

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to provide a private meeting space for residents' monthly council meetings for 14 of 35 confidential residents who were reviewed for resident council. The facility failed to provide a private space for resident council meetings. Based on observation, interview, and record review, the facility failed to provide a private meeting space for residents' monthly council meetings for 14 of 35 confidential residents who were reviewed for resident council. The facility failed to provide a private space for resident council meetings. This failure could place residents at risk of not being able to voice concerns due to a lack of privacy. Findings include: Observation of the dining room on 9/15/25 revealed multiple staff and residents coming in and out of the dining room while the Resident Council meeting was in session. In a confidential group interview on 9/15/25 14 alert and orientated residents, who attended resident council, stated resident council was always held in the dining room. They stated staff came in and out with no privacy, and they filtered what they said due to staff presence. Residents stated there was no sign posted asking for privacy during Resident Council. They also stated they are not comfortable with the Resident Council being held in the dining room as it was right outside the ADM's office. They stated they would prefer the Resident Council be held in a more private setting. Interview on 9/16/25 at 2:40PM, the Activities Director stated Resident Council was held in the dining room for the entirety of her employment with the facility, 10 years. The AD stated it was not a private space; she stated there was no sign posted during resident council to request privacy. The AD stated there was a partition that could be pulled on the East side of the dining room to hold Resident Council in a more private area. The AD stated she did not hold Resident Council with the partition being used because she is not used to utilizing the partition. There were no doors to close to the dining room. She stated there were no barriers to utilizing the partition in the future for Resident Council meetings. The AD stated the potential negative outcome for not providing privacy during the Resident Council meeting was Residents may not speak freely due to staff overhearing their conversations. Interview on 9/16/25 at 3:00PM the Administrator stated she did not feel the dining room was a private setting for hosting Resident Council. She stated she thought the AD would host Resident council behind the partition on the East side of the Dining Room. The ADM stated the AD did not host Resident Council behind the partition due to lack of training. The ADM stated she oversaw training the AD to hold Resident Council in a private setting. She stated the potential negative outcome of not having a private setting for Resident Council was the Residents may not feel comfortable sharing their needs, thoughts, feelings, and complaints. Record review of Resident Council Minutes for June 2025 revealed Resident Council was held in the dining room with 8 residents present. Record review of Resident Council Minutes for July 2025 revealed Resident Council was held in the dining room with 10 residents present. Record review of Resident Council Minutes for August 2025 revealed Resident Council was held in the dining room with 12 residents present. Record Review of the facility's Resident Council Policy Revised April 2017, revealed the following: Policy Statement The facility supports residents' rights to organize and participate in the Resident Council. Policy Interpretation and Implementation 1. The purpose of the Resident Council is to provide a forum for: a. Residents, families, and resident representatives to have input in the operation of the facility. b. Discussion of concerns (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 14 of 35 confidential residents reviewed for resident rights. The facility failed to ensure 14 confidential residents were provided, the Grievance Procedure, information in regard to who the facilities' grievance officer was, their contact information, and how to file an anonymous grievance. Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 14 of 35 confidential residents reviewed for resident rights. The facility failed to ensure 14 confidential residents were provided, the Grievance Procedure, information in regard to who the facilities' grievance officer was, their contact information, and how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings included: Interviews and Record Review during Resident Council on 09/15/2025 revealed 14 confidential residents stated they did not have access to a Grievance form, they did not know they could file a Grievance anonymously, and they had not observed a posting of the Grievance procedure on the Resident bulletin board. Observation of the facility on 9/15/2025 at 3:45pm revealed the following: Facility postings did not include instructions regarding the Grievance procedure with any of the prominent postings. Grievance forms were not available to Residents in the facility. There was no access to submit a Grievance anonymously. Interview with the ADM on 9/16/2025 at 3:15pm, the ADM stated she was the Grievance Officer for the facility. The ADM stated she was responsible for the review of Grievances and to assign them to department heads. The ADM stated the Grievance forms are available, upon request, at the nurses' station. The ADM stated the staff complete a Grievance form if a resident has a complaint. The ADM stated there was no procedure for Residents to submit Grievances anonymously. The ADM stated the facility had a responsibility to resolve Grievances immediately with a final resolution being completed within 5 days. The ADM stated she assigned the Grievance to the appropriate department, that department addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The ADM stated completed Grievance forms were kept in a notebook. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the ADM stated she would also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated the CNA supervisor, laundry supervisor, and the DON were responsible for ensuring staff were trained on the Grievance process. Record Review of the Grievance Policy updated April 2017 reflected the following: Policy Statement: Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or their representative. The Resident and/or the representative has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Policy Interpretation and Implementation: Any resident, family member, or representative may file a grievance or complaint. Upon admission, residents are provided with written information on how to file a grievance. A copy of the Grievance/Complaint Procedure should be posted on the resident bulletin board. Grievances may be submitted orally or in writing and may be filed anonymously. The contact (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interviews, the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, seven days a week for 3 of 30 days (8/30/2025, 9/4/2025, and 9/13/2025) reviewed for RN coverage.- The facility failed to ensure that a Registered Nurse (RN) worked 8 consecutive hours a day, seven days a week on 8/30/2025, 9/4/2025, and 9/13/2025. This failure could place residents at risk of not having adequate qualified personnel in case of a health crisis. Findings include:Record review of facility document titled Punch details- Report, revealed on 8/30/2025 the facility had RN coverage for 3.5 hours. On 9/4/2025 the facility had RN coverage for 7.02 hours. On 9/13/2025 the facility did not have any documented RN coverage. During an interview on 9/16/2025 at 12:29pm with the DON she stated she was responsible for ensuring the facility had RN coverage. She stated one of those days, the RN for that day was delayed at the airport and was unable to provide coverage for the rest of the day. She stated on 9/13/2025 she had been sick and was unable to provide coverage and she was unable to find anyone to come in. She stated she did expect her RN staff to provide coverage for the entire 8 hours they are on schedule and not to clock out early. She stated she was always available for coverage and was available by phone if needed. She stated the RN coverage was required for RN assessments, or physician orders that require an RN's scope of practice. She stated the facility had hired another RN that would be covering the weekends. During an interview on 9/16/2025 at 3:01pm with the ADM, she stated the DON was responsible for ensuring the facility had RN coverage. She stated RN coverage was required to ensure quality care for residents. She stated a potential negative outcome of not having the RN coverage could be residents not having their daily care overseen by an RN. She stated she was not aware there had been days with low or no RN coverage. Record review of facility policy titled Departmental Supervision dated 8/2006, revealed; .an RN nurse supervisor/charger nurse is responsible for the supervision of all nursing department activities including the supervision of direct care staff for 8 consecutive hours per 24-hour period beginning at midnight.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed to ensure frozen pork was not stored above ready-to-eat foods in the freezer. The facility failed to ensure the window seal directly above the kitchen sink was free of dirt build-up and grime. The facility failed to ensure a container of ice used to prepare drinks for lunch, did not have a scoop stored inside of it. The facility failed to ensure all condiments had expiration or use-by dates. The facility failed to ensure a cleaning schedule was followed and monitored. These failures could place residents who received meals and/or snacks from the kitchen at risk of food contamination and food borne illness. Findings included: During the initial tour and observation of the kitchen on 09/14/25 at 11:20 AM the following were revealed: *Two packages of uncooked pork loin stored in a kitchen freezer above ready-to-eat and prepared food items such as a chocolate pie and sweet potato casserole. *A window seal above the kitchen sink had a thick yellow and brown build-up of dirt and grime. *The wall above the kitchen stove contained a yellow layer of grease, dirt, and grim. *The cart used for storing silverware and meal trays contained a build-up of food and grease. *The floor and wall beside the refrigerator in the kitchen were soiled with dirt, grease, and grime. *Plastic containers of individual condiments such as mayonnaise, mustard, picante sauce, tabasco sauce, tartar sauce, ranch dressing, and ketchup did not contain expiration or used by dates on the individual packets or on the storage containers. *A plastic scoop was observed to be stored in a bucket of ice used to prepare resident's drinks for lunch. During an observation of the kitchen on 09/15/2025 at 10:30 AM revealed the following: *Two packages of pork loin were stored above ready-to-eat and prepared food items in the kitchen freezer. *A window seal above the kitchen sink had a thick yellow and brown build-up of dirt and grime. *The wall above the kitchen stove contained a yellow layer of grease, dirt, and grim. *The cart used for storing silverware and meal trays contained a build-up of food and grease. *The floor and wall beside the refrigerator in the kitchen were soiled with dirt, grease, and grime. *Plastic containers of individual condiments such as mayonnaise, mustard, picante sauce, tabasco sauce, tartar sauce, ranch dressing, and ketchup did not contain expiration or used by dates on the individual packets or on the storage containers. During an interview on 09/16/2025 at 2:30 PM the DM stated she had been the dietary manager for approximately one week. The DM stated uncooked meats should have been stored under ready-to-eat and prepared food items. The DM stated she was responsible for putting away food items in the freezer and refrigerator. The DM stated this was a task she did herself. The DM stated she was unaware the pork loins were stored above ready-to-eat food items and stated she did not see it. The DM stated she would reorganize the freezer to ensure food was stored properly. The DM stated it was important for uncooked meats to be stored properly as it could have caused cross contamination. The DM stated she was unaware the individual condiments did not contain expiration or use by dates on the individual packages. The DM stated as they received new orders, the condiments were rotated, and the new condiments were placed at the bottom of the containers. The DM stated the individual condiments did not usually last more than one month because the residents used them often. The DM stated there was not a way to ensure the individual condiments were rotated since they did not have a date. The DM stated she was unaware the window seal above the kitchen sink contained a thick layer of dirt and grime. The DM stated she was unaware the wall behind the kitchen stove contained a layer of grease, dirt, and grime. The DM stated she observed the wall and floor beside the refrigerator, and she was aware of the dirt and grime build-up. The DM stated she was not aware the ice scoop was left inside the ice container. The DM stated the dietary staff had a cleaning schedule, but it had not been updated recently as the dietary staff have been short-handed recently. The DM stated it was her expectation that all areas in the kitchen were deep (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaned regularly and maintained through daily cleaning. The DM stated she planned to work on a deep cleaning schedule as soon as possible. The DM stated it was important to maintain a clean and sanitary kitchen to ensure residents did not get sick. The DM stated all dietary staff received training on storing and labelling food items in the kitchen as well as ensuring the kitchen area was clean and sanitary to prevent food borne illnesses. The DM stated all food items must be labeled and dated as consuming expired or outdated items may cause residents to get sick. The DM stated she would ensure all items were dated as soon as possible. The DM stated she planned to rearrange the freezer as soon as possible to ensure there were no items stored improperly and to prevent cross contamination. During an interview on 09/16/2025 at 3:05 PM the ADM stated it was her expectation that the kitchen was clean and sanitary. The ADM stated the DM was responsible for ensuring the kitchen was clean. The ADM stated the DM should have had a cleaning schedule for all dietary staff. The ADM stated the DM was responsible for ensuring food was stored properly and food items were labeled and dated with an expiration or used by date. The ADM stated the DM, and all dietary staff received training on cleanliness and sanitation as well as proper food storage. The ADM stated uncooked pork should not have been stored above ready-to-eat food items as it could result in cross contamination, leading to food borne illnesses. The ADM stated all food items, including condiments, should contain an expiration or used by date. The ADM stated residents could become sick if the kitchen is not clean and sanitary and food items were not stored properly. Record review of the facility's policy titled, Sanitation, dated October 2008, revealed the following: Policy Statement: The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation: 1- All kitchens, kitchen area and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects. 2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair. 16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. 17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. Record review of the facility's policy titled, Food Receiving and Storage, dated October 2017, revealed the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: I. Food Services, or other designated staff, will maintain clean food storage areas at all times. 7. Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such foods will be rotated using a first in - first out system. 13. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables, and other ready-to-eat foods		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 1 of 16 (Resident # 37) residents reviewed for abuse and neglect.- The facility did not report to the State Agency when Resident #37, was found unresponsive and not breathing in her room on 8/3/2025. On 8/9/2025 the DON was made aware that EMS reported food in Resident #37 airway, as a possible cause for Resident #37's medical emergency. This failure could place residents at risk of abuse, neglect and eliminate the opportunity for a timely investigation by the State Agency. Findings include: Record review of Resident #37s undated face sheet, revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #37 had a medical history of absence of right and left leg below the knee (amputation below the knee), gastro esophageal reflux disease (a condition where stomach contents flow back up into the esophagus, causing irritation and various symptoms), bipolar disorder (a chronic mental health condition characterized by extreme mood swings), schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder), muscle wasting (a condition characterized by the loss of muscle mass and strength), lack of coordination, insomnia (persistent problems falling and staying asleep), obesity (excessive body fat accumulation that can negatively impact health), muscle weakness, anxiety and type two diabetes. Record review of Resident #37's annual MDS dated [DATE], Section C- Cognitive Patterns revealed a BIMS score of 7 which indicated Resident #37 had severe cognitive impairment. Section K - Swallowing/Nutritional status revealed Resident #37 did not have signs and symptoms of a possible swallowing disorder. Section GG- Functional Abilities revealed Resident #37 required setup or clean-up assistance with eating. Record review of Resident #37's care plan dated 8/12/2025 did not reveal residents had any swallowing difficulty or required direct supervision during meals. Record review of Resident #37's physician orders revealed an order for a reduced concentrated sweets diet, regular texture/consistency and double portions, with an order start date of 9/23/2024. Record review of Resident #37's nutritional risk and dietary assessment dated [DATE], revealed Resident #37 did not have symptoms related to a swallowing disorder. Record review of Resident #37's progress notes revealed an entry dated 8/3/2025 at 5:20pm Resident [#37] was observed lying on her mat in her room unresponsive with no heart rate or respirations. CPR initiated. 911 called by CNA [unknown CNA]. After four cycles of CPR, AED placed on resident's chest. After analyzing, no shock advised, continue CPR. CPR continued x 22 minutes when first responder arrived and continued CPR. EMS here at 5:45pm and took over CPR and transferred resident to stretcher x 3 assist and exited facility with CPR in progress. Paperwork given to EMS and left facility at 1800 [6:00pm], signed by LVN A [agency nurse]. Record review of Resident #37's progress notes revealed an entry dated 8/9/2025 at 3:37pm, Spoke with [MDI], Resident [#37] passed away. Looks like cause of death will be choking. EMS found food in her airway. [MDI] will be doing a record review before final cause of death will be determined signed by the DON. Record review of EMS report dated 8/3/2025 revealed EMS arrived at the facility at 5:42pm. At 5:43pm, the summary of findings did not reveal any external abnormalities to Resident #37's head, neck, bilateral eyes, front and back torso, pelvis, abdomen, or peripheral extremities. EMS report revealed Resident #37 had no pulse and no respirations upon EMS arrival. EMS report revealed upon first look foreign body noted in the upper airway.removed a large piece of possible meat like gray foreign body obstruction from the upper airway with [NAME] forceps (angled surgical tongs used to guide breathing tubes into the windpipe) .ETT (a tube inserted into the (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	windpipe for ventilation and airway protection) was then able to pass. At 5:52pm, EMS reported Resident #37 had a pulse of 80, a blood sugar of 68, and a blood pressure of 90/XX [diastolic not obtained], no respirations noted. At 6:07pm, EMS reported Resident #37 had a blood pressure of 173/126, a pulse of 80, and respiratory rate 18 with mechanical ventilation (a medical procedure that assists or takes over breathing for a patient who is unable to breathe adequately on their own). Resident #37 did not obtain consciousness and was transported to a local hospital. During an interview on 9/16/2025 at 10:35 AM with VPOO, she stated they had not reported the incident with Resident #37 to the State Agency as they were unable to determine if the resident had choked at the facility or at the hospital. She stated Resident #37 was at the hospital for a few days after she was found unresponsive in her room. She stated the facility had performed CPR and there had been no indication Resident #37 had choked at that time. She stated they had worked with the medical examiner and were told they did not have any fault in her death and had nothing to worry about. During an interview on 9/16/2025 at 12:29 with the DON, she stated on 8/3/2025 she was notified of the incident with Resident #37 by LVN A, who was no longer at the facility. She stated the agency nurse told them they had been passing food trays out to the residents. She stated LVN A had gone in to check on Resident #37 and she had found her unresponsive, and they began CPR. The DON stated EMS was called and when they arrived, they took over CPR and Resident #37 was transported to the hospital. She stated at that time there had been no reports of food being in Resident #37's airway. The DON stated she was not sure when she spoke to the MDI (Medicolegal Death Investigator, who assist with the investigation of reported deaths to the Medical Examiner's Office), but she was told Resident #37s had passed away after a few days on palliative care at the hospital. She stated the MDI had asked some questions about how the resident was found and what had transpired. She stated the MDI told her, this case would be accidental and there would be no autopsy performed. She stated the MDI did mention EMS reporting food being in her throat but that the food could have come up during CPR. She stated she was not aware of food being in her airway when she was found and she had not seen the EMS report. The DON stated there was nothing that suggested Resident #37 had fallen, or that it was negligent on the facilities part. She stated the facility, and staff did everything the way it was supposed to happen. She stated there was no question whether the facility was negligent. The DON stated Resident #37 was able to feed herself and did not require supervision. She stated Resident #37 did not have a history of swallowing impairments or dysphagia (medical term for difficulty swallowing food or liquids). She stated Resident #37 did not have any signs of end of life and was not on hospice. The DON stated there was no neglect or delay in CPR to report that the facility had not done their job. The DON stated Resident #37 had not fallen and no one had gone into Resident #37s room and harmed her; she was found unresponsive. The DON stated she did not believe the incident was suspicious due to Resident #37s history health problems, and therefore did not believe it would be something that needed to be reported. The DON stated the MDI did not report it as a suspicious death but more of an incident. She stated EMS was able to get her back and Resident #37 lived a few more days at the hospital. She stated she believed that once they spoke to the MDI, the facility felt they were not negligent. During an interview on 9/16/2025 at 3:13 with the ADM, she stated she was not the ADM at the time of that incident. She stated the potential negative outcome of not reporting incidents to state agencies could be harm to the residents. She stated without knowing all the facts of the incident or being here during that time, it was difficult to determine why the incident was not reported to the State Agency. She stated if any resident is found unresponsive and it was unwitnessed, it should be reported. During an interview on 9/17/2025 at 10:02AM with the MDI, she stated on 8/9/2025 the hospital reported to her Resident #37's death. She stated the deceased [Resident #37] was found unresponsive and slumped over in her room. She stated EMS had reported food in the airway at the time of intubation. The MDI stated food in the airway does not mean the resident choked. She stated the food in the airway could have been from CPR or regurgitating (vomiting) after she became unresponsive. She stated after reviewing Resident #37s medical history, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	there was nothing that indicated she was at risk for choking on her food. She stated she could only speculate on what happened such as a stroke (stroke occurs when the blood supply to part of the brain is blocked or reduced), or an infarct (a small, localized area of dead tissue resulting from failure of blood supply). She stated when she reviewed the EMS report, there were no signs of her choking, only that they had found food when intubating but that could have been from CPR. The MDI stated she did not suspect any trauma or abuse that contributed to this incident. She stated there were no suspicions or evidence of foul play and Resident #37s had been released to a funeral home with no autopsy. The MDI stated she never instructed the facility not to notify the State Agency, only that she had not suspected the facility was negligent. She stated she did speak to Resident #37's family and explained her findings and they had no concerns over her care at the facility and did not have any other questions in regard to the incident. Record review of undated facility policy titled Allegations of Abuse, Neglect, Exploitations, or Mistreatment revealed Purpose: Ensure alleged violations related to mistreatment, exploitation, neglect or abuse, including injuries of unknown source and misappropriation of resident property and the results of all investigations are thoroughly investigated and reported to the proper authorities within required time frames.2. All alleged violations, whether oral or in writing, must be immediately reported to the administrator of this facility and to other official in accordance with State law through established procedures (including to the state survey and certification agency. Definitions: alleged violations is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source.injuries of unknown source- an injury should be classified when both of the following criteria are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury.		