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	11/18/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to review and revise resident care plans based on changing goals, preferences, and in response to current interventions for 1 of 6 residents reviewed for care plans (Resident #1). The facility failed to ensure Resident #1's care plan was revised and updated to address safety, mental health, and nursing needs related to a history of exploitation and changes in discharge planning. This failure could place residents at risk for not having their safety, mental health, and goal setting needs addressed and communicated to the appropriate staff. Findings included:A record review of Resident #1's face sheet dated 11/17/2025 indicated Resident #1 was an [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included dementia, cognitive deficit, diabetes, and COPD (a condition which causes difficulty in breathing), and weakness. Resident #1's face sheet indicated Resident #1 was not to leave the facility with anyone except his family member #1 who had medical and financial power of attorney. A record review of a quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 11 indicating his cognition was moderately impaired. He was ambulatory for short distances, continent of bowel and bladder, and able to voice needs. A review of Resident #1's care plan dated 11/17/2025 indicated there was no identification or mention of any concerns for Resident #1's history of exploitation nor potential for elopement. There were no interventions to reduce the risk of future exploitation nor instructions regarding visitor restrictions. There were no interventions to address concerns of elopement. Resident #1's mental status and feelings regarding not being able to call anyone or leave the facility were not addressed in the care plan. The care plan included a discharge plan with an initiation date of 11/27/2024 and revised on 12/05/2024 with a goal for Resident #1 to return to the community/home. The care plan had not been revised or updated to reflect Resident #1's long term plan for permanent residency at the facility. A review of the progress notes dated 01/05/2025 indicated a family member called the facility to let them know Resident #1 was wanting to leave the facility and the unnamed caller was afraid Resident #1 would either elope or call someone to come get him. A review of progress notes dated 01/06/2025 indicated Female A came to the facility and said she was going to take Resident #1 to his home and to the bank. Further review of the notes indicated family member #1 was notified of Female A's attempt to leave with Resident #1 with family member #1 giving instructions to not allow it to happen. The progress notes reflected Female A, and boyfriend left the facility. A review of Resident #1's MDS history indicated MDS assessments were completed as follows: 2 comprehensive MDS assessments were completed on 11/28/2024 and 09/01/2025 and 4 quarterly MDS assessments were completed on 02/28/2025, 04/07/2025, 07/08/2025, and 11/05/2025. No updates or revisions to the discharge planning section of the care plan were noted following these MDS assessments. Resident #1's care plan was not updated or revised to reflect his history of exploitation nor interventions to reduce further occurrence after the MDS assessments. During an observation and interview on 11/17/2025 at 09:45 AM, Resident #1 said one of his two family members lived close by and visited him about once week and brought him snacks. He said he could not call anybody because his family member took his phone away from him and he wasn't allowed to leave the facility. He said he had some money, but his family member would not tell him how much he had left. He said he had a woman that came in and helped him when he lived in his house, but he didn't know where she was. He said, I just have to sit here. Resident #1 did not look at this surveyor while talking. He kept his face downcast toward his hands and lap and spread his hands apart in front of him when he ended that part of the conversation by saying there was nothing he could do about his circumstances. Resident #1 said the BOM knew about it. During a phone interview on 11/17/2025 at 09:40 AM, Resident #1's family member who lived close by said Resident #1 was admitted to the facility after being hospitalized for a fall. He said that prior to Resident #1 admitting to the facility, Resident #1 had allowed Female A to move in with him after his mother passed away. The family member said Female A exploited Resident #1 by taking him to the bank multiple times where Resident #1 wrote checks and withdrew money. He said the bank called him one time and told him Resident #1 and Female A were at the bank, and Resident #1 had withdrawn $9,999.00 after they asked the bank how much money he could write a check for without it being reported. The family member said multiple items were missing from Resident #1's farm including trailers, lawn [NAME], and other equipment. The family member said Female A had used his Resident #1's information to obtain credit cards and had tried to purchase a car about 6 months ago using Resident #1's information. He said he tried to make Resident #1 understand that

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 6 residents (Resident #2) reviewed for pharmacy services. The facility failed to ensure Medication Aides used available resources to administer 3 missed doses of eye drops to Resident #2 as ordered by the physician. This failure could place residents at risk of not receiving medications as ordered. Findings included: A record review of Resident #2's face sheet indicated she was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dry eye syndrome, anxiety, dementia, and quadriplegia C5-C7 (paralysis of all four limbs). A record review of the quarterly MDS assessment dated [DATE] indicated Resident #2 had a BIMS score of 14 which indicated her cognition was intact. Further review of the MDS indicated she was dependent on staff for most activities of daily living and was able to voice needs and concerns. A record review of the physician orders dated 11/18/2025 indicated Resident #2 had an order to receive 0.5% Carboxymethylcellulose Ophthalmic Solution 1 applicator in both eyes at bedtime for dry eyes. Record review of Resident #2's MAR dated 11/18/2025 indicated Resident #2 was to receive 0.5% Carboxymethylcellulose Ophthalmic Solution (eye drops) at 09:00 PM every night. The doses scheduled for 09:00 PM on 11/12/2025, 11/13/2025, and 11/17/2025 were documented as not being administered. Record review of Risk Management reports indicated there were no Medication Error Reports for the 3 missed doses of Carboxymethylcellulose Ophthalmic Solution. Record review of the progress notes did not reflect any reason for the eye drops not being administered on 11/12/25, 11/13/25, and 11/17/25. During observation and interview on 11/18/2025 at 09:40 AM, Resident #2 said she had not received her eye drops for the last 6 days. She said the medication aides kept telling her they didn't have any eye drops available to give her. Resident #2 said her eyes would get irritated and burn a little if she went too long without the eye drops. She said her eyes were ok then but did not want them to become irritated. During an interview on 11/18/2025 at 09:50 AM, MA F said the eye drops were an over-the-counter medication and come in a box with multiple individual ampules. She pointed to an area in a drawer of the medication cart and said that was where they would be but there were none there. MA F continued to look throughout the cart and located 4 single plastic ampules of the Carboxymethylcellulose Ophthalmic Solution in a basket in the small, top drawer. MA F said if she did not have an over-the-counter medication, she would look in the medication room first and if none were there, she would talk to the other medication aides to see if they had any in their carts. If they had none, she would tell the nurse or ADON. She said the ADON would run to one of the stores and get over the over-the-counter medications. During an interview on 11/18/2025 at 11:55 AM, MA G said he worked the evening of 11/17/2025. He said he did not administer the ordered eye drops to Resident #2 because he did not have any in his cart. He said Resident #2 told him she had not received her eye drops in 3 or 4 days. He said he notified the nurse after he checked the medication room and did not find any there. MA G said he only worked as needed and did not know the name of the nurse he spoke to about the missing eye drops. MA G said he had been a medication aide about 6 months. He said he forgot to document the reason for not administering the eye drops. On 11/18/2025 at 12:30 PM, an attempt to interview the medication aide who worked on the evenings of 11/12/20225 and 11/13/2025 by phone was unsuccessful. A message was received that the telephone number was no longer a working number. During an interview on 11/18/2025 at 12:05 PM, LVN H said she worked the evening of 11/17/2025. She said she was not made aware that Resident #2 did not have any eye drops for administration. During an interview on 11/18/2025 at 12:20 PM, the DON said the medication aides were supposed to tell the charge nurse, ADON, or her when they did not have prescribed medication available for administration. She said the Carboxymethylcellulose eye solution had been ordered last week, and the facility was awaiting delivery. She said there was an ample supply of the eye drops on the other medication carts and there was enough for all residents who had orders for the eye drops for several days. The DON said the 11/12/2025, 11/13/2025, and 11/17/2025 doses of Carboxymethylcellulose eye drops solution were documented as not being given. She said the reason for not administering a medication was supposed to be documented but she said she did not see where that was documented for the 3 missed doses of Resident #2's eye drops. She said someone would go out and purchase more if needed before the order was delivered. A review of the facility's policy dated 01/09/2024 and revised 04/06/2023 and titled Medication-Treatment Administration and Documentation included the