refusing med or therapies, sense of hopelessness or helplessness,impaired judgment or safety awareness. Date initiated 05/02/22.Record review of progress notes for Resident #1 revealed on 12/22/25 at 9:46 AM, the ADON documented Resident #1 voiced that she had been dragged down the hall on a blanket when she refused to go to bed a t an early time. She wanted to watch TV in the dining room and the night shift would not let her they turned it off and forced her. Stated that they dumped her out of her wheelchair and then dragged her down the hall on a blanket. Issue reported to ADM, Medical Director, and family.Record review of skin assessment for (continued on next page)

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	01/14/2026

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 dated 12/22/25, completed by the ADON revealed: Bruising to lower forearm.Record review of Resident #1's physician orders dated 1/13/26 Resident #1 was not prescribed blood thinners at the time of the incident.During an interview on 1/12/26 at 11:30 AM, the DON stated after the incident with Resident #1 on 12/19/25, LVN A, CNA B and CNA C continued to work because they were the only staff that worked at the time of the incident and none of them reported the incident to any administrative staff. She stated the incident happened around 7:00 PM on Friday 12/19/25 and it was not reported until 12/21/25. On Sunday 12/21/25 LVN A, CNA B, and CNA C started their shift 6:00 PM - 6:00 AM and the incident was discovered on facility video footage shortly after that time. LVN A, CNA B, and CNA C were the only staff on shift on 12/19/25, and none of them reported the incident because they didn't think they had done anything wrong because Resident #1 was not taking her medication.During an interview on 1/12/26 at 12:30 PM, the NP stated she came to the facility for her regular visit on Monday 12/22/25 and staff notified her of the incident with Resident #1 and LVN A, CNA B and CNA C. She stated she did not recall getting notified over the weekend and her phone number was posted at the nurse's station, and she has received calls from the facility.During an interview on 1/12/26 at 2:00 PM, the ADM stated that the incident with Resident #1 that he had video of all of that and it was bad. He stated LVN A, CNA B and CNA C abused Resident #1, and it was on video. He stated the bad thing is all 3 staff LVN A, CNA B, and CNA C were implicated and didn't report it. Resident #1 reported it to ADON two days later on Sunday 12/21/25. He stated he fired them for abuse and for failure to report.During an interview on 1/12/26 at 2:46 PM, the BOM stated that the ADON called her on that Sunday when she left work around 6PM. She stated the ADON told her that Resident #1 reported an allegation of abuse at the end of her shift. The ADON asked her to please review the video. She stated the ADON did not know if the allegation happened and if it did happen what staff were involved. She reviewed the footage and found the incident and notified the ADM, ADON and corporate nurse. She stated at that time the ADM, ADON and her returned to the facility since the staff involved LVNa, CNA b and CNA C were working. Staff were terminated immediately. She stated, during an interview with CNA C it was explained to her that when she put her hand on that sheet and pulled Resident #1, she was involved, and she didn't call and report the incident.During an interview on 01/12/26 at 3:59 PM,MA M said she did not witness the incident involving Resident #1 being dragged to her room. MA M said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse, that included taking a test and was in-serviced on resident rights.Review of the facility's Inservice Training Report dated 01/07/26 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated MA signed these in-services on 01/07/2026.During an interview on 01/12/26 at 4:38 PM, CNA G said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-serviced on resident rights. CNA G, said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a (continued on next page)

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	01/14/2026

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA G signed these in-services on 12/21/25.During an interview on 1/12/26 at 4:43 PM, LVN A stated she worked at the facility a little over a year. She stated it had never been policy to not do that and whatever is safest for her staff and resident she will do. The administrative staff doesn't understand this goes on all the time. Resident #1 hits hard and gets agitated and she had been up all night and all day and since she had gone a month and a half without her meds. That she did what she thought was the safest thing for all involved that night. That in no way did anyone abuse Resident #1 that night. That her pride was really hurt because there was no way she would hurt anyone. She would never cause harm and the safest way was to use a sheet or blanket because you can't always use a mechanical lift to move them to get a blanket and carry a resident was safer that using the mechanical lift. That resident's had the right to stay up all night but Resident #1 did not have the right to go into other resident's rooms. She knew she was upset that night and she thought about calling the police that night because it was out of hand. She stated the facility has trained her on ANE and put papers out. She stated she was trained over resident rights. There was so many different behaviors that she did not know how to explain it but it was very, very hard. She stated she was the night nurse, and she knew it was up to her to take care of the residents. She stated she felt that night she made the best decision for everyone so no one got hurt. She stated she did not remember everything that happened. That they have the right to sit up all night if they want that is their home. She stated she did not know if dragging her on the bed sheet was abuse because she was heavy and there was no way she could have been hurt on the sheet because each staff had each end of the sheet, she would not get hurt. During an interview on 01/12/26 at 5:00 PM, CNA E said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-serviced on resident rights. CNA E, said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA E signed these in-services on 12/21/25.During an interview on 1/12/26 at 5:40 PM, ADON stated she worked on Sunday, and when she left for the day staff told her Resident #1 reported an allegation of abuse, that staff were mean to her. She stated she did not know if the allegation happened and if it did what staff were involved. She called the BOM and asked her to look at the videos. She stated once the video footage was reviewed, they discovered LVN A, CNA B and CNA C were the staff involved. Stated she reported back to the facility Sunday evening, when she got there, she met BOM, ADM and Law Enforcement Officer outside. They interviewed LVN A in the office and she told them yes we did that we dragged her down the hall what else am I supposed to do with her y'all know she has been off her meds for a long time. That's on me because I told (continued on next page)

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	01/14/2026

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	them to do it, we are getting beat up slapped and kicked and y'all don't do anything about it. We told her that it was resident abuse and staff cannot do that. Resident #1 had the right to refuse medications, the right to sit up and watch tv when she wanted. She could read her Bible do puzzle books because this was her home. They could not make her go to bed. That was abuse to do those things to her. She stated that after the incident with Resident #1 she printed out anything she could on ANE and then spoke with the Corporate Nurse Regional Nurse and went over with staff that you cannot drag a resident down the hall, you do not turn the lights off, that they have rights and can watch tv, stay up. Stated when staff turned the lights off on Resident #1 that was violation of her rights. When staff dragged her down the hall on a bed sheet it was abuse. ADON stated she received training and in-service on abuse and neglect reporting abuse and protecting the residents. Review of the facility's Inservice Training Report dated 12/21/25 and /01/07/26 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse, protecting residents with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated ADON signed these in-services on 12/21/25. and 01/07/26. During an interview on 01/12/26 at 6:01 PM, CNA I said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse that included, taking a test and was in-service on resident rights. CNA I, said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA I signed these in-services on 12/21/25.During an interview on 01/12/26 at 6:17 PM, CNA J said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse and take a test and was in-service on resident rights. CNA J said a resident should not be forced to go to bed and go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA J signed these in-services on 12/21/25.During an interview on 01/12/26 at 6:33 PM, LVN K indicated Resident #1 does not sleep during the night and spends most of the night watching the tv in the dining area. LVN K said most of the residents go to bed around 8:00 pm to 8:30 pm, and it is unusual for Resident #1 to (continued on next page)

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	01/14/2026

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	be the only resident awake during the nights. LVN K said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-service on resident rights. LVN K said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated LVN K signed these in-services on 12/21/25.On 01/13/26 at 10:18 AM, Resident #1 said she was watching tv show in the dining area, when the lady turned off the tv and told her she had to go to bed. The lady put a blanket over her head, and the ladies grabbed her feet and dragged her to her room. When she tried to leave her room that night, the lady (CNA) would tell her to go back to her room, and she would say no, you are not my boss. Resident #1 said she stayed in her room all night and did not come out. On Saturday 12/20/25, she did not report to anyone she had been abused, instead she stayed in her room, and the ladies did not hit her because she told them to leave her alone. Resident #1 said on Sunday she reported the abuse to CNAs E and G, and the ladies who dragged her to her room are not here anymore because they took them to jail.During an interview on 1/13/26 at 3:34 PM, attempted to call CNA B, no answer left a voice message with call back information. Followed up with a text message. CNA B did not respond to the call or text.During an interview on 1/13/26 at 3:36 PM, Attempted call to previous staff CNA C no answer mailbox is full unable to leave a voice message. Followed up with a text message. CNA C did not respond to the call or text.During an interview on 1/14/26 10:22 AM, ADON stated She stated based on policy she expects staff to report any abuse immediately. She stated staff did not follow the policy when they did not report the abuse the night it happened. She stated they did not follow the ANE policy of free from abuse.During an interview on 1/14/26 at 10:26 AM, the AD, stated she learned of the incident with Resident #1 after it happened. She stated that at her resident council meeting last month she went over forms of abuse and reporting abuse to try and help the residents to under to report it. She stated she felt like they were hearing her and understood. Stated no one had made any complaints of abuse to her prior. Stated she was in-serviced on resident rights, types of abuse to report immediately resident property, misappropriation of property.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated AD signed these in-services on 12/21/25.During an interview on 1/14/26 at 11:58 AM, Local Law Enforcement stated an officer did report to the facility over an incident with Resident #1 and staff. He stated after the local law enforcement office reviewed the details it was believed it would be more of a violation of policy that staff broke. That they would not be filing charges against the staff involved.Record review of the facility's in-service dated 12-21-25, (continued on next page)

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	01/14/2026

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident.Abuse and neglect in-service test dated 12/22/25 were completed and signed by staff.Behavioral Management test dated 12/22/25 - 1/7/26 were completed and signed by staff, staff. Abuse and neglect questionnaires for staff dated 12/22/25- 1/7/26 were completed and signed by staff.Record Review of Resident Safety Survey dated 12/21/25, 01/06/26 and 01/12/26 indicated the facility's residents were asked the following.1. Do you feel safe here?2. Do you have any concerns you would like to report?3. Are you afraid or fearful of any staff member here? If yes, who?There were no negative findings on these reports, including Resident #1.Record review statement LVN A provided to the ADM, ADON and BOM, typed by ADON revealed the following: on 12/21/2025 at 8:30 PM LVN A was asked about pulling Resident #1 down the hall on a blanket. LVN A replied, yes, we did it, that's on me. Are we supposed to just get hit and kicked all the time? Y'all know she's not been taking her meds for a long time now and no one has done anything about it. Typed statement signed by ADON and ADM as staff did not provide a written statement to the facility.Record review statement by CNA B provided to the ADM and BOM typed by the ADM revealed the following: on 12/21/2025 at or around 8:30 PM CNA B stated she did not do anything wrong because of all the behaviors they have in the building, and the resident was attacking them. CNA B was informed she was terminated, and she violated the resident's rights by physical and verbal abuse according to the video evidence. Typed and signed by ADM as staff did not provide a written statement to the facility.Record review statement by CNA C provided to the ADM and BOM typed by the ADM revealed the following: on 12/21/2025 at or around 8:30 PM CNA C stated she did not do anything wrong because she did what she was told, and she didn't think it was a big deal. CNA C was informed that she did something wrong by failure to report the incident and she grabbed the sheet to drag the resident down the hall with the others. Staff terminated staff failed to report a violation of resident rights and abuse of a resident.Record review of LVN A ‘s employee file revealed hire date 07/18/2024 and termination date 12/21/2025. LVN A was trained on abuse, awareness and prevention on 10/03/2024. Record review of CNA B's employee file revealed hire date 04/19/2023 and termination date 12/21/2025. CNA B was trained on abuse, awareness and prevention 07/22/2024.Record review of CNA C's employee files revealed hire date of 12/04/2023 and termination date of 12/21/2025. CNA C was trained on abuse, awareness and prevention 07/26/2024.Record review of punch time detail for LVN A revealed she worked 12/19/25 from 5:52 PM until 6:37 AM; on 12/20/2025 from 5:47 PM until 6:33 AM and 12/21/25 from 5:30 PM until 9:06 PM.Record review of punch time detail for CNA B revealed she worked 12/19/25 from 5:56 PM until 6:12 AM; on 12/20/2025 from 6:03 PM until 6:05 AM and 12/21/25 from 5:30 PM until 9:0 6PM.Record review of punch time detail for CNA C revealed she worked 12/19/25 from 5:52 PM until 6:14 AM; on 12/20/2025 from 5:46 PM until 6:04 AM and 12/21/25 from 5:57 PM until 7:45 PM.Record review of corrected action plan by ADM dated 12/21/2025 revealed safe surveys were to be done weekly for three months to make sure this did not happen again. In-service abuse and neglect, resident rights, and misappropriation. Reviewed in QAPI for three months and discussed with staff. Monitored camera footage from different shifts to monitor staff.Record review of policy and procedure for Abuse, Neglect, Exploitation, Misappropriation Prevention Program dated 2001 and revised April 2021 indicated:Residents have the right to be free from abuse, neglect, misappropriation of resident property and (continued on next page)

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	01/14/2026

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.Policy Interpretation and Implementation:The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to:a. facility staffe. staff from other agenciesj. any other individual2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment3. Ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and turnover rates.5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.7. Implement measures to address factors that may lead to abusive situations, for example: a. adequately prepare staff for caregiving responsibilities b. provided staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation.8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.9. Investigate and report any allegations within timeframes required by federal requirements.10. Protect residents from any further harm during investigations.The noncompliance was identified as PNC. The IJ began on 12/19/25 and ended on 01/07/26. The facility had corrected the noncompliance before the survey began on 01/12/26.

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	01/14/2026

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 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. **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 1 of 5 residents (Resident #1) reviewed for abuse. The facility failed to follow their policy for reporting abuse and neglect when LVN A, CNA B and CNA C did not report an incident with Resident #1 for 2 days. LVN A, CNA B and CNA C continued to work with Resident #1 because they failed to report the abuse to the ADM. The noncompliance was identified as PNC. The IJ began on 12/19/25 and ended on 01/07/2026. The facility had corrected the noncompliance before the survey began on 01/12/2026.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 1/13/26 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (memory loss), paranoid schizophrenia (delusions), muscle weakness, difficulty in walking, generalized anxiety (worrying), conversion disorder with seizures and convulsions (jerking, limb shaking), insomnia (sleep disorder), schizoaffective disorder, bipolar type (hallucinations with mood swings), intermittent explosive disorder (sudden aggressive outburst).Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C BIMS summary score revealed a score of 6 which indicated severe cognitive impairment. Section E Behavior indicated Resident #1 had potential behavior of psychosis that included hallucinations and delusions. Resident #1 rejected care and this type of behavior occurred daily. Section GG Mobility devices indicated Resident #1 used a wheelchair.Record review of Resident #1's care plan dated 12/14/25 revealed:Focus: I (Resident #1) made an allegation that I was abused verbally and physically by staff on 12/19/25.Interventions: Monitor me for signs of fear, crying, increased agitation and notify MD if indicated. Date initiated 12/22/25.Focus: Resident #1 had potential for physical/verbal aggressive secondary to Alzheimer's disease and schizoaffective disorder.Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated 05/02/22Focus: I have potential for delirium and am at risk for an acute confusional episode r/t inattention and disorganized thinking.Interventions: Communication: Use my preferred name. Identify yourself at each interaction.Face me when speaking and make eye contact. Reduce any distractions- turn off TV,radio, close door etc. I understand consistent, simple, directive sentences. Provide me with necessary cues- stop and return if agitated. Date initiated 05/02/22Focus - I have a mood problem r/t depression/anxiety AEB pacing, sitting in floor, aggressive behaviors. I take medication to help me feel less anxious and happier. Interventions - Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing toeat or drink, refusing med or therapies, sense of hopelessness or helplessness,impaired judgment or safety awareness. Date initiated 05/02/22Record review of progress notes for Resident #1 revealed on 12/22/25 at 9:46 AM, the ADON documented Resident #1 voiced that she had been dragged down the hall on a blanket when she refused to go to bed a t an early time. She wanted to watch TV in the dining room and the night shift would not her they turned it off and forced her. Stated that they dumped her out of her wheelchair and then dragged her down the hall on a blanket. Issue reported to ADM, Medical Director, and family.Record review of skin assessment for Resident #1 dated 12/22/25, completed by ADON revealed: Bruising to lower forearm.Record review of Resident #1's physician (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	orders dated 1/13/26 Resident #1 was not prescribed blood thinners at the time of the incident.During an interview on 1/12/26 at 11:30 AM, the DON stated LVN A, and CNA B, and CNA C continued to work after this incident, because no one reported the incident. On 12/21/25 Resident #1 mentioned the incident to the ADON, and the ADON asked the BOM to review the camera's video. The BOM informed the ADON of the findings that included an incident confirming Resident #1 had been dragged to her room. On 12/21/25 the ADON and the ADM returned to the facility and LVN A, CNA B, and CNA C were terminated immediately. The DON said this incident occurred at 7:00 PM on Friday 12/19/25 and LVN A and CNA B, and CNA C continued to work the night shift until 6:00 AM on 12/20/25, and Resident #1 had no other incidents during this shift. The DON said the next day on 12/20/25 LVN A, and CNA B, and CNA C returned to work and worked the night shift from 6 PM until 6 AM on 12/21/25 and continued to care for Resident #1. On Sunday 12/21/25 LVN A, and CNA B, and CNA C returned to work; they started their shift at 6:00 PM shortly after that time they were terminated. LVN A, CNA B, and CNA C were the only staff on shift and none of them reported the incident because they didn't think they had done anything wrong since Resident #1 had not been taking her medication.During an interview on 1/12/26 at 2:00 PM, the ADM stated he reviewed the video that included the incident with Resident #1 and and it was bad. He stated LVN A, CNA B, and CNA C abused Resident #1 and it was on video. The bad thing was all 3 staff were implicated and didn't report it. Resident #1 reported it to the ADON two days later on Sunday, 12/21/25. It happened on a Friday 12/19/25; however, Resident #1 report to the ADON they dragged me down the hall last night. The ADON was at work when Resident #1 told her and the ADON told the BOM and asked her to review the camera footage. Once it was found on the video footage the ADM, the ADON and the BOM went to the facility and immediately fired LVN A, CNA B, and CNA C, who were at the facility to start their shift at 6 PM on 12/21/25.During an interview on 1/12/26 at 2:46 PM, the BOM stated that the ADON called her on that Sunday when she left work around 6PM. She stated the ADON told her that Resident #1 reported an allegation of abuse at the end of her shift. The ADON asked her to please review the video. She stated the ADON did not know if the allegation happened and if it did happen what staff were involved. She reviewed the footage and found the incident and notified the ADM, ADON and corporate nurse. She stated at that time the ADM, ADON and her returned to the facility since the staff involved LVNa, CNA b and CNA C were working. Staff were terminated immediately. She stated, during an interview with CNA C it was explained to her that when she put her hand on that sheet and pulled Resident #1, she was involved, and she didn't call and report the incident.During an interview on 01/12/26 at 3:59 PM, Medication Aide (MA) said she did not witness the incident involving Resident #1 being dragged to her room. MA said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse, that included taking a test and was in-serviced on resident rights.Review of the facility's Inservice Training Report dated 01/07/26 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated MA signed these in-services on 01/07/2026.During an interview on 01/12/26 at 4:38 PM CNA, G said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-serviced on resident rights. CNA G, said a resident should not be forced to go to bed and to go to sleep, should not be (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA G signed these in-services on 12/21/25.During an interview on 1/12/26 at 4:43 PM, LVN A stated she worked at the facility a little over a year. She stated it had never been policy to not do that and whatever is safest for her staff and resident she will do. The administrative staff doesn't understand this goes on all the time. Resident #1 hits hard and gets agitated and she had been up all night and all day and since she had gone a month and a half without her meds. That she did what she thought was the safest thing for all involved that night. That in no way did anyone abuse Resident #1 that night. That her pride was really hurt because there was no way she would hurt anyone. She would never cause harm and the safest way was to use a sheet or blanket because you can't always use a mechanical lift to move them to get a blanket and carry a resident was safer that using the mechanical lift. That resident's had the right to stay up all night but Resident #1 did not have the right to go into other resident's rooms. She knew she was upset that night and she thought about calling the police that night because it was out of hand. She stated the facility has trained her on ANE and put papers out. She stated she was trained over resident rights. There was so many different behaviors that she did not know how to explain it but it was very, very hard. She stated she was the night nurse, and she knew it was up to her to take care of the residents. She stated she felt that night she made the best decision for everyone so no one got hurt. She stated she did not remember everything that happened. That they have the right to sit up all night if they want that is their home. She stated she did not know if dragging her on the bed sheet was abuse because she was heavy and there was no way she could have been hurt on the sheet because each staff had each end of the sheet, she would not get hurt.During an interview on 01/12/26 at 5:00 PM, CNA E said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-serviced on resident rights. CNA E, said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA E signed these in-services on 12/21/25.During an interview on 1/12/26 at 5:40 PM, ADON stated she worked on Sunday, and when she left for the day staff told her Resident #1 reported an allegation of abuse, that staff were mean to her. She stated she did not know if the allegation happened and if it did what staff were involved. She called the BOM and asked her to look at the videos. She stated once the video footage was reviewed, they discovered LVN A, CNA B and CNA C were the staff involved. (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Stated she reported back to the facility Sunday evening, when she got there, she met BOM, ADM and Law Enforcement Officer outside. They interviewed LVN A in the office and she told them yes we did that we dragged her down the hall what else am I supposed to do with her y'all know she has been off her meds for a long time. That's on me because I told them to do it, we are getting beat up slapped and kicked and y'all don't do anything about it. We told her that it was resident abuse and staff cannot do that. Resident #1 had the right to refuse medications, the right to sit up and watch tv when she wanted. She could read her Bible do puzzle books because this was her home. They could not make her go to bed. That was abuse to do those things to her. She stated that after the incident with Resident #1 she printed out anything she could on ANE and then spoke with the Corporate Nurse Regional Nurse and went over with staff that you cannot drag a resident down the hall, you do not turn the lights off, that they have rights and can watch tv, stay up. Stated when staff turned the lights off on Resident #1 that was violation of her rights. When staff dragged her down the hall on a bed sheet it was abuse. ADON stated she received training and in-service on abuse and neglect reporting abuse and protecting the residents. Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse, protecting resident's, with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated ADON signed these in-services on 12/21/25 and 01/07/26. During an interview on 01/12/26 at 6:01 PM, CNA I said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse that included taking a test and was in-service on resident rights. CNA I said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated CNA I signed these in-services on 12/21/25.During an interview on 01/12/26 at 6:17 PM, CNA J said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse and take a test and was in-service on resident rights. CNA J said a resident should not be forced to go to bed and go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident. Indicated CNA J signed these in-services on 12/21/25.During an interview on 01/12/26 at 6:33 PM, LVN K indicated Resident #1 does not sleep during the night and spends most of the night watching the tv in the dining area. LVN K said most of the residents go to bed around 8:00 pm to 8:30 pm, and it is unusual for Resident #1 to be the only resident awake during the nights. LVN K said before and after Resident #1 was dragged to her room, she had received training to prevent abuse and neglect, reporting abuse which included taking a test and was in-service on resident rights. LVN K said a resident should not be forced to go to bed and to go to sleep, should not be forcefully pushed in their wheelchair from one area to another, when they are refusing to leave the area, and should not be dragged on the floor to their room.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated LVN K signed these in-services on 12/21/25.On 01/13/26 at 10:18 AM, Resident #1 said she was watching tv show in the dining area, when the lady turned off the tv and told her she had to go to bed. The lady put a blanket over her head, and the ladies grabbed her feet and dragged her to her room. When she tried to leave her room that night, the lady (CNA) would tell her to go back to her room, and she would say no, you are not my boss. Resident #1 said she stayed in her room all night and did not come out. On Saturday 12/20/25, she did not report to anyone she had been abused, instead she stayed in her room, and the ladies did not hit her because she told them to leave her alone. Resident #1 said on Sunday she reported the abuse to CNAs E and G, and the ladies who dragged her to her room are not here anymore because they took them to jail.During an interview on 1/13/26 at 11:30 AM, the ADM stated once the video footage was observed that it was clear the staff (LVN A, CNA B and CNA C) that worked on Friday violated Resident #1's residents rights, and it was verbal and physical abuse.During an interview on 1/13/26 at 12:20 PM, DON stated that what those staff did to Resident #1 was horrible. What they said to her was verbal abuse and physical abuse when they dragged her down the hall and grabbed her arm. That resident rights were violated when they told her she had to go to bed and when staff turned off the lights to leave her in the dark.During an interview on 1/13/26 at 3:34 PM, attempted to call CNA B , no answer left a voice message with call back information. Followed up with a text message. CNA B did not respond to the call or text.During an interview on 1/13/26 at 3:36 PM, Attempted call to previous staff CNA C no answer mailbox is full unable to leave a voice message. Followed up with a text message. CNA C did not respond to the call or text.During an interview on 1/14/26 10:22 AM, the ADON stated she did not understand why staff did that to Resident #1. She stated staff violated her rights when they turned the lights off in the dining room. This was her home, and they shouldn't have done that.Staff could have caused injury to her when they dumped her out of the wheelchair. They put her in harm's way when we are supposed to be protecting her. They put her at risk in so many ways when all they had to do was leave her alone. She has rights everyone in here to do what they want in their own home (within reason). Just because you (staff) want to have a nice and easy night and do what you want, doesn't give you the right to turn off the lights and make them go to bed. Its abuse mental, emotionally and physical. We are dealing with people that already had trauma and all they did was make it worse. She stated based on policy she expects staff to report any abuse immediately. She stated staff did not follow the policy when they did not report the (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	abuse the night it happened. She stated they did not follow the ANE policy of free from abuse.During an interview on 1/14/26 at 10:26 AM, the AD stated she learned of the incident with Resident #1 after it happened. She stated that at her resident council meeting last month she went over forms of abuse and reporting abuse to try and help the residents to under to report it. She stated she felt like they were hearing her and understood. Stated no one had made any complaints of abuse to her prior. Stated she was in-serviced on resident rights, types of abuse to report immediately resident property, misappropriation of property.Review of the facility's Inservice Training Report dated 12/21/25 for Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident. Indicated AD signed these in-services on 12/21/25.During an interview on 1/14/26 at 11:58 AM, Local Law Enforcement stated an officer did report to the facility over an incident with Resident #1 and staff. He stated after the local law enforcement office reviewed the details it was believed it would be more of a violation of policy that staff broke. That they would not be filing charges against the staff involved.Record review of the facility's in-service dated 12-21-25, Abuse & Neglect revealed the facility in-serviced staff on abuse and neglect, reporting abuse with an emphasize on dragging a resident down the hall on a blanket is in fact abuse. Turning off the lights when staff want them to go to bed, which is also considered abuse. The residents have the rights in their home to sit up and watch TV all night if they want to. Residents have the right to read a book all night long if they want to. Staff are not allowed to force a resident to go to bed, turn off the lights or any other form that would cause injury or distress to a resident.Abuse and neglect in-service test dated 12/22/25 were completed and signed by staff.Behavioral Management test dated 12/22/25 - 1/7/26 were completed and signed by staff, staff.Abuse and neglect questionnaires for staff dated 12/22/25- 1/7/26 were completed and signed by staff.Record Review of Resident Safety Survey dated 12/21/25, 01/06/26 and 01/12/26 indicated the facility's residents were asked the following.1. Do you feel safe here?2. Do you have any concerns you would like to report?3. Are you afraid or fearful of any staff members here? If yes, who?There were no negative findings on these reports, including Resident #1.Record review statement LVN A provided to the ADM, ADON and BOM, typed by ADON revealed the following: on 12/21/2025 at 8:30 PM LVN A was asked about pulling Resident #1 down the hall on a blanket. LVN A replied, yes we did it, that's on me. Are we supposed to just get hit and kicked all the time? Y'all know she's not been taking her meds for a long time now and no one has done anything about it. Typed statement signed by ADON and ADM as staff did not provide a written statement to the facility.Record review statement by CNA B provided to the ADM and BOM typed by the ADM revealed the following: on 12/21/2025 at or around 8:30 PM CNA B stated she did not do anything wrong because of all the behaviors they have in the building, and the resident was attacking them. CNA B was informed she was terminated, and she violated the resident's rights by physical and verbal abuse according to the video evidence. Typed and signed by ADM as staff did not provide a written statement to the facility.Record review statement by CNA C provided to the ADM and BOM typed by the ADM revealed the following: on 12/21/2025 at or around 8:30 PM CNA C stated she did not do anything wrong because she did what she was told, and she didn't think it was a big deal. CNA C was informed that she did something wrong by failure to report the incident and she grabbed the sheet to drag the resident down the hall with the others. Staff (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	terminated staff failed to report a violation of resident rights and abuse of a resident.Record review of LVN A ‘s employee file revealed hire date 07/18/2024 and termination date 12/21/2025. LVN A was trained on abuse, awareness and prevention on 10/03/2024. Record review of CNA B's employee file revealed hire date 04/19/2023 and termination date 12/21/2025. CNA B was trained on abuse, awareness and prevention 07/22/2024.Record review of CNA C's employee files revealed hire date of 12/04/2023 and termination date of 12/21/2025. CNA C was trained on abuse, awareness and prevention 07/26/2024.Record review of punch time detail for LVN A revealed she worked 12/19/25 from 5:52 PM until 6:37 AM; on 12/20/2025 from 5:47 PM until 6:33 AM and 12/21/25 from 5:30 PM until 9:06 PM.Record review of punch time detail for CNA B revealed she worked 12/19/25 from 5:56 PM until 6:12 AM; on 12/20/2025 from 6:03 PM until 6:05 AM and 12/21/25 from 5:30 PM until 9:0 6PM.Record review of punch time detail for CNA C revealed she worked 12/19/25 from 5:52 PM until 6:14 AM; on 12/20/2025 from 5:46 PM until 6:04 AM and 12/21/25 from 5:57 PM until 7:45 PM.Record review of corrected action plan by ADM dated 12/21/2025 revealed safe surveys were to be done weekly for three months to make sure this did not happen again. In-service abuse and neglect, resident rights, and misappropriation. Reviewed in QAPI for three months and discussed with staff. Monitored camera footage from different shifts to monitor staff.Record review of facility policy revised April 2021: Abuse, Neglect, Exploitation and Misappropriation Prevention Program undated revealed the following:Policy Statement: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This Includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical abuse or chemical restraint not required to treat the resident's symptoms. and any physical or chemical restraint not required to treat the residents' medical symptoms.Policy Interpretation and ImplementationThe resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to:Facility staff5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.9. Investigate and report any allegations within timeframes as required by federal requirements.10. Protect resident from any further harm during investigations.Record review of facility policy: Freedom From Abuse, Neglect and Exploitation undated revealed the following:Purpose: Ensure each resident's right to be free from abuse, neglect, and corporal punishment of any type by anyone.Procedure:1. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This Includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.2. This facility does not tolerate abuse, neglect, or exploitation of any kind. Any staff member that has reason to suspect such activity is going on or has witnessed such activity, must immediately report same to the Administrator or his/her designee when Administrator is absent.Definitions:Abuse Is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause (continued on next page)

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	01/14/2026

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. (S'183.5)Covered Individual is anyone who Is an owner, operator, employee, manager, agent or contractor of the facility.Willful as used in the definition of abuse, means the individual must have acted deliberately, not that the Individual must have intended to inflict injury or harm. (S483,5)The noncompliance was identified as PNC. The IJ began on 12/19/25 and ended on 01/07/26. The facility had corrected the noncompliance before the survey began on 01/12/26.