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	05/15/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents received medication at time ordered by the physician for 2 of 3 residents (Resident #'s 1 and 2) reviewed for medication administration. The facility failed to ensure Resident #'s 1 and 2 received their medications timely according to the physician's orders on 5/13/2026. This failure could place residents at risk for adverse outcome, ineffective therapeutic response, and decline in health status. Findings included: During an interview on 05/14/2026 at 10:41 A.M., Resident #1 was in her bed with husband at bedside the resident was interviewable, alert, oriented, clean, and well groomed, bed in regular position, water at bedside, and the call light was in reach. Resident #1 stated she had an issue with yesterday's medication pass (5/13/2026) in that she received all her morning medications around two o'clock in the afternoon. A record review of Resident #1'sface sheet, dated 5/14/2026, revealed a [AGE] year-old female admitted on [DATE], diagnoses included diverticulitis(small bulging pouches) of large intestine, colostomy, anxiety disorder, insomnia, personal history of other diseases of circulatory system, acquired absence of right leg below the knee, neuropathic bladder, chronic atrial fibrillation, chronic pain syndrome muscle weakness, chronic obstructive pulmonary disease, acute respiratory failure, obesity due to excess calories, and methicillin resistant staphylococcus aureus infection(an infection resistance to methicillin or other common antibiotics) A record review of Resident #1's quarterly MDS assessment, Section C(focuses on assessing a resident's attention, orientation and ability to register and recall new information and signs of delirium), dated 3/31/2026, revealed a BIMS score of 15, which indicated she was cognitively intact. During a record review of Resident #1's Medication Administration Record, dated 5/15/2026, it was determined that all morning medications were administered, there was no negative outcome to the resident as a result of the late administration. During an observation and interview on 05/14/2026 at 11:00 A.M., Resident #2, was in her room sitting in a wheelchair beside her bed. She was alert, oriented, clean, well groomed, water at bedside, and call light was in reach. Resident #2 stated she had an issue with yesterday's medication pass (5/13/2026) in that she received all her morning medication about 1:30 p.m. in the afternoon. A record review of Resident #2's face sheet, dated 5/14/2026, revealed a [AGE] year-old female admitted on [DATE], diagnoses included Peripheral Vascular Disease(disease or disorder of the circulatory system outside of the brain or heart), acute embolism and Thrombosis of Left lower extremity, chronic diastolic heart disease, anemia, impacted cerumen right ear (occurs when earwax (cerumen) builds up and hardens in the ear canal, blocking it) overactive bladder, bursitis(inflammation of the bursae in your hip), abnormal gait, muscle weakness, adjustment disorder with anxiety, dyspnea(difficulty breathing), Osteoarthritis (occurs when the cartilage that cushions the ends of bones in your joints gradually deteriorates), hypertension(high blood Pressure). A record review of Resident #2's quarterly MDS assessment, Section C (focuses on assessing a resident's attention, orientation and ability to register and recall new information and signs of delirium),, dated 3/31/2026, revealed a BIMS score of 15, which indicated she was cognitively intact. A record review of Resident #2's Medication Administration Record, dated 5/14/2026, it was determined that all morning medications were administered, there was no negative (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outcome to the residents as a result of the late administration. During an interview on 5/14/2026 at 11:44 A.M., LVN B, charge nurse for hall 3, stated that between 6:30 A.M. to 7:00 A.M. On 5/14/2026 she reported to the scheduler that the medication aide for Hall 3 had not showed up and there was no one to give meds. LVN B stated during the morning department head meeting, at around 9:00 A.M., she informed the DON, ADON, Administrator, and Social Worker that there was still no medication aide for morning medication pass. LVN B stated she was told by the DON it would be taken care of. LVN B stated she did pass some pain medications, and at around 1:30 P.M. - 2:00 P.M. the morning meds, which were anytime medications, were passed by the scheduler MA D, who was also a medication aide. During an interview on 5/14/2026 at 12:21 P.M., MA D stated she was also the scheduler and was aware they were shorthanded. MA D stated that all residents did receive their medications. During an interview and record review on 5/14/2026 at 1:30 P.M., the DON provided in-services where staff were educated on giving medications timely. She stated any nurse or medication aid could have done the medication pass, and that she had instructed the scheduler, who was also a MA, to pass the medications and she assumed it was done.; however, it was not done until after 1:30 p.m. The DON stated there was no policy for anytime medication (that the medication can be taken usually daily at any time). Per DON, the medical director was notified of the medication error(s) and there was no negative outcome. During an interview with MA D on 5/15/2026 at 9:30 A.M., she stated she was also the scheduler and was to be on a training call on the 5/13/2026. She stated the DON and Administrator knew she was on the call for the day. MA D stated they knew by nine o'clock that morning there was no medication aide on hall 3. She stated she assumed they had covered and resolved the issue. She stated she was not notified until one o'clock that afternoon that medications were not passed. She stated she then got on the cart and passed all medications. She repeatedly said she didn't want to say the wrong thing regarding who all was aware of the issues. During an interview with the Administrator on 5/15/2026 at 12:00 P.M., she said there was no negative outcome with any medications that were given late.Record review of the facility policy titled, Medication Administration, dated 2/10/2020,Indicated, Purpose: to safely and accurately prepare and administer medication according to physicians' orders and patient needs. 9.Administer medication - Administer medication in accordance with frequency prescribed by physician - within 60 minutes before or after prescribed dosing time - if patient is not in room to receive medication lag the MAR and at conclusion of medication pass, roll cart to patients' location and administer medications In-services were reviewed and were compliant.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to distribute ice under sanitary conditions for 1 of 3 ice chests on hall 200. The facility failed to ensure ice was distributed under sanitary conditions on hall 200. These failures could place residents at risk of being served in unsanitary conditions and for waterborne illnesses.Findings included: During an observation on 05/15/2026 at 10:46 A.M., CNA Awas observed passing ice on Hall 2 without a proper scoop. She was using a pink water pitcher and allowing the ice scoop to touch the rims of used residents' pitches before dipping it back into the ice chest then leaving the pink water pitcher in the ice chest. During an interview on 5/15/2026 at 10:46 A.M., CNA A said she knew she was not supposed to use a pitcher for a scoop and the pitcher should not be left in the ice chest. CNA A said she was not sure how the ice chest got cleaned and who was responsible for cleaning the chest. During an observation of the Halls 2,3,4 on 05/15/2026 at 10:55 A.M.,, the ice Chest on halls 2,3,4 all had improper drainage for the ice chest. Observation indicated the ice chests were dirty with black, slimy scum, build up on the bottom of chest. During an interview with the DON on 05/15/2026 at 10:58 A.M., she said they did not have any more ice scoops and CNA A was using a pink pitcher as an ice scoop but did not know CNA A was leaving it in the ice chest. She said they would go get ice scoopers and have a container to store the scoop properly. During an interview with the DM on 05/15/2026 at 11:00 A.M., she said dietary was responsible for cleaning the ice chest but it was the CNA's job to get the ice chest to the kitchen. During an Record review of the Dietary Cleaning Log on 5/15/2026, there was not a cleaning schedule for the Ice Chest. During an interview on 5/15/2026 at 11:05 AM, the Administrator said they did not have a policy for dietary on how and when the hall ice chest was to be cleaned and knew this could lead to some kind of waterborne illness. During an Record review of the facility's policy on 05/15/2026, titled, Safe Ice Handling, dated 11/2006 and revision date of 3/2012, indicated, Policy: Ice will be handled in a manner to protect the ice from contamination. Appropriate ice handling practices prevent contamination and the potential for waterborne illness.1. Only ice scoops, held by the handle or ice dispensers, will be used for dispensing ice2. Ice chest used for ice pass and or ice service will be kept clean and sanitized and will have holders do ice scoops storage a. clean ice chest at least weekly and as needed b. Discard ice3. Ice Scoops and holders will be cleaned, sanitized and allowed to dry air routinely.