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	02/13/2026

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 0600 Level of Harm - Actual harm 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 residents the right to be free from abuse and/or neglect for 4 (Resident #1, Resident #2, Resident #3, and Resident #4) of 12 residents reviewed for abuse and/or neglect. 1. The facility failed to ensure Resident #1, Resident #3, and Resident #4 were provided with a call light to call for assistance when their call light was thrown on the floor and provided an extra one dummy that was not plugged into the call light system. 2. The facility failed to ensure Resident #2 was free from verbal abuse when CNA A told him Shut the [F-word] up and mind your business. These failures could place residents at risk of emotional harm. Findings included: 1. Record review of Resident #1's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cervical disc disorder with myelopathy (a serious, progressive condition where degenerated discs and bone spurs compress the spinal cord in the neck), Parkinson's disease (a progressive neurodegenerative disorder caused by the loss of dopamine-producing brain cells, leading to movement-related symptoms), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cervical spinal cord injury (involves damage to the vertebrae or nerves in the neck), neurogenic bowel (the loss of normal bowel function due to nerve damage), and neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Record review of Resident #1's quarterly MDS assessment, dated 12/12/25, reflected he had a BIMS score of 03, which indicated severe cognitive impairment. He was able to make himself understood, and he was able to understand others. He had a functional limitation in range of motion for all four extremities. He required supervision or touching assistance with eating and oral hygiene. He required substantial assistance with toileting, bathing, upper body dressing, personal hygiene, and roll left and right, and sit to lying bed mobility. He was dependent on staff for lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfers, and tub/shower transfers. He required moderate assistance with wheelchair ambulation. He was always incontinent of both bowel and bladder. Record review of Resident #1's care plan, included a focus of falls, last revised on 05/21/24. The focus reflected Resident had the potential for falls related to unspecified injury at unspecified level of cervical spinal cord. Interventions included, place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker concerns that another CNA, [CNA B], has been switching out [Resident #1's] call light cord/button with a dummy one that does not work. The concern is that this is happening during evening/weekend shifts when [CNA B] is working.Facility follow up was assigned to the Administrator/DON. A meeting was not held. Specific actions taken to resolve the grievance was maintenance assessed call lights. Results of action taken was Lights working - no (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 0600 Level of Harm - Actual harm Residents Affected - Few	dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/05/26. Record review of Resident #3's face sheet, dated 02/12/26, reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), wedge compression fracture of 4th thoracic vertebra (occurs when the front part of this upper-back bone collapses), and dysphagia (difficulty swallowing). Record review of Resident #3's quarterly MDS assessment, dated 12/26/25, reflected that she had a BIMS score of 14, which indicated intact cognition. She was able to make herself understood, and she was able to understand others. She required supervision or touching assistance with toileting hygiene, and sit to lying, sit to stand, chair/bed-to-chair transfer, toilet transfers, and tub/shower transfer. She required setup or clean-up assistance with oral hygiene, upper body dressing, and roll left and right. She required moderate assistance with bathing and putting on/taking off footwear. She was frequently incontinent of bowel and bladder. Record review of Resident #3's care plan reflected a focus of Falls, last revised on 03/02/23. The focus further reflected Resident had the potential for falls related to poor safety awareness, bowel and bladder incontinence, weakness, debility, and varying cognition. The focus identified 3 fall incidents. Interventions included patient educated on use of call light and assist from staff to assist with mobility tasks and place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker a concern that another CNA, [CNA B], had given [Resident #3] a dummy call light cord/button that does not work, the weekend of January 31st and February 1st.Facility follow-up was assigned to the Administrator / DON. A meeting was not held. Specific action taken to resolve the grievance was Maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/05/26. Record review of Resident #4's face sheet, dated 02/12/26, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included displaced fracture of right femur (a serious injury where the thighbone is broken and the pieces are misaligned), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and repeated falls. Record review of Resident #4's quarterly MDS assessment, dated 01/02/26, reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. She was able to make herself understood, and she was able to understand others. She required substantial assistance with toileting, bathing, lower body dressing, and sit to lying, lying to sitting, chair/bed-to-chair transfers, toilet transfer, and tub/shower transfer. She required moderate assistance with upper body dressing, personal hygiene, roll left and right, and sit to stand. She was always incontinent of both bowel and bladder. Record review of Resident #4's care plan reflected a focus of Resident will call out loudly instead of using call light, last revised 01/28/26. Interventions included Redirect resident to utilize call light for assistance. The care plan further reflected a focus of Falls, last revised on 11/10/25. This focus included Resident had the potential for falls related to history of falls. Interventions included Place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Worker, and initiated by CNA E stated: CNA reported to Social Worker concern that another CNA, [CNA B], has possibly been switching out [Resident #4's] call light cord/button with a dummy one that does not work. It is believed this is happening during evening/weekend shifts when [CNA B] is working.Facility follow-up was assigned to the Administrator / DON. A meeting was not held. Specific action taken to resolve the grievance was Maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/06/26. Record review of an untitled document, dated 02/05/26 and provided by the Administrator on 02/12/26 at 11:36AM reflected: Date 02.05.2026Re: Dummy Call LightsOn 02.02.2026 around 4:30 pm, Administrator received Grievances from Social Worker regarding employees using a Fake Call Light.I asked staff about Dummy Call Lights, and they stated they had heard about it, but they were not sure if it [was] true or who was doing it.On 02.03.2026, Administrator asked Maintenance Director to assess all the call lights in the building, which he did. He found all Lights in working order and functioning properly.I interviewed [Resident #4] and she says it happens sometimes in the evening that her call light isn't answered timely. She wasn't too clear on the exact dates. She did not see two call lights in her room, but says it takes a long time for anyone to answer the lights.I interviewed [Resident #1], and he said it takes a long time to get his call light answered. He did not give the Administrator a name, but his roommate, [Resident #2] stated that it was [CNA A] who was unplugging the call Lights. I asked [Resident #2] if he had seen two call lights and he answered No but [The HR Director] told him a few weeks ago that she saw two Call Lights in [Resident #1's] room.Administrator later returned to [Resident #1's] room and found his Call Light tangled in the wheels of his wheelchair and the Call Light was pulled out of the wall. Administrator asked for help from ADON and she assisted the Resident and placed his Call Light back into his wall.I interviewed both [CNA B] and [CNA A] together on 02.04.2026. Both denied unplugging call lights, but [CNA B] stated that she heard it was [CNA A].CNA B does not work on [Resident #1's hall], but [CNA A] does. Record review of an undated statement signed by the HR Director reflected: I don't remember the exact day, but it was the end of December. I pushed [Resident #1] into his room after breakfast and found a call light on the floor, not plugged in. I looked over at the call light plug on the wall and saw another call light plugged in. I handed him the call light that was plugged in and took the other one to the ADON office as I assumed it was broken. Record review of an email, dated 02/04/26 at 09:28PM, sent by LVN F to the Administrator, reflected: On February 2, 2026, at around 0700 my [Resident #3's hall] aide approached me with a call light issue that had happened the night before. A resident by the name of [Resident #3] stated the night aide [CNA B] had put her call light out of reach and put another light in her room that wasn't plugged in as a dummy light. The day shift aide mentioned two other residents she had done the same thing [to]. This incident was reported to the social worker who then wrote grievances on the aide. Record review of an Associate Disciplinary Memorandum, dated 02/12/26, reflected that CNA B was suspended pending an investigation on 02/12/26 related to .Staff member was involved in an incident where it was alleged that she was changing out [resident] call lights with ones that didn't work. 2. Record review of Resident #2's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included respiratory failure (Respiratory failure is a condition where there's not enough oxygen or too much carbon dioxide in your body), sleep apnea (a common, serious disorder where breathing repeatedly stops and starts during sleep, causing low blood oxygen and poor sleep quality), and type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood). Record review of Resident #2's quarterly MDS (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	assessment, dated 01/09/26, reflected he had a BIMS score of 15, which indicated intact cognition. He was able to make himself understood and he was able to understand others. Record review of a Provider Investigation Report, dated 02/11/26, reflected in the investigation summary section: On 02.04.2026, [Resident #2] reported he asked [CNA A] to get [Resident #1], and she said she would in a few minutes. The Resident stated he said No, get him up now! According to [Resident #2] she still refused to follow his instructions. He began using profanity towards [CNA A]. The CNA replied, You need to mind your business. He yelled, [F-word] you! The CNA responded to [Resident #2], You need to shut the [F-word] up and mind your business![CNA A] denied making that statement.The Resident stated he was offended when he heard [CNA A] curse.[LVN G] stated she overheard [Resident #2] yelling and using profanity, but did not hear [CNA A] yell or curse at Resident. Record review of Resident #5's face sheet, dated 02/12/26, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a term for lung and airway diseases that restrict your breathing), aphasia (an impairment in a person's ability to comprehend or formulate language), and dysphagia (difficulty swallowing). Record review of Resident #5's quarterly MDS assessment, dated 11/11/25, reflected she had a BIMS score of 14, which indicated intact cognition. She was usually able to make herself understood, and she was able to understand others. Record review of an Associate Disciplinary Memorandum, dated 02/04/26, reflected that CNA A was suspended pending an investigation on 02/04/26, related to .CNA was named as the employee that spoke [with] resident using foul language towards them . and .Staff member allegedly told a resident to shut up. Record review of timesheets for CNA A and CNA B, dated 02/02/26 through 02/12/26, reflected:CNA A worked on 02/04/26 from 07:26 AM through 05:20PM for a total of 9.25 clocked hours.CNA B worked 02/01/26-02/02/26 from 05:55PM through 06:01AM for a total of 11.5 clocked hours.CNA B worked on 02/05/26-02/06/26 from 05:45PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/07/26-02/08/26 from 05:47PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/08/26-02/09/26 from 03:31PM through 06:01AM for a total of 13.5 clocked hours.CNA B worked on 02/09/26-02/10/26 from 05:40PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/10/26-02/11/26 from 05:53PM through 06:03AM for a total of 11.5 clocked hours. Record review of Nurse/CNA schedules for February 2nd through the 11th reflected:*On 02/04/26, CNA A was assigned to Resident #1, Resident #2, and Resident #4's hall.*On 02/05/26, CNA B was assigned to Resident #3's hall.*On 02/09/26, CNA B was assigned to Resident #3's hall.*On February 10th, 2026, CNA B was assigned to Resident #3's hall. During an interview on 02/11/26 at 12:09PM, Family Member H said she was a family member of Resident #1. She said she had major complaints about the administration in the facility. She said when she was reporting the call light issue to the Administrator, she would not help her unless she told the Administrator what residents had talked to her. She said she heard that CNA A and CNA B take the resident's call light away and then provide a call light that is not plugged into the wall. She said sometimes, he did not have water when some aides took care of him. She said she had came up to the facility and there have been many times Resident #1's sheets were saturated. She said Resident #1 had an old spinal cord injury and is not aware when he is in pain. She said Resident #1 fell a few years ago and had to have a lifesaving surgery on his C1-T2 vertebrae. He did not have any bowel/bladder control. She said his pain receptors did not work due to this surgery. She said on February 3rd she came up to the facility to report the call light problem to the DON. She said she received a voicemail from the DON on 04/04/25 at 09:24 am and the DON told her that CNA A and CNA B had been suspended. She said she came to visit Resident #1 on 04/04/25 at 4:00PM and CNA A was in the facility working and taking care of Resident #1. She said the DON had a different story then. She said she then spoke (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	with the Administrator and she would not help her. She said she saw CNA A in the facility and confronted her. She said at 04:38PM, the DON came to her and apologized to her for the situation. She said the DON did not know who CNA A was. She said she took videos of these interactions and would provide them to this surveyor. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/03/26 at 02:10PM, this surveyor observed the following:*Family Member H can be heard talking to the DON and asking about her day.*Family Member H identifies herself to the DON as a family member of Resident #1.*Family Member H notifies the DON about someone removing Resident #1's call light and providing one that is not plugged in to him.*Family Member H said she heard that a man from Maintenance had came into Resident #1's room and checked his call light and had further indicated to her that he also was going to check Resident #4's room.*Family Member H identified CNA B and CNA A as the two aides she heard that may have removed Resident #1's call light and provided him with an unplugged call light.*Family Member H said she heard this from several different people.*The DON said she heard about the call lights this morning in a meeting this morning, but I was not told of the specific rooms. During an observation of a voicemail recording provided to this surveyor by Family Member H, dated 02/04/26 09:24AM, this surveyor observed the following:*The DON identified herself by name and said this call was for Family Member H. She further identified the facility name she was calling from.*The DON identified she was calling about the call light situation.*The DON said CNA B was off the schedule.*The DON said she was suspending CNA A off the schedule until further notice, as of today [02/04/26]. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:07PM, this surveyor observed the following:*Family Member H can be heard initiating a conversation with the DON who is in view on the video.*Family Member H asked the DON is [CNA A] still here?*The DON said, one of them was here earlier.*Family Member H said, well you told me [CNA A] was suspended earlier.*Family Member H said, was she here earlier?*DON said, she may have been here a little bit.*Family Member H and the DON argue about the situation and then the DON walked away from Family Member H. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 4:12PM, this surveyor observed the following:*Family Member H asked the Administrator how she was doing and the Administrator replied fine.*The Administrator can be heard identifying Family Member H as Resident #1's family member and asking her tell me what's going on.*Family Member H can be heard So you don't know about the call light situation?*The Administrator said, I am asking you, I want to hear from your mouth. I am hearing different stories.* Family Member H said, Well obviously this has been a thing going on.*The Administrator said, Have you seen it?*Family Member H said No, but I have been told by several people.*The Administrator said But have you seen it, because.*Family Member H interrupted the Administrator and said, So you're trying to say it didn't happen?*The Administrator said, I'll listen to you.*Family Member H said I know for a fact that the call light has been, I heard from multiple people who have witnessed it. Okay? She has unplugged the call light. [CNA B] started it, and [CNA A] has continued it. I know she got moved off that hall and she has been doing it to more than [Resident #1]. I know these things. *The Administrator said but my question is.*Family member H interrupted the Administrator and said No, I have not seen it, and I am not going to tell you who told me either, so don't ask me please.*The Administrator said, If you can't tell me where you got the information from, how am I going to help solve this?*The Administrator said, I need to know where this information is coming from.*The Administrator said, when you unplug the cord, it sends an alarm.*Family Member H said, They don't unplug it, they put it in the floor and give them a fake one.*The Administrator said, We don't have a fake one.*Family Member H said, Yeah you do, in the other rooms.*The Administrator said So show (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	me.*Family Member H said Show you? You think I know where to find stuff in this place?. Family Member H then stood up and left the Administrator's office. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:15PM, this surveyor observed the following:*The Administrator entered the room and asked Family Member H, so show me what you are talking about.*Family Member H said I'm talking about this call light.It is on the floor, and they are giving him one in his hand.*Family Member H explained to the Administrator about the voicemail she received from the DON explaining CNA A and CNA B were suspended. She told the Administrator that CNA A was present in the facility this day and at this time. She said CNA A was assigned to Resident #1. So, what I want to know is why somebody who took a call light from someone is still here right now and still with [Resident #1]. *The Administrator said, I'll have to find that out for you, because I didn't know that. The Administrator then identified herself as the Administrator after being asked by Family Member H. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:19PM, this surveyor observed the following:*The Administrator can be seen speaking. She said she discussed the call lights with her supervisor, the regional. we wrote a grievance about it. We are trying to figure it out. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:23PM, this surveyor observed the following:Family Member H can be heard approaching and speaking with a female staff member. The staff member denied giving anyone a fake call light. She identified herself as CNA A. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:38PM, this surveyor observed the following:The DON can be seen on the video speaking. She said, I gave my resignation to the director because of that. We did not know specific rooms. I did not realize that girl was [CNA A]. I dropped the ball. We dropped the ball. I had every intention of going to the Administrator, pulling her in there, and getting this resolved this morning when I left you that message. And then other drama unfolded The DON then acknowledged that Family Member H reported the call light issue to her on 02/03/26 and they were made aware of the issue the morning of 02/03/26. The DON said she reported this to the Administrator on 02/03/26. I gave them my resignation; I did not want them to pin me with patient abandonment. During an observation on 02/12/26 at 12:53PM, this surveyor observed an extra call light in a drawer at the central nurse's station. During an interview on 02/11/26 at 02:56PM, Resident #2 said that he was Resident #1's roommate. He said CNA A moved Resident #1's call light out of his reach. He said he goes over to Resident #1 when this happens and gives him the light back. He said that had been ongoing for at least a month or so. He said he had reported this to the ADON, the Administrator, and the HR Director. He said the Administrator spoke with him about the call light on 02/05/26. He said the Administrator told him they were going to investigate it. He said the Administrator asked him who told him about the call light. He said he reported to her that CNA A was plugging a fake call light into the wall on his roommate's side. He said on 02/05/26, he was told CNA A was suspended. During an interview on 02/12/26 at 08:47AM, the HR Director said her office was on Resident #1's hall. She said back in December, she went into Resident #1's room and noticed his light was on the floor. She said there were two call lights on his side of the room. She said the one that was plugged in, was draped over between his bed and bedside table. She said the other call light on his side of the room was not plugged in and was coiled up on the floor. She said she did not notify the Administrator about this. She said she assumed that it was not working, and they forgot to take the old one out when they changed it. She said she took it to the ADON. She said she did not know at the time of the allegations of a fake call light being used. She said this was towards the end of December. During an interview on 02/12/26 at 9:25AM, the Administrator said she did (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	not suspend CNA B related to the call light incident. She said she spoke with Resident #2, and he said CNA A did it to Resident #1. During an interview on 02/12/26 at 9:56AM, Resident #2 said Resident #1 got upset when he was not able to use his call light. He said Resident #1 hollers and screams when he does not have his call light. He said he tries to help Resident #1 when he can and he gives him the call light back. He said Resident #1 uses his call light a lot. During an interview on 02/12/26 at 10:17AM, CNA D said she usually took care of Resident #1. She said she had worked at this facility for about 7 months. She said a while back, she found an extra call light on the floor in Resident #1's room. She said his regular call light was plugged into the wall and draped over his bedside drawers. She said the other call light was not plugged in and it was in his hand. She said this was about 2-3 months ago. She said when she found this, she went to the DON at the time. She said she grabbed the extra call light and tried to turn it into the Maintenance Director, but he was already gone for the day. She said she gave the light to the HR Director. She said she only saw this happen one time. She said she has not seen this happen to any other residents, only Resident #1. She said she did not know who it may have been. She said the schedule changes a lot. She said Resident #1 hits his call light a lot. She said he hollers out when he does not have it or when the staff do not answer. She said she felt like the person that did this, did it because Resident #1 calls a bunch and they did not want to let him call. She said she felt like the resident may feel secluded or neglected when this happens. She said the resident is forgetful and may not remember this happening. During an interview on 02/12/26 at 11:00AM, the Administrator said CNA A was suspended on 02/04/26 at 5:20PM. She said she was aware of the call light issue at that point. She said she was aware of a complaint of dummy call lights in the facility. She said she had the Maintenance Director go check all the call lights. She said CNA A was named as a potentially involved staff. She said Resident #2 told her a dummy call light was being used. She said she did not suspend CNA B because she was not on the schedule that day. She said she learned about the call light issue on the 2nd or 3rd of February. She said then she heard it could have been [CNA B] or [CNA A]. She said she was told CNA A's name on the 2nd or 3rd of February. She said she talked to CNA B on the 4th of February. She said CNA A worked on the 4th of February. She said the DON told the family of Resident #1 that they were going to suspend CNA A on the 4th. They did not suspend her until 5:20PM on the 4th of February, for the incident regarding alleged verbal abuse of Resident #2. She said she also was told CNA B may be involved on the 2nd or 3rd of February. During an interview on 02/12/26 at 11:20AM, the DON said she was aware of the call light allegation. She said she was made aware of this during a clinical meeting on the 3rd of February. She said she was told someone was doing this with the light. She said they had the Maintenance Director go and check all the call lights. She said she was told the names of CNA A and CNA B on the evening of the 3rd of February. She said the Family Member of Resident #1 notified her of this issue and the names of the two CNAs and which rooms she heard of this. She said she did not suspend CNA A or CNA B. She said they should have been suspended at this point. She said this could be considered neglect or seclusion, especially because Resident #1's means of communication was taken away. She said Resident #1 depended on staff for his needs and ADLs. She said she told the Administrator on the 3rd of February of the allegations with the call light and the two identified staff. She said the Administrator should have suspended CNA A and CNA B when she learned of the allegation. She said she did not know if any of this was reported to HHSC. She said an allegation of neglect or seclusion should have been reported to the state. She said CNA A worked on Resident #1's hall on the 4th of February. She said there was a risk that CNA A could have replaced or moved Resident #1's call light while she was working on the 4th of February. She said she did not feel like the (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Administrator did a thorough investigation. She said she should have done the investigation as soon as she knew about it on the 3rd, not the 4th. She said she was not sure if CNA B was suspended. She said she was not sure when CNA A was suspended. She said she has not seen this issue personally with her eyes. She said no other resident complained about this, other than Resident #1 and his family. She said in the time she had been in the facility, she was not aware of any issues between Resident #1 and CNA B or CNA A. She said these failures put the residents at risk for further neglect, seclusion, and mistreatment. During an interview on 02/12/26 at 11:35AM, the Administrator said she received a grievance of an issue of fake call lights on the 2nd of February. She said she heard CNA B's name on the 2nd. She heard CNA A's name on the 3rd. She said the complaint was that a fake call light or extra call light was being used. She said her understanding was that the resident would have a call light and it would not work. She said her understanding was that the light was pulled from the wall. She said she thought it was impossible because if it was unplugged it would alarm. She said the next day on the 3rd she was told, no they use two call lights. She said she was told that an extra call light was being used and given to the resident. She said this could be considered an allegation of neglect or seclusion. She said the two identified aides should have been suspended immediately. She said they were not suspended on the 3rd of February. She said CNA B was not on the schedule around the time this was going on. She said CNA B came back around 2-3 days after this. She said CNA A was allowed to work on the 4th of February. She said CNA A was suspended later in the evening on the 4th related to a verbal abuse allegation. She said allowing CNA A to work on the 4th put Resident #1 at risk for further neglect or seclusion. She said this was not reported to HHSC. She said it should have been reported to HHSC. She said another resident reported this issue to her in a grievance. She said the grievance was for another resident and named CNA B. She said she felt like she could have done a more thorough investigation. She said these failures put the residents at risk for further neglect, seclusion, and mistreatment. During an interview on 02/12/26 at 12:02PM, the Social Worker said CNA E informed her that CNA B was using dummy lights on 02/02/26. She said she was told the aide was moving the good light out of the resident's reach and using an extra one to give to the residents. She said she reported this to her about Resident #1, Resident #3, and Resident #4. She said she did not investigate this, but the Administrator was responsible for investigating this. She said the allegat

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F 0609 Level of Harm - 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 observation, 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 the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 3 (Resident #1, Resident #3, and Resident #4) of 12 residents reviewed for abuse and/or neglect. The facility failed to report an allegation of neglect to HHSC within 24 hours. An allegation of neglect was reported to the Administrator regarding Resident #1, Resident #3, and Resident #4 on 02/02/26. The allegation was that the identified residents were provided extra dummy call lights. This failure could place residents at risk of emotional and physical harm.Findings included: 1. Record review of Resident #1's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cervical disc disorder with myelopathy (a serious, progressive condition where degenerated discs and bone spurs compress the spinal cord in the neck), Parkinson's disease (a progressive neurodegenerative disorder caused by the loss of dopamine-producing brain cells, leading to movement-related symptoms), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cervical spinal cord injury (involves damage to the vertebrae or nerves in the neck), neurogenic bowel (the loss of normal bowel function due to nerve damage), and neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Record review of Resident #1's quarterly MDS assessment, dated 12/12/25, reflected he had a BIMS score of 03, which indicated severe cognitive impairment. He was able to make himself understood, and he was able to understand others. He had a functional limitation in range of motion for all four extremities. He required supervision or touching assistance with eating and oral hygiene. He required substantial assistance with toileting, bathing, upper body dressing, personal hygiene, roll left and right, and sit to lying. He was dependent on staff for lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfers, and tub/shower transfers. He required moderate assistance with wheelchair ambulation. He was always incontinent of both bowel and bladder. Record review of Resident #1's care plan, included a focus of falls, last revised on 05/21/24. The focus reflected Resident has the potential for falls related to unspecified injury at unspecified level of cervical spinal cord. Interventions included place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker concerns that another CNA, [CNA B], has been switching out [Resident #1's] call light cord/button with a dummy one that does not work. The concern is that this is happening during evening/weekend shifts when [CNA B] is working.Facility follow up was assigned to the Administrator/DON. A meeting was not held. Specific actions taken to resolve the grievance was maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/05/26. 2. Record review of Resident #3's face sheet, dated 02/12/26, reflected she was an [AGE] year-old (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	female, admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), wedge compression fracture of 4th thoracic vertebra (occurs when the front part of this upper-back bone collapses), and dysphagia (difficulty swallowing). Record review of Resident #3's quarterly MDS assessment, dated 12/26/25, reflected that she had a BIMS score of 14, which indicated intact cognition. She was able to make herself understood, and she was able to understand others. She required supervision or touching assistance with toileting hygiene, sit to lying, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. She required setup or clean-up assistance with oral hygiene, upper body dressing, and roll left and right. She required moderate assistance with bathing and putting on/taking off footwear. She was frequently incontinent of bowel and bladder. Record review of Resident #3's care plan reflected a focus of Falls, last revised on 03/02/23. The focus further reflected Resident has the potential for falls related to poor safety awareness, bowel and bladder incontinence, weakness, debility, and varying cognition. The focus identified 3 fall incidents. Interventions included patient educated on use of call light and assist from staff to assist with mobility tasks and place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker a concern that another CNA, [CNA B], had given [Resident #3] a dummy call light cord/button that does not work, the weekend of January 31st and February 1st.Facility follow-up was assigned to the Administrator / DON. A meeting was not held. Specific action taken to resolve the grievance was Maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/05/26. 3. Record review of Resident #4's face sheet, dated 02/12/26, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included displaced fracture of right femur (a serious injury where the thighbone is broken and the pieces are misaligned), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and repeated falls. Record review of Resident #4's quarterly MDS assessment, dated 01/02/26, reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. She was able to make herself understood, and she was able to understand others. She required substantial assistance with toileting, bathing, lower body dressing, sit to lying, lying to sitting, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. She required moderate assistance with upper body dressing, personal hygiene, roll left and right, and sit to stand. She was always incontinent of both bowel and bladder. Record review of Resident #4's care plan reflected a focus of Resident will call out loudly instead of using call light, last revised 01/28/26. Interventions included Redirect resident to utilize call light for assistance. The care plan further reflected a focus of Falls, last revised on 11/10/25. This focus included Resident has the potential for falls related to history of falls. Interventions included Place the resident's call light within reach and encourage the resident to use it for assistance as needed. 4. Record review of Resident #2's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included respiratory failure (Respiratory failure is a condition where there's not enough oxygen or too much carbon dioxide in your body), sleep apnea (a common, serious disorder where breathing repeatedly (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	stops and starts during sleep, causing low blood oxygen and poor sleep quality), and type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood). Record review of Resident #2's quarterly MDS assessment, dated 01/09/26, reflected he had a BIMS score of 15, which indicated intact cognition. He was able to make himself understood and he was able to understand others. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker concern that another CNA, [CNA B], has possibly been switching out [Resident #4's] call light cord/button with a dummy one that does not work. It is believed this is happening during evening/weekend shifts when [CNA B] is working.Facility follow-up was assigned to the Administrator / DON. A meeting was not held. Specific action taken to resolve the grievance was Maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/06/26. Record review of an untitled document, dated 02/05/26 and provided by the Administrator on 02/12/26 at 11:36AM reflected: Date 02.05.2026Re: Dummy Call LightsOn 02.02.2026 around 4:30 pm, Administrator received Grievances from Social Worker regarding employees using a Fake Call Light.I asked staff about Dummy Call Lights, and they stated they had heard about it, but they were not sure if it [was] true or who was doing it.On 02.03.2026, Administrator asked Maintenance Director to assess all the call lights in the building, which he did. He found all Lights in working order and functioning properly.I interviewed [Resident #4] and she says it happens sometimes in the evening that her call light isn't answered timely. She wasn't too clear on the exact dates. She did not see two call lights in her room, but says it takes a long time for anyone to answer the lights.I interviewed [Resident #1], and he said it takes a long time to get his call light answered. He did not give the Administrator a name, but his roommate, [Resident #2] stated that it was [CNA A] who was unplugging the call Lights. I asked [Resident #2] if he had seen two call lights and he answered No but [The HR Director] told him a few weeks ago that she saw two Call Lights in [Resident #1's] room.Administrator later returned to [Resident #1's] room and found his Call Light tangled in the wheels of his wheelchair and the Call Light was pulled out of the wall. Administrator asked for help from ADON and she assisted the Resident and placed his Call Light back into his wall.I interviewed both [CNA B] and [CNA A] together on 02.04.2026. Both denied unplugging call lights, but [CNA B] stated that she heard it was [CNA A].CNA B does not work on [Resident #1's hall], but [CNA A] does. Record review of an undated statement signed by the HR Director reflected: I don't remember the exact day, but it was the end of December. I pushed [Resident #1] into his room after breakfast and found a call light on the floor, not plugged in. I looked over at the call light plug on the wall and saw another call light plugged in. I handed him the call light that was plugged in and took the other one to the ADON office as I assumed it was broken. Record review of an email, dated 02/04/26 at 09:28PM, sent by LVN F to the Administrator, reflected: On February 2, 2026, at around 0700 my [Resident #3's hall] aide approached me with a call light issue that had happened the night before. A resident by the name of [Resident #3] stated the night aide [CNA B] had put her call light out of reach and put another light in her room that wasn't plugged in as a dummy light. The day shift aide mentioned two other residents she had done the same thing [too]. This incident was reported to the social worker who then wrote grievances on the aide. Record review of an Associate Disciplinary Memorandum, dated 02/04/26, reflected that CNA A was suspended pending an investigation on 02/04/26, related to .CNA was named as the employee that spoke [with] resident using foul language towards them . and .Staff member allegedly told a resident to shut up. Record review of an Associate Disciplinary Memorandum, dated 02/12/26, reflected that CNA B (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	was suspended pending an investigation on 02/12/26 related to .Staff member was involved in an incident where it was alleged that she was changing out [resident] call lights with ones that didn't work. Record review of timesheets for CNA A and CNA B, dated 02/02/26 through 02/12/26, reflected:CNA A worked on 02/04/26 from 07:26 AM through 05:20PM for a total of 9.25 clocked hours.CNA B worked 02/01/26-02/02/26 from 05:55PM through 06:01AM for a total of 11.5 clocked hours.CNA B worked on 02/05/26-02/06/26 from 05:45PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/07/26-02/08/26 from 05:47PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/08/26-02/09/26 from 03:31PM through 06:01AM for a total of 13.5 clocked hours.CNA B worked on 02/09/26-02/10/26 from 05:40PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/10/26-02/11/26 from 05:53PM through 06:03AM for a total of 11.5 clocked hours. Record review of Nurse/CNA schedules for February 2nd through the 11th reflected:*On February 4th, 2026, CNA A was assigned to Resident #1, Resident #2, and Resident #4's hall.*On February 5th, 2026, CNA B was assigned to Resident #3's hall.*On February 9th, 2026, CNA B was assigned to Resident #3's hall.*On February 10th, 2026, CNA B was assigned to Resident #3's hall. During an interview on 02/11/26 at 12:09PM, Family Member H said she was a family member of Resident #1. She said she has major complaints about the administration in this facility. She said when she was reporting the call light issue to the Administrator, she would not help her unless she told the Administrator what residents had talked to her. She said she heard that CNA A and CNA B take the resident's call light away and then provide a call light that is not plugged into the wall. She said sometimes he does not have water when some aides take care of him. She said she had came up to the facility and there have been many times Resident #1's sheets were saturated. She said Resident #1 has an old spinal cord injury and is not aware when he is in pain. She said Resident #1 fell a few years ago and had to have a lifesaving surgery on his C1-T2 vertebrae. He does not have any bowel/bladder control. She said his pain receptors do not work due to this surgery. She said on February 3rd she came up to the facility to report the call light problem to the DON. She said she received a voicemail from the DON on 04/04/25 at 09:24 am and the DON told her that CNA A and CNA B had been suspended. She said she came to visit Resident #1 on 04/04/25 at 4:00PM and CNA A was in the facility working and taking care of Resident #1. She said the DON had a different story then. She said she then spoke with the Administrator and she would not help her. She said she saw CNA A in the facility and confronted her. She said at 04:38PM the DON came to her and apologized to her for the situation. She said the DON did not know who CNA A was. She said she took videos of these interactions and would provide them to this surveyor. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/03/26 at 02:10PM, this surveyor observed the following:*Family Member H can be heard talking to the DON and asking about her day.*Family Member H identifies herself to the DON as a family member of Resident #1.*Family Member H notifies the DON about someone removing Resident #1's call light and providing one that is not plugged in to him.*Family Member H said she heard that a man from Maintenance had came into Resident #1's room and checked his call light and had further indicated to her that he also was going to check Resident #4's room.*Family Member H identified CNA B and CNA A as the two aides she had heard may have removed Resident #1's call light and provided him with an unplugged call light.*Family Member H said she had heard this from several different people.*The DON said she heard about the call lights this morning in a meeting this morning, but I was not told of the specific rooms. During an observation of a voicemail recording provided to this surveyor by Family Member H, dated 02/04/26 09:24AM, this surveyor observed the following:*The DON identified herself by name and said this call was for Family Member H. She further identified the facility name she was calling from.*The DON identified she was (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	calling about the call light situation.*The DON said CNA B was off the schedule.*The DON said she was suspending CNA A off the schedule until further notice, as of today [02/04/26]. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:07PM, this surveyor observed the following:*Family Member H can be heard initiating a conversation with the DON who is in view on the video.*Family Member H asked the DON is [CNA A] still here?*The DON said, one of them was here earlier.*Family Member H said, well you told me [CNA A] was suspended earlier.*Family Member H said, was she here earlier?*DON said, she may have been here a little bit.*Family Member H and the DON argue about the situation and then the DON walks away from Family Member H. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 4:12PM, this surveyor observed the following:*Family Member H asked the Administrator how she was doing and the Administrator replied fine.*The Administrator can be heard identifying Family Member H as Resident #1's family member and asking her tell me what's going on.*Family Member H can be heard So you don't know about the call light situation?*The Administrator said, I am asking you, I want to hear from your mouth. I am hearing different stories.* Family Member H said, Well obviously this has been a thing going on.*The Administrator said, Have you seen it?*Family Member H said No, but I have been told by several people.*The Administrator said But have you seen it, because.*Family Member H interrupted the Administrator and said, So you're trying to say it didn't happen?*The Administrator said, I'll listen to you.*Family Member H said I know for a fact that the call light has been, I heard from multiple people who have witnessed it. Okay? She has unplugged the call light. [CNA B] started it, and [CNA A] has continued it. I know she got moved off that hall and she has been doing it to more than [Resident #1]. I know these things. *The Administrator said but my question is.*Family member H interrupted the Administrator and said No, I have not seen it, and I am not going to tell you who told me either, so don't ask me please.*The Administrator said, If you can't tell me where you got the information from, how am I going to help solve this?*The Administrator said, I need to know where this information is coming from.*The Administrator said, when you unplug the cord, it sends an alarm.*Family Member H said, They don't unplug it, they put it in the floor and give them a fake one.*The Administrator said, We don't have a fake one.*Family Member H said, Yeah you do, in the other rooms.*The Administrator said So show me.*Family Member H said Show you? You think I know where to find stuff in this place?. Family Member H then stood up and left the Administrator's office. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:15PM, this surveyor observed the following:*The Administrator entered the room and asked Family Member H, so show me what you are talking about.*Family Member H said I'm talking about this call light. It is in the floor, and they are giving him one in his hand.*Family Member H explained to the Administrator about the voicemail she received from the DON explaining CNA A and CNA B were suspended. She told the Administrator that CNA A was present in the facility this day and at this time. She said CNA A was assigned to Resident #1. So, what I want to know is why somebody who took a call light from someone is still here right now and still with [Resident #1]. *The Administrator said, I'll have to find that out for you, because I didn't know that. The Administrator then identified herself as the Administrator after being asked by Family Member H. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:19PM, this surveyor observed the following:*The Administrator can be seen speaking. She said she discussed the call lights with her supervisor, the regional. we wrote a grievance about it. We are trying to figure it out. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:23PM, this surveyor observed the following:Family Member H can be heard approaching and (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Actual harm Residents Affected - Few	speaking with a female staff member. The staff member denied giving anyone a fake call light. She identified herself as CNA A. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:38PM, this surveyor observed the following:The DON can be seen on the video speaking. She said, I gave my resignation to the director because of that. We did not know specific rooms. I did not realize that girl was [CNA A]. I dropped the ball. We dropped the ball. I had every intention of going to the Administrator, pulling her in there, and getting this resolved this morning when I left you that message. And then other drama unfolded The DON then acknowledged that Family Member H reported the call light issue to her on 02/03/26 and they were made aware of the issue the morning of 02/03/26. The DON said she reported this to the Administrator on 02/03/26. I gave them my resignation; I did not want them to pin me with patient abandonment. During an observation on 02/12/26 at 12:53PM, this surveyor observed an extra call light in a drawer at the central nurse's station. During an interview on 02/11/26 at 02:56PM, Resident #2 said that he was Resident #1's roommate. He said CNA A moves Resident #1's call light out of his reach. He said he goes over to Resident #1 when this happens and gives him the light back. He said this had been ongoing for at least a month or so. He said he has reported this to the ADON, the Administrator, and the HR Director. He said the Administrator spoke with him about the call light on 02/05/26. He said the Administrator told him they were going to investigate this. He said the Administrator asked him who told him about the call light. He said he reported to her that CNA A was plugging a fake call light into the wall on his roommate's side. He said on 02/05/26 he was told CNA A was suspended. During an interview on 02/12/26 at 08:47AM the HR Director said her office is on Resident #1's hall. She said back in December she went into Resident #1's room and noticed his light was on the floor. She said there were two call lights on his side of the room. She said the one that was plugged in was draped over between his bed and bedside table. She said the other call light on his side of the room was not plugged in and was coiled up on the floor. She said she did not notify the Administrator about this. She said she assumed that it was not working, and they forgot to take the old one out when they changed it. She said she took it to the ADON. She said she did not know at the time of the allegations of a fake call light being used. She said this was towards the end of December. During an interview on 02/12/26 at 9:25AM, the Administrator said she did not suspend CNA B related to the call light incident. She said she spoke with Resident #2, and he said CNA A did it to Resident #1. During an interview on 02/12/26 at 9:56AM, Resident #2 said Resident #1 gets upset when he is not able to use his call light. He said Resident #2 hollers and screams when he does not have his call light. He said he tries to help Resident #1 when he can and he gives him the call light back. He said Resident #1 uses his call light a lot. During an interview on 02/12/26 at 10:17AM, CNA D said she usually takes care of Resident #1. She said she had worked at this facility for about 7 months. She said a while back she found an extra call light on the floor in Resident #1's room. She said his regular call light was plugged into the wall and draped over his bedside drawers. She said the other call light was not plugged in and it was in his hand. She said this was about 2-3 months ago. She said when she found this she went to the DON at the time. She said she grabbed the extra call light and tried to turn it into the Maintenance Director, but he was already gone for the day. She said she gave the light to the HR director. She said she only saw this happen one time. She said she has not seen this happen to any other residents, only Resident #1. She said she did not know who it may have been. She said the schedule changes a lot. She said Resident #1 hits his call light a lot. She said he hollers out when he does not have it or when the staff do not answer. She said she felt like the person that did this did it because Resident #1 calls a bunch and they did not want to let him call. She said she felt like (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	the resident may feel secluded or neglected when this happens. She said the resident is forgetful and may not remember this happening. During an interview on 02/12/26 at 11:00AM, the Administrator said CNA A was suspended on 02/04/26 at 5:20PM. She said she was aware of the call light issue at that point. She said she was aware of a complaint of dummy call lights in the facility. She said she had the Maintenance Director go check all the call lights. She said CNA A was named as a potentially involved staff. She said Resident #2 told her a dummy call light was being used. She said she did not suspend CNA B because she was not on the schedule that day. She said she learned about the call light issue on the 2nd or 3rd of February. She said then she heard it could have been [CNA B] or [CNA A]. She said she was told CNA A's name on the 2nd or 3rd of February. She said she talked to CNA B on the 4th of February. She said CNA A worked on the 4th of February. She said the DON told the family of Resident #1 that they were going to suspend CNA A on the 4th. They did not suspend her until 5:20PM on the 4th of February, for the incident regarding alleged verbal abuse of Resident #2. She said she also was told CNA B may be involved on the 2nd or 3rd of February. During an interview on 02/12/26 at 11:20AM, the DON said she was aware of the call light allegation. She said she was made aware of this during a clinical meeting on the 3rd of February. She said she was told someone was doing this with the light. She said they had the Maintenance Director go and check all the call lights. She said she was told the names of CNA A and CNA B on the evening of the 3rd of February. She said the Family Member of Resident #1 notified her of this issue and the names of the two CNAs and which rooms she heard of this. She said she did not suspend CNA A or CNA B. She said they should have been suspended at this point. She said this could be considered neglect or seclusion, especially because Resident #1's means of communication was taken away. She said Resident #1 depended on staff for his needs and ADLs. She said she told the Administrator on the 3rd of February of the allegations with the call light and the two identified staff. She said the Administrator should have suspended CNA A and CNA B when she learned of the allegation. She said she did not know if any of this was reported to HHSC. She said an allegation of neglect or seclusion should have been reported to the state. She said CNA A worked on Resident #1's hall on the 4th of February. She said there was a risk that CNA A could have replaced or moved Resident #1's call light while she was working on the 4th of February. She said she did not feel like the Administrator did a thorough investigation. She said she should have done the investigation as soon as she knew about it on the 3rd, not the 4th. She said she was not sure if CNA B was suspended. She said she was not sure when CNA A was suspended. She said she has not seen this issue personally with her eyes. She said no other resident has complained about this other than Resident #1 and his family. She said in the time she had been in the facility she was not aware of any issues between Resident #1 and CNA B or CNA A. She said these failures put the residents at risk for further neglect, seclusion, and mistreatment. During an interview on 02/12/26 at 11:35AM, the Administrator said she received a grievance of an issue of fake call lights on the 2nd of February. She said she heard CNA B's name on the 2nd. She heard CNA A's name on the 3rd. She said the complaint was that a fake call light or extra call light was being used. She said her understanding was that the resident would have a call light and it would not work. She said her understanding was that the light was pulled from the wall. She said she thought it was impossible because if it was unplugged it would alarm. She said the next day on the 3rd she was told, no they use two call lights. She said she was told that an extra call light was being used and given to the resident. She said this could be considered an allegation of neglect or seclusion. She said the two identified aides should have been suspended immediately. She said they were not suspended on the 3rd of February. She said CNA B was not on the schedule around the time this was going on. She said CNA B came back around (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	2-3 days after this. She said CNA A was allowed to work on the 4th of February. She said CNA A was suspended later in the evening on the 4th related to a verbal abuse allegation. She said allowing CNA A to work on the 4th put Resident #1 at risk for further neglect or seclusion. She said this was not reported to HHSC. She said it should have been reported to HHSC. She said another resident reported this issue to her in a grievance. She said the grievance was for another resident and named CNA B. She said she felt like she could have done a more thorough investigation. She said these failures put the residents at risk for further neglect, seclusion, and mistreatment. During an interview on 02/12/26 at 12:02PM the Social Worker said CNA E informed her that CNA B was using dummy lights on 02/02/26. She said she was told the aide was moving the good light out of the resident's reach and using an extra one to give to the residents. She said she reported this to her about Resident #1, Resident #3, and Resident #4. She said she did not investigate this, but the Administrator was responsible for investigating this. She said the allegation related to the call light could be considered neglect or seclusion. She said she has not heard this allegation about any other residents. During an interview on 02/12/26 at 12:23PM, CNA E said she had heard of the call light situation. She said she had not observed it herself. She said CNA A told her about it. She said CNA A told her about the call light being moved away from the resident and then the resident being given a dummy call light. She said CNA [NAME] told her that she had seen this done before. She said this situation could be considered seclusion. During an interview on 02/12/26 at 12:28PM, CNA B said she had not noticed anyone use a fake call light in the facility. She said she had not heard of anyone doing this to a resident other than these allegations. She said she was not suspended until this day on 02/12/26. She said she was inv

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure they took steps to prevent further potential abuse or neglect while the investigation was in progress and they took appropriate corrective action after the alleged violation was verified for all alleged violations involving abuse, neglect, exploitation or mistreatment, including misappropriation of resident property for 4 (Resident #1, Resident #2, Resident #3, and Resident #4) of 12 residents reviewed for abuse and/or neglect. 1. The facility failed to correct identified neglect identified in grievances filed on 02/02/26 related to Resident #1, Resident #3, and Resident #4 extra dummy call lights. 2. The facility failed to suspend CNA A and CNA B when they were identified in an allegation of neglect related to grievances filed on 02/02/26 for Resident #1, Resident #3, and Resident #4's extra dummy call lights. 3. The facility failed to prevent verbal abuse of Resident #2 on 02/04/26, when they did not suspend CNA A after an allegation of neglect that was reported on 02/02/26 and after confirmation from the DON to Family Member H on 02/04/26 at 9:24 AM that CNA A would be suspended. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 02/13/26 at 10:20AM, While the IJ was removed on 02/13/26 at 04:43PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of emotional harm and neglect.Findings included: 1. Record review of Resident #1's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cervical disc disorder with myelopathy (a serious, progressive condition where degenerated discs and bone spurs compress the spinal cord in the neck), Parkinson's disease (a progressive neurodegenerative disorder caused by the loss of dopamine-producing brain cells, leading to movement-related symptoms), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cervical spinal cord injury (involves damage to the vertebrae or nerves in the neck), neurogenic bowel (the loss of normal bowel function due to nerve damage), and neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Record review of Resident #1's quarterly MDS assessment, dated 12/12/25, reflected he had a BIMS score of 03, which indicated severe cognitive impairment. He was able to make himself understood, and he was able to understand others. He had a functional limitation in range of motion for all four extremities. He required supervision or touching assistance with eating and oral hygiene. He required substantial assistance with toileting, bathing, upper body dressing, personal hygiene, and roll left and right, and sit to lying bed mobility. He was dependent on staff for lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfers, and tub/shower transfers. He required moderate assistance with wheelchair ambulation. He was always incontinent of both bowel and bladder. Record review of Resident #1's care plan, included a focus of falls, last revised on 05/21/24. The focus reflected Resident had the potential for falls related to unspecified injury at unspecified level of cervical spinal cord. Interventions included, place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker concerns that another CNA, [CNA B], has been switching out [Resident #1's] call light cord/button with a dummy one that does not work. The concern is that this is happening during evening/weekend shifts when [CNA B] is working.Facility follow up was assigned to the Administrator/DON. A meeting was not held. Specific actions taken to resolve the grievance was maintenance (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/05/26. Record review of Resident #3's face sheet, dated 02/12/26, reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), wedge compression fracture of 4th thoracic vertebra (occurs when the front part of this upper-back bone collapses), and dysphagia (difficulty swallowing). Record review of Resident #3's quarterly MDS assessment, dated 12/26/25, reflected that she had a BIMS score of 14, which indicated intact cognition. She was able to make herself understood, and she was able to understand others. She required supervision or touching assistance with toileting hygiene, and sit to lying, sit to stand, chair/bed-to-chair transfer, toilet transfers, and tub/shower transfer. She required setup or clean-up assistance with oral hygiene, upper body dressing, and roll left and right. She required moderate assistance with bathing and putting on/taking off footwear. She was frequently incontinent of bowel and bladder. Record review of Resident #3's care plan reflected a focus of Falls, last revised on 03/02/23. The focus further reflected Resident had the potential for falls related to poor safety awareness, bowel and bladder incontinence, weakness, debility, and varying cognition. The focus identified 3 fall incidents. Interventions included patient educated on use of call light and assist from staff to assist with mobility tasks and place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker a concern that another CNA, [CNA B], had given [Resident #3] a dummy call light cord/button that does not work, the weekend of January 31st and February 1st.Facility follow-up was assigned to the Administrator / DON. A meeting was not held. Specific action taken to resolve the grievance was Maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/05/26. Record review of Resident #4's face sheet, dated 02/12/26, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included displaced fracture of right femur (a serious injury where the thighbone is broken and the pieces are misaligned), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and repeated falls. Record review of Resident #4's quarterly MDS assessment, dated 01/02/26, reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. She was able to make herself understood, and she was able to understand others. She required substantial assistance with toileting, bathing, lower body dressing, and sit to lying, lying to sitting, chair/bed-to-chair transfers, toilet transfer, and tub/shower transfer. She required moderate assistance with upper body dressing, personal hygiene, roll left and right, and sit to stand. She was always incontinent of both bowel and bladder. Record review of Resident #4's care plan reflected a focus of Resident will call out loudly instead of using call light, last revised 01/28/26. Interventions included Redirect resident to utilize call light for assistance. The care plan further reflected a focus of Falls, last revised on 11/10/25. This focus included Resident had the potential for falls related to history of falls. Interventions included Place the resident's call light within reach and encourage the resident to use it for assistance as needed. Record review of (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a Grievance/Complaint Report, dated 02/02/26, received by the Social Worker, and initiated by CNA E stated: CNA reported to Social Worker concern that another CNA, [CNA B], has possibly been switching out [Resident #4's] call light cord/button with a dummy one that does not work. It is believed this is happening during evening/weekend shifts when [CNA B] is working.Facility follow-up was assigned to the Administrator / DON. A meeting was not held. Specific action taken to resolve the grievance was Maintenance assessed call lights. Results of action taken was Lights working - no dummy lights found. The grievance was marked as resolved and an in-service was conducted on call lights. The grievance was signed by the Administrator and dated 02/06/26. Record review of an untitled document, dated 02/05/26 and provided by the Administrator on 02/12/26 at 11:36AM reflected: Date 02.05.2026Re: Dummy Call LightsOn 02.02.2026 around 4:30 pm, Administrator received Grievances from Social Worker regarding employees using a Fake Call Light.I asked staff about Dummy Call Lights, and they stated they had heard about it, but they were not sure if it [was] true or who was doing it.On 02.03.2026, Administrator asked Maintenance Director to assess all the call lights in the building, which he did. He found all Lights in working order and functioning properly.I interviewed [Resident #4] and she says it happens sometimes in the evening that her call light isn't answered timely. She wasn't too clear on the exact dates. She did not see two call lights in her room, but says it takes a long time for anyone to answer the lights.I interviewed [Resident #1], and he said it takes a long time to get his call light answered. He did not give the Administrator a name, but his roommate, [Resident #2] stated that it was [CNA A] who was unplugging the call Lights. I asked [Resident #2] if he had seen two call lights and he answered No but [The HR Director] told him a few weeks ago that she saw two Call Lights in [Resident #1's] room.Administrator later returned to [Resident #1's] room and found his Call Light tangled in the wheels of his wheelchair and the Call Light was pulled out of the wall. Administrator asked for help from ADON and she assisted the Resident and placed his Call Light back into his wall.I interviewed both [CNA B] and [CNA A] together on 02.04.2026. Both denied unplugging call lights, but [CNA B] stated that she heard it was [CNA A].CNA B does not work on [Resident #1's hall], but [CNA A] does. Record review of an undated statement signed by the HR Director reflected: I don't remember the exact day, but it was the end of December. I pushed [Resident #1] into his room after breakfast and found a call light on the floor, not plugged in. I looked over at the call light plug on the wall and saw another call light plugged in. I handed him the call light that was plugged in and took the other one to the ADON office as I assumed it was broken. Record review of an email, dated 02/04/26 at 09:28PM, sent by LVN F to the Administrator, reflected: On February 2, 2026, at around 0700 my [Resident #3's hall] aide approached me with a call light issue that had happened the night before. A resident by the name of [Resident #3] stated the night aide [CNA B] had put her call light out of reach and put another light in her room that wasn't plugged in as a dummy light. The day shift aide mentioned two other residents she had done the same thing [to]. This incident was reported to the social worker who then wrote grievances on the aide. Record review of an Associate Disciplinary Memorandum, dated 02/12/26, reflected that CNA B was suspended pending an investigation on 02/12/26 related to .Staff member was involved in an incident where it was alleged that she was changing out [resident] call lights with ones that didn't work. 2. Record review of Resident #2's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included respiratory failure (Respiratory failure is a condition where there's not enough oxygen or too much carbon dioxide in your body), sleep apnea (a common, serious disorder where breathing repeatedly stops and starts during sleep, causing low blood oxygen and poor sleep quality), and type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	up in the blood). Record review of Resident #2's quarterly MDS assessment, dated 01/09/26, reflected he had a BIMS score of 15, which indicated intact cognition. He was able to make himself understood and he was able to understand others. Record review of a Provider Investigation Report, dated 02/11/26, reflected in the investigation summary section: On 02.04.2026, [Resident #2] reported he asked [CNA A] to get [Resident #1], and she said she would in a few minutes. The Resident stated he said No, get him up now! According to [Resident #2] she still refused to follow his instructions. He began using profanity towards [CNA A]. The CNA replied, You need to mind your business. He yelled, [F-word] you! The CNA responded to [Resident #2], You need to shut the [F-word] up and mind your business![CNA A] denied making that statement.The Resident stated he was offended when he heard [CNA A] curse.[LVN G] stated she overheard [Resident #2] yelling and using profanity, but did not hear [CNA A] yell or curse at Resident. Record review of Resident #5's face sheet, dated 02/12/26, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a term for lung and airway diseases that restrict your breathing), aphasia (an impairment in a person's ability to comprehend or formulate language), and dysphagia (difficulty swallowing). Record review of Resident #5's quarterly MDS assessment, dated 11/11/25, reflected she had a BIMS score of 14, which indicated intact cognition. She was usually able to make herself understood, and she was able to understand others. Record review of an Associate Disciplinary Memorandum, dated 02/04/26, reflected that CNA A was suspended pending an investigation on 02/04/26, related to .CNA was named as the employee that spoke [with] resident using foul language towards them . and .Staff member allegedly told a resident to shut up. Record review of timesheets for CNA A and CNA B, dated 02/02/26 through 02/12/26, reflected:CNA A worked on 02/04/26 from 07:26 AM through 05:20PM for a total of 9.25 clocked hours.CNA B worked 02/01/26-02/02/26 from 05:55PM through 06:01AM for a total of 11.5 clocked hours.CNA B worked on 02/05/26-02/06/26 from 05:45PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/07/26-02/08/26 from 05:47PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/08/26-02/09/26 from 03:31PM through 06:01AM for a total of 13.5 clocked hours.CNA B worked on 02/09/26-02/10/26 from 05:40PM through 06:02AM for a total of 11.75 clocked hours.CNA B worked on 02/10/26-02/11/26 from 05:53PM through 06:03AM for a total of 11.5 clocked hours. Record review of Nurse/CNA schedules for February 2nd through the 11th reflected:*On 02/04/26, CNA A was assigned to Resident #1, Resident #2, and Resident #4's hall.*On 02/05/26, CNA B was assigned to Resident #3's hall.*On 02/09/26, CNA B was assigned to Resident #3's hall.*On February 10th, 2026, CNA B was assigned to Resident #3's hall. During an interview on 02/11/26 at 12:09PM, Family Member H said she was a family member of Resident #1. She said she had major complaints about the administration in the facility. She said when she was reporting the call light issue to the Administrator, she would not help her unless she told the Administrator what residents had talked to her. She said she heard that CNA A and CNA B take the resident's call light away and then provide a call light that is not plugged into the wall. She said sometimes, he did not have water when some aides took care of him. She said she had came up to the facility and there have been many times Resident #1's sheets were saturated. She said Resident #1 had an old spinal cord injury and is not aware when he is in pain. She said Resident #1 fell a few years ago and had to have a lifesaving surgery on his C1-T2 vertebrae. He did not have any bowel/bladder control. She said his pain receptors did not work due to this surgery. She said on February 3rd she came up to the facility to report the call light problem to the DON. She said she received a voicemail from the DON on 04/04/25 at 09:24 am and the DON told her that CNA A and CNA B had been suspended. She said she came to visit Resident #1 on 04/04/25 at 4:00PM and CNA A was in the facility working and taking care of Resident #1. She (continued on next page)

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	675424	A. Building B. Wing	02/13/2026

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	said the DON had a different story then. She said she then spoke with the Administrator and she would not help her. She said she saw CNA A in the facility and confronted her. She said at 04:38PM, the DON came to her and apologized to her for the situation. She said the DON did not know who CNA A was. She said she took videos of these interactions and would provide them to this surveyor. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/03/26 at 02:10PM, this surveyor observed the following:*Family Member H can be heard talking to the DON and asking about her day.*Family Member H identifies herself to the DON as a family member of Resident #1.*Family Member H notifies the DON about someone removing Resident #1's call light and providing one that is not plugged in to him.*Family Member H said she heard that a man from Maintenance had came into Resident #1's room and checked his call light and had further indicated to her that he also was going to check Resident #4's room.*Family Member H identified CNA B and CNA A as the two aides she heard that may have removed Resident #1's call light and provided him with an unplugged call light.*Family Member H said she heard this from several different people.*The DON said she heard about the call lights this morning in a meeting this morning, but I was not told of the specific rooms. During an observation of a voicemail recording provided to this surveyor by Family Member H, dated 02/04/26 09:24AM, this surveyor observed the following:*The DON identified herself by name and said this call was for Family Member H. She further identified the facility name she was calling from.*The DON identified she was calling about the call light situation.*The DON said CNA B was off the schedule.*The DON said she was suspending CNA A off the schedule until further notice, as of today [02/04/26]. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:07PM, this surveyor observed the following:*Family Member H can be heard initiating a conversation with the DON who is in view on the video.*Family Member H asked the DON is [CNA A] still here?*The DON said, one of them was here earlier.*Family Member H said, well you told me [CNA A] was suspended earlier.*Family Member H said, was she here earlier?*DON said, she may have been here a little bit.*Family Member H and the DON argue about the situation and then the DON walked away from Family Member H. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 4:12PM, this surveyor observed the following:*Family Member H asked the Administrator how she was doing and the Administrator replied fine.*The Administrator can be heard identifying Family Member H as Resident #1's family member and asking her tell me what's going on.*Family Member H can be heard So you don't know about the call light situation?*The Administrator said, I am asking you, I want to hear from your mouth. I am hearing different stories.* Family Member H said, Well obviously this has been a thing going on.*The Administrator said, Have you seen it?*Family Member H said No, but I have been told by several people.*The Administrator said But have you seen it, because.*Family Member H interrupted the Administrator and said, So you're trying to say it didn't happen?*The Administrator said, I'll listen to you.*Family Member H said I know for a fact that the call light has been, I heard from multiple people who have witnessed it. Okay? She has unplugged the call light. [CNA B] started it, and [CNA A] has continued it. I know she got moved off that hall and she has been doing it to more than [Resident #1]. I know these things. *The Administrator said but my question is.*Family member H interrupted the Administrator and said No, I have not seen it, and I am not going to tell you who told me either, so don't ask me please.*The Administrator said, If you can't tell me where you got the information from, how am I going to help solve this?*The Administrator said, I need to know where this information is coming from.*The Administrator said, when you unplug the cord, it sends an alarm.*Family Member H said, They don't unplug it, they put it in the floor and give them a fake one.*The Administrator said, We don't have a fake one.*Family Member H said, (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Yeah you do, in the other rooms.*The Administrator said So show me.*Family Member H said Show you? You think I know where to find stuff in this place?. Family Member H then stood up and left the Administrator's office. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:15PM, this surveyor observed the following:*The Administrator entered the room and asked Family Member H, so show me what you are talking about.*Family Member H said I'm talking about this call light.It is on the floor, and they are giving him one in his hand.*Family Member H explained to the Administrator about the voicemail she received from the DON explaining CNA A and CNA B were suspended. She told the Administrator that CNA A was present in the facility this day and at this time. She said CNA A was assigned to Resident #1. So, what I want to know is why somebody who took a call light from someone is still here right now and still with [Resident #1]. *The Administrator said, I'll have to find that out for you, because I didn't know that. The Administrator then identified herself as the Administrator after being asked by Family Member H. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:19PM, this surveyor observed the following:*The Administrator can be seen speaking. She said she discussed the call lights with her supervisor, the regional. we wrote a grievance about it. We are trying to figure it out. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:23PM, this surveyor observed the following:Family Member H can be heard approaching and speaking with a female staff member. The staff member denied giving anyone a fake call light. She identified herself as CNA A. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/04/26 at 04:38PM, this surveyor observed the following:The DON can be seen on the video speaking. She said, I gave my resignation to the director because of that. We did not know specific rooms. I did not realize that girl was [CNA A]. I dropped the ball. We dropped the ball. I had every intention of going to the Administrator, pulling her in there, and getting this resolved this morning when I left you that message. And then other drama unfolded The DON then acknowledged that Family Member H reported the call light issue to her on 02/03/26 and they were made aware of the issue the morning of 02/03/26. The DON said she reported this to the Administrator on 02/03/26. I gave them my resignation; I did not want them to pin me with patient abandonment. During an observation on 02/12/26 at 12:53PM, this surveyor observed an extra call light in a drawer at the central nurse's station. During an interview on 02/11/26 at 02:56PM, Resident #2 said that he was Resident #1's roommate. He said CNA A moved Resident #1's call light out of his reach. He said he goes over to Resident #1 when this happens and gives him the light back. He said that had been ongoing for at least a month or so. He said he had reported this to the ADON, the Administrator, and the HR Director. He said the Administrator spoke with him about the call light on 02/05/26. He said the Administrator told him they were going to investigate it. He said the Administrator asked him who told him about the call light. He said he reported to her that CNA A was plugging a fake call light into the wall on his roommate's side. He said on 02/05/26, he was told CNA A was suspended. During an interview on 02/12/26 at 08:47AM, the HR Director said her office was on Resident #1's hall. She said back in December, she went into Resident #1's room and noticed his light was on the floor. She said there were two call lights on his side of the room. She said the one that was plugged in, was draped over between his bed and bedside table. She said the other call light on his side of the room was not plugged in and was coiled up on the floor. She said she did not notify the Administrator about this. She said she assumed that it was not working, and they forgot to take the old one out when they changed it. She said she took it to the ADON. She said she did not know at the time of the allegations of a fake call light being used. She said this was towards the end of December. During an (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	interview on 02/12/26 at 9:25AM, the Administrator said she did not suspend CNA B related to the call light incident. She said she spoke with Resident #2, and he said CNA A did it to Resident #1. During an interview on 02/12/26 at 9:56AM, Resident #2 said Resident #1 got upset when he was not able to use his call light. He said Resident #1 hollers and screams when he does not have his call light. He said he tries to help Resident #1 when he can and he gives him the call light back. He said Resident #1 uses his call light a lot. During an interview on 02/12/26 at 10:17AM, CNA D said she usually took care of Resident #1. She said she had worked at this facility for about 7 months. She said a while back, she found an extra call light on the floor in Resident #1's room. She said his regular call light was plugged into the wall and draped over his bedside drawers. She said the other call light was not plugged in and it was in his hand. She said this was about 2-3 months ago. She said when she found this, she went to the DON at the time. She said she grabbed the extra call light and tried to turn it into the Maintenance Director, but he was already gone for the day. She said she gave the light to the HR Director. She said she only saw this happen one time. She said she has not seen this happen to any other residents, only Resident #1. She said she did not know who it may have been. She said the schedule changes a lot. She said Resident #1 hits his call light a lot. She said he hollers out when he does not have it or when the staff do not answer. She said she felt like the person that did this, did it because Resident #1 calls a bunch and they did not want to let him call. She said she felt like the resident may feel secluded or neglected when this happens. She said the resident is forgetful and may not remember this happening. During an interview on 02/12/26 at 11:00AM, the Administrator said CNA A was suspended on 02/04/26 at 5:20PM. She said she was aware of the call light issue at that point. She said she was aware of a complaint of dummy call lights in the facility. She said she had the Maintenance Director go check all the call lights. She said CNA A was named as a potentially involved staff. She said Resident #2 told her a dummy call light was being used. She said she did not suspend CNA B because she was not on the schedule that day. She said she learned about the call light issue on the 2nd or 3rd of February. She said then she heard it could have been [CNA B] or [CNA A]. She said she was told CNA A's name on the 2nd or 3rd of February. She said she talked to CNA B on the 4th of February. She said CNA A worked on the 4th of February. She said the DON told the family of Resident #1 that they were going to suspend CNA A on the 4th. They did not suspend her until 5:20PM on the 4th of February, for the incident regarding alleged verbal abuse of Resident #2. She said she also was told CNA B may be involved on the 2nd or 3rd of February. During an interview on 02/12/26 at 11:20AM, the DON said she was aware of the call light allegation. She said she was made aware of this during a clinical meeting on the 3rd of February. She said she was told someone was doing this with the light. She said they had the Maintenance Director go and check all the call lights. She said she was told the names of CNA A and CNA B on the evening of the 3rd of February. She said the Family Member of Resident #1 notified her of this issue and the names of the two CNAs and which rooms she heard of this. She said she did not suspend CNA A or CNA B. She said they should have been suspended at this point. She said this could be considered neglect or seclusion, especially because Resident #1's means of communication was taken away. She said Resident #1 depended on staff for his needs and ADLs. She said she told the Administrator on the 3rd of February of the allegations with the call light and the two identified staff. She said the Administrator should have suspended CNA A and CNA B when she learned of the allegation. She said she did not know if any of this was reported to HHSC. She said an allegation of neglect or seclusion should have been reported to the state. She said CNA A worked on Resident #1's hall on the 4th of February. She said there was a risk that CNA A could have replaced or moved Resident #1's call light while she was working on the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4th of February. She said she did not feel like the Administrator did a thorough investigation. She said she should have done the investigation as soon as she knew about it on the 3rd, not the 4th. She said she was not sure if CNA B was suspended. She said she was not sure when CNA A was suspended. She said she has not seen this issue personally with her eyes. She said no other resident complained about this, other than Resident #1 and his family. She said in the time she had been in the facility, she was not aware of any issues between Resident #1 and CNA B or CNA A. She said these failures put the residents at risk for further neglect, seclusion, and mistreatment. During an interview on 02/12/26 at 11:35AM, the Administrator said she received a grievance of an issue of fake call lights on the 2nd of February. She said she heard CNA B's name on the 2nd. She heard CNA A's name on the 3rd. She said the complaint was that a fake call light or extra call light was being used. She said her understanding was that the resident would have a call light and it would not work. She said her understanding was that the light was pulled from the wall. She said she thought it was impossible because if it was unplugged it would alarm. She said the next day on the 3rd she was told, no they use two call lights. She said she was told that an extra call light was being used and given to the resident. She said this could be considered an allegation of neglect or seclusion. She said the two identified aides should have been suspended immediately. She said they were not suspended on the 3rd of February. She said CNA B was not on the schedule around the time this was going on. She said CNA B came back around 2-3 days after this. She said CNA A was allowed to work on the 4th of February. She said CNA A was suspended later in the evening on the 4th related to a verbal abuse allegation. She said allowi

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 12 residents reviewed for quality of care. The facility failed to ensure CNA DD properly transferred Resident #1 on 02/10/26. This deficient practice could place residents at risk of injury.Findings included: 1. Record review of Resident #1's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included cervical disc disorder with myelopathy (a serious, progressive condition where degenerated discs and bone spurs compress the spinal cord in the neck), Parkinson's disease (a progressive neurodegenerative disorder caused by the loss of dopamine-producing brain cells, leading to movement-related symptoms), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cervical spinal cord injury (involves damage to the vertebrae or nerves in the neck), neurogenic bowel (the loss of normal bowel function due to nerve damage), and neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems). Record review of Resident #1's quarterly MDS assessment, dated 12/12/25, reflected he had a BIMS score of 03, which indicated severe cognitive impairment. He was able to make himself understood, and he was able to understand others. He had a functional limitation in range of motion for all four extremities. He required supervision or touching assistance with eating and oral hygiene. He required substantial assistance with toileting, bathing, upper body dressing, personal hygiene, roll left and right, and sit to lying. He was dependent on staff for lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfers, and tub/shower transfers. He required moderate assistance with wheelchair ambulation. Record review of Resident #1's care plan, included a focus of ADLs, last revised 05/21/24. The focus reflected, Resident had an ADL self care performance deficit and was at risk for not having their needs met in a timely manner, performance deficit is related to unspecified injury at unspecified level of cervical spinal cord. Interventions included transfers Total/mechanical lift x2 (two person assist). Record review of Resident #1's Visual/Bedside Kardex Report, dated 02/12/26, reflected Resident #1 required total assist with a mechanical lift for transfers with two people. Record review of Resident #1's Post Fall Evaluation, dated 02/10/26, reflected: .In IDT meeting, after in person interview and reading CNA statement along with resident's current POC, it is determined that resident is a total/[mechanical lift] x2. CNA did not check Kardex prior to providing care to patient. In person education was completed at facility by DON and employee advised he may be placed on suspension pending final results of investigation. Record review of Resident #1's incident form titled Witnessed Fall, dated 02/10/26, reflected: .CNA came to the nurses station and said he needed help getting resident off the floor. Upon arrival to room, resident found to be sitting in floor next to bed. CNA stated he was transferring him from the wheel chair to his bed and his grip was slipping so he started to lower him to the floor. CNA guided resident down to floor before calling for assistance. 2. Record review of Resident #2's face sheet, dated 02/11/26, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included respiratory failure (Respiratory failure is a condition where there's not enough oxygen or too much carbon dioxide in your body), sleep apnea (a common, serious disorder where breathing repeatedly stops and starts during sleep, causing low blood oxygen and poor sleep quality), and type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood). Record review of Resident #2's quarterly (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS assessment, dated 01/09/26, reflected he had a BIMS score of 15, which indicated intact cognition. He was able to make himself understood and he was able to understand others. During an observation of a video recording provided to this surveyor by Family Member H, dated 02/10/26 at 06:44PM, this surveyor observed the following:*Family Member H can be heard speaking with someone at the nurse's station. Family Member H asked the nurse .So, was it just [CNA DD]?.was he supposed to have two people getting him in and out of bed?*the nurse can be heard telling Family Member H: yes, I let him know, he should have had two people.I guess he misjudged his capabilities. I let the DON know, and someone else will be taking care of [Resident #1] tonight.*Family Member H said .was he supposed to be using the [mechanical lift]? was there a [mechanical lift] available?*the nurse said Yes, there was a [mechanical lift] available. Record review of CNA DD's statement, dated 02/10/26, reflected: I was trying to manually transfer the resident because he did not have a [mechanical lift] pad under him. In the process I lost my grip and had to sit the resident on the floor. I notified the charge nurse and she came down and helped get the resident in bed. On the statement there were two sets of handwriting, and the above quote was written in the same handwriting as CNA DD's signature. The additions to the statement are in a different handwriting, and included under both arms Nurse [and] CNA use a sheet for transfer back to bed and He did try stand on lift but [due to] contractures of both hands he could not hold his own weight up. During an interview on 02/11/26 at 12:09PM, Family Member H said she was a family member of Resident #1. She said on 02/10/26 at 06:13PM, she received a phone call from RN O. She said RN O sounded like she was out of breath. She said the nurse had to call her and tell her that CNA DD was trying to put Resident #1 to bed and dropped him. She said Resident #1 was unable to feel pain so she was worried he may have broken something. She said she drove over to the facility to check on Resident #1. She said Resident #1 told her he hit his head. During an interview on 02/11/26 at 02:41PM, Resident #1 said he had a fall on 02/10/26. He said CNA DD was going to use a mechanical lift but did not. He said CNA DD was the only staff in the room. He said CNA DD told him something was wrong with the mechanical lift. He said CNA DD did not explain to him what was wrong with the mechanical lift. He said CNA DD tried to lift him with his hands and he was unable to transfer him and then dropped him. He said he did not remember if CNA DD stayed or left the room. He said someone came and helped get him off the floor. He said someone looked him over and made sure he did not have any injuries. He said he did not think he had any injuries or pain from the fall. During an interview on 02/11/26 at 02:56PM, Resident #2 said he was Resident #1's roommate. He said he was in the room around the time that Resident #1 fell on [DATE]. He said he did not see what happened, but he heard a loud noise and then he heard CNA DD call for help. He said the nurse came to check on Resident #1. He said when he heard Resident #1 hit the floor he heard a scream. He said at the time of the transfer CNA DD was the only staff in the room. He said the mechanical lifts were working again at that time. He said the staff usually used a mechanical lift to transfer Resident #1. During an interview on 02/11/26 at 03:33PM, RN O said she recalled Resident #1's fall on 02/10/26. He said CNA DD came to the nurse's station and requested help because Resident #1 was on the floor. She said CNA DD told her I Dropped him. She said she asked from the [mechanical lift]? and he said no. She said she went to the room and the resident was lying on the floor next to the bed. She said his head was at the foot of the bed and his feet were toward the head of the bed. She said she assessed him, checked for pain, asked him if he hit his head or heard anything pop. Resident #1 denied this. She said she helped Resident #1 up to his bottom with his back to the bed. She said her, another CNA, and CNA DD lifted Resident #1 to the bed. She said she thoroughly looked him over. She said Resident #1 was normally a mechanical lift transfer. She said CNA DD did not say why he did not use 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
	675424	A. Building B. Wing	02/13/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mechanical lift. She said she assessed Resident #1's neuro status. She said she called Resident #1's family member as she was texting the DON and the doctor. She said she thought CNA DD knew better and should have used the mechanical lift to transfer Resident #1. During an interview on 02/11/26 at 03:48PM, the DON said she added to CNA DD's statement. She said she did not have him initial the changes. She said the additions were what CNA DD said to her while writing the statement. During an interview on 02/12/26 at 09:13AM, the DON said she was notified about Resident #1's fall the evening of the 10th of February. She said the nurse told her that the aide was trying to put Resident #1 in the bed and was unable to carry him. She said the nurse did say that CNA DD did not use the mechanical lift. She said he was supposed to use the mechanical lift. She said that the aide told her that the resident did not have a sling under him and he did not check the Kardex. She said it was possible to put a sling on someone in the wheelchair. She said she did not suspend him until the following morning, and he was allowed to work all night. She said she was not sure if he should have been suspended at the time of the incident. She said she was not aware of the policy. During an interview on 02/12/26 at 09:25AM, the Administrator said she was not aware of Resident #1's fall with CNA DD until the morning of February 11th. She said she did not know that the aide improperly transferred him until the morning of the 11th. She said she suspended CNA DD on the morning of the 11th. She said the DON did not inform her of the extent of the fall on the evening of February 10th. She said if she had known all the details at the time of the fall she would have suspended him at that time. Record review of the facility's policy, Mechanical Lift, last revised on 09/08/23, reflected: Purpose:To move immobile or obese patients for whom manual transfer poses potential for a resident injury.NOTE: Although one (1) person can operate most models of hydraulic lifts, it is advisable to have two (2) staff members present to stabilize and support the resident.