STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675424	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Athens	121 Commons Drive Athens, TX 75751

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record, review the facility failed to provide care in a manner that ensured the residents dignity for 3 of 4 residents reviewed for dignity (Resident # 3, #4, and #5.) 1. The facility failed to provide Resident #3 with briefs that fit. 2. Resident #5 said she was anxious, and was afraid she would embarrass herself due to not having briefs that would fit.3. Resident #4 said she had briefs but that caused her discomfort because they were the wrong size.4. Residents and staff voiced concerns about not having briefs over the weekend on 8/9/25 and 8/10/25. These facility failure to provide residents with briefs that fit could place residents at risk at risk of anxiety, embarrassment and discomfort.Findings included: During an interview on 8/11/25 at 3:10 p.m. the Administrator said they had a shortage on briefs and wipes over this past weekend. He said they had ordered some last Tuesday, 8/5/25, and the order was supposed to arrive today 8/11/25. The Administrator said their census was 104 and they had about 10 or more residents that used bariatric briefs. He said they had bought some at the local store and had a limited amount available at the current time. During a telephone interview on 8/11/25 at 12:06 p.m., an unidentified staff revealed Resident #3's POA called the police because he had to lay in urine all day. The staff member said the facility did not have any bariatric briefs to fit Resident #3 or large residents during the weekend. The staff member said staff went to a neighboring facility to borrow a few briefs, but residents had to go without care, and the facility was also out of wipes. During an interview on 8/11/25 at 4:20 p.m., the HR Director said she had been appointed to order supplies after the former Administrator had left a few weeks ago. She said the problem was that staff waited until they were out of things before, they let her know. She said she did not work the floor, so she did not know what was needed until someone told her. She said they had put in an order on 8/5/25 and it was supposed to be delivered today but it did not look like it will be. However, they were out of some supplies or at least she had been informed they were out of briefs and wipes. During an observation and interview on 8/11/15 at 4:45 p.m. with CNA B revealed she was just placed over generating the orders for supplies. She said they did not have large, extra-large briefs, or bariatric briefs. She said they had issues over the weekend due to staff not having briefs that fit the residents. She said the Administrator had bought some wipes and a couple of bags of bariatric briefs that morning. CNA B said they had an overstock of medium briefs, so the smaller residents were fine. However, most of their residents wore, large and extra-large briefs. She said they had 10 or more that wore the bariatric briefs. Observation of the main supply room with CNA B revealed one package of 12 bariatric briefs, plenty of small briefs, and multiple packs of medium. However, there were no large or extra-large briefs. There was one package of bariatric briefs on the shelf. CNA B said the Administrator had purchased this morning. Observation throughout the facility revealed they had about 3 packs of large briefs. Some of the aides had hidden them away in the linen closets. They had less than 10 bariatric briefs on the hallway. Record review of Resident #3's quarterly MDS dated [DATE] indicated he was cognitively stable with a BIMS of 14. During an interview on 8/13/25 at 10:40 a.m., the DON said they were running low on briefs and wipes, but the staff had enough supplies to make do. She said they could put briefs together if needed. The DON stated the family of Resident #3 called the police and said he was laying in urine all day. The police came and she was told they found no issues. She also said they had the police incident written down; a copy was requested. There was no police report provided. During an interview on 8/13/25 at 1:40 p.m., Resident #3 said he was very upset this weekend at the way he was treated. He said the facility did not have briefs to fit him and he had to lay in urine most of the day. He said they did not have briefs from 7:30 p.m. Saturday night until about 2:30 p.m. Sunday 8/10/25. He said he was mad because he was told he could not get out of bed. He said he had called his family member and told them about the situation. He said the police came and the RN Weekend Supervisor came in and lied to the police in front of his face about having briefs. He said they brought a pack of brief in at that time with two briefs in it. He said he felt it was a stupid situation to have to lay in urine all that time because the facility did not have what they needed. He said he was told they had smaller briefs, but none that would fit him. He said it make him feel very low, like what he needed did not matter. He said they had some good aids, and they tried but had nothing to work with. During an interview on 8/13/25 at 1:54 p.m., the RN Weekend Supervisor said she was made aware the facility was out of bariatric briefs on Sunday morning, 8/10/25. She said she called the sister facility, and they loaned them one package of bariatric briefs about 10 in the pack. She said on Sunday afternoon, the police came after Resident #3's family member called them to report. Resident #3

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the physician when a need to alter treatment significantly due to adverse consequences for 2 of 5 residents reviewed for resident rights. (Resident #1 and Resident #2) The facility failed to notify or consult with Residents #1 and #2's physician for the following: Resident #1 was readmitted to the facility on [DATE] with surgical incisionto the left groin, right groin, and left knee. He did not have treatment orders for these wounds.On 8/10/25 Resident #1's groin area was noted to have signs of infection. Resident #1 went to the hospital on 8/11/25 with a diagnosis of groin infection. Resident #2 was readmitted to the facility on [DATE] at 10:00 p.m. with a stage 4 to her sacrum. She did not have orders to treat the wound as of 6:00 p.m. on 8/13/25. An Immediate Jeopardy (IJ) situation was identified on 8/14/25 at 1:00 p.m. While the IJ was removed on 8/15/25 at 3:22 p. m., the facility remained out of compliance at a potential for not actual harm with a potential for more than minimal harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk for pain and suffering. Findings included: Record review of Resident #1's face sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He had a readmission date of 8/5/25. He had diagnoses of peripheral vascular disease (PVD) (a condition where the arteries and veins in the arms, legs, and feet become narrowed or blocked reducing blood flow.) and a history of stroke. Record review of Resident #1's admission MDS assessment dated [DATE] indicated his cognition was intact with a BIMS score of 13. The MDS indicated he used a walker and a wheelchair, but required supervision or touching assistance with most ADLs. Record review of Resident #1's care plan dated 6/2/25 indicated he was incontinent of bowel and bladder. Some of the interventions were to assist to toilet as needed, provide weekly skin checks to monitor for redness, circulatory problems, breakdown or skin concerns, and report any new skin conditions to the physician. Record review of Resident #1's computerized physician orders dated 8/11/25 indicated no orders for treatment to his groin incisions were listed. Record review of Resident #1's After Visit Summary dated 8/4/25 provided instructions to call the provider if redness, tenderness or signs of infection (pain, swelling, redness, odor or green/yellow discharge around incision site, and for severe uncontrolled pain. Record review of Resident #1's Admit/Readmit Evaluation dated 8/5/25 at 1:32 a.m. indicated he had surgical incision wounds on the left groin, right groin, and left front knee. There were no other descriptions. Record review of Resident #1's Admit/Readmit note dated 8/5/25 at 1:32 a.m. indicated he was admitted from the hospital with a diagnosis of deep vein thrombosis, and PVD. He needed limited assistance with transfers, self-performance. He was continent of urine and bowels and needed limited assistance with toileting, self-performance. He had pitting edema to both lower extremities. He complained of pain and was given pain medications. (no mention of surgical wounds) Record review of Resident #1's nursing notes dated 8/5/25 indicated he had a telehealth visit. The resident was readmitted last night with bilateral groin stent placement for PVD. He reported difficult urinating and severe incisional pain. He was requesting to be sent back to the ER and was transferred at 6:12 a.m. to the hospital. At 8:00 a.m. the resident returned from the hospital and was given pain medications. Record review of Resident #1's nursing notes dated 8/7/25 at 1:14 p.m. indicated Resident has open wounds; vascular and surgical. The resident received wound care with no changes in skin condition noted, and there were no signs and symptoms of infection. Record review of Resident #1's Skilled Observation note dated 8/10/25 at 9:37 p.m. indicated no infection was present the wound had redness and inflammation. The skin was warm and dry. The surgical incision was open with wound care and notable changes in skin condition. The observation described the incision with staples on the left side of the groin to have a foul-smelling drainage. The area was red and inflamed, it was cleansed with wound cleanser and was tender to touch. The groin on the right side had no visible signs and symptoms of infection. The note indicated would report to the oncoming charge nurse. Written by LVN E (there was no indication the physician was notified. Record review of Resident #1's nursing notes dated 8/11/25 at 5:50 p.m. the resident was sent to the hospital due to altered mental status. No other information was documented. Record review of Resident #1's hospital records dated 8/11/25 revealed the resident was admitted due to generalized weakness. He had bilateral groin incisions with staples that were irritated, with redness to the left and right groin and a foul smell. It appeared yeasty in nature. He stated his groin infections hurt and itched. His diagnosis was surgical incision infection. He was prescribed Cephalexin 500 mg two times a day for 7 days and Nystatin cream apply to groin area two times

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 of 5 residents reviewed for resident rights. (Resident #1 and Resident #2) The facility failed to notify or consult with Residents #1 and #2's physician for the following: Resident #1 was readmitted to the facility on [DATE] with surgical incisionto the left groin, right groin, and left knee. He did not have treatment orders for these wounds. On 8/10/25 Resident #1's groin area was noted to have signs of infection. Resident #2 was readmitted to the facility on [DATE] at 10:00 p.m. with a stage 4 to her sacrum. She did not have orders to treat the wound as of 6:00 p.m. on 8/13/25. An Immediate Jeopardy (IJ) situation was identified on 8/14/25 at 1:00 p.m. While the IJ was removed on 8/15/25 at 3:22 p.m., the facility remained out of compliance at a potential for not actual harm with a potential for more than minimal harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk for pain and suffering.Findings included: Record review of Resident #1's face sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He had a readmission date of 8/5/25. He had diagnoses of peripheral vascular disease (PVD) (a condition where the arteries and veins in the arms, legs, and feet become narrowed or blocked reducing blood flow.) and a history of stroke. Record review of Resident #1's admission MDS assessment dated [DATE] indicated his cognition was intact with a BIMS score of 13. 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