STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 1 resident (Resident #5) reviewed for respiratory care related to tracheostomy care.1. The facility failed to ensure LVN A, who worked for a staffing agency, had the needed competencies/knowledge to care for Resident #5 with a tracheostomy prior to attempting to perform tracheostomy (surgical procedure creating an opening (stoma) into the neck into the trachea (tube-windpipe- that allowed air to pass to and from lungs) to establish an airway)) care and suctioning on 2/25/26 and required surveyor intervention for the safety of the resident.2.The facility failed to ensure LVN A performed intratracheal (directly into the trachea-windpipe-airway) suctioning using sterile technique (used in healthcare to create a completely germ-free environment to prevent the introduction of germs to the resident-sterile items only touch sterile items).3. The facility failed to ensure staff answered the call light when LVN A pushed Resident #5's call light for assistance during tracheostomy care on 2/25/26.4. The facility failed to ensure Resident #5's suction tubing was not on the floor and was not stored unbagged on top of clean supplies in the nightstand drawer on separate occasions on 2/23/26.An Immediate Jeopardy (IJ) situation was identified on 2/25/26 at 5:28 PM. While the IJ was lifted on 2/26/26 at 12:38 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of their corrective systems.Findings included: Record review of Resident #5's face sheet dated 2/26/26 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #5 had diagnoses which included acute respiratory failure, epilepsy (seizures), hypertension (high blood pressure), and traumatic subdural hemorrhage (bleeding between the brain's surface and the lining caused from a head injury), resistance to multiple antibiotics, aphasia (unable to speak), and dysphagia (difficulty swallowing).Record review of Resident #5's admission MDS assessment dated [DATE] indicated she was rarely/never understood and was unable to complete the BIMS interview, which indicated she had severe cognitive impairment. Resident #5 was dependent on staff for all ADLs. Resident #5 had a tracheostomy. Resident #5 received respiratory treatments of suctioning and tracheostomy care.Record review of Resident #5's Care Plan dated 2/24/26 indicated she had impaired verbal communication related to an artificial airway due to tracheostomy, may get congested and need suctioning of tracheostomy, has tracheostomy related respiratory failure.Record review of Resident #5's Order Summary Report dated 2/25/26 indicated an order for trach (tracheostomy) care every shift, cleanse stoma (opening in neck), replace split gauze with an order date of 2/04/2026; may suction as needed for tracheostomy with a start date of 2/04/26; and Resident #5 was on Enhanced Barrier Precautions (EBP).During an observation on 2/23/26 at 11:00 AM, revealed Resident #5 was lying in bed. Resident #5 had a tracheostomy. There was a suction machine on top of the nightstand, and the canister was approximately 1/3 full of pale-yellow fluid. There was suction tubing attached to the suction canister, with a long red rubber tube on the end of the suction tubing lying directly on the floor and it was not bagged. The suction tubing was dated 2/12/26.During an observation on 2/23/26 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 3:45 PM, revealed Resident #5 was lying in bed. The suction machine continued to be on top of the nightstand. There continued to be suction tubing attached to the suction canister, with the same long red rubber tube on the end of the suction tubing dated 2/12/26 lying unbagged in the top drawer of the nightstand on top of clean sealed supplies.During an interview on 2/25/26 at 9:30 AM, the surveyor informed the nurse on the 600 hall, LVN A, of the need to observe tracheostomy care. LVN A said she worked for a staffing agency, and she would ask LVN M who they wanted to do the tracheostomy care and let the surveyor know when they were ready.During an interview on 2/25/26 at 12:15 PM, LVN M told the surveyor LVN A would be performing the tracheostomy care and was ready.During an observation on 2/25/26 beginning at 12:22 PM, revealed LVN A donned (put on) PPE (gloves and gown), washed her hands, and put on non-sterile gloves. LVN A opened a tracheostomy care tray and placed it on top of Resident #5's legs and poured sterile water into the basin of tracheostomy care tray. LVN A then removed Resident #5's inner cannula of her tracheostomy and placed it in the sterile water in the tray and attempted to clean the inner cannula with cleaning brushes included in the tray. LVN A had difficulty trying to remove thick stringy secretions from the inner cannula. LVN A removed her gloves and donned sterile gloves and reached into the nightstand top drawer and grabbed the suction tubing out of a plastic bag. LVN A contaminated her sterile gloves by touching non-sterile items, then opened a suction catheter and connected it to the suction tubing, contaminating the suction catheter by touching with it with contaminated sterile gloves, then suctioned Resident #5's tracheostomy with the contaminated suction catheter. LVN A suctioned a large amount of clear/white thick secretions from Resident #5's tracheostomy. LVN A then unhooked the suction catheter from the suction tubing and placed it on top of the bag it came out of, on top of the nightstand. Then LVN A donned another pair of sterile gloves and contaminated the gloves while putting them on by pulling them up over her sleeves. LVN A attempted to replace the inner cannula with the end of the inner cannula pointing up (upside down). LVN A was forcefully pushing it, and she did not secure the outer cannula at Resident #5's neck and while she pushed the inner cannula, the tracheostomy was pushed backwards. Resident #5 began forcefully coughing and coughed up a large amount of secretions covering the hand of LVN A. LVN A then removed the inner cannula and placed it back into the tray and said, I think I'm going to have to suction her again, but there aren't any more suction tubes. LVN A then looked through the nightstand and said, I don't know. and I'm sorry this is taking so long. LVN A then obtained a pair of gloves out of the top drawer of the nightstand that looked to have been a sterile pair but was not in the sterile packaging and donned them attempting to use sterile technique, and put on the right-hand glove, then touched her ungloved hand with her gloved hand. LVN A then used cotton tip applicators from the tracheostomy tray to clean the inside of Resident #5's outer canula. Resident #5's oxygen saturation (oxygen in blood) ranged from 90 to 97 % during care (considered normal for residents with chronic respiratory issues). LVN A then attempted to replace Resident #5's inner cannula again and had the tip of cannula pointing up and was forcefully pushing the inner cannula without stabilizing the outer cannula, which pushed the tracheostomy backwards. Resident #5 begun forcefully coughing and large amounts of secretions came out of the tracheostomy covering LVN A's hand. LVN A then placed the inner cannula back into the tracheostomy care tray and removed her gloves. LVN A said she needed more supplies and pushed Resident #5's call light at 1:17 PM for assistance. LVN A said, I'm so sorry this is taking so long. and stood there for a few minutes. LVN A then donned new sterile gloves, contaminated top of the gloves while pulling them on by the top of the cuffs and touching her forearm with her gloved fingers and then grabbed the top of each glove with her fingers and pulled the gloves up over her sleeves. LVN A then moved the gauze out of the tracheostomy tray and poured peroxide into the tray. LVN A placed the inner cannula in the peroxide and cleaned it with the peroxide and cleaning brushes and then rinsed it with sterile water. LVN A then shook off the water from the inner cannula and tapped it on the inside of the tracheostomy care tray. LVN A then placed the inner cannula back into the outer cannula and was trying to forcefully push the inner cannula back in with the curve of the inner cannula pointing up (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	without securing the outer cannula, then would pull back some and then try to forcefully push the inner cannula in again, and said multiple times I don't know, I just don't know. for approximately 1 minute. Resident #5 was forcefully coughing, and large amounts of secretions were coming out of the tracheostomy. Observed oxygen saturation at 93%. The surveyor then notified the survey team coordinator via text at 1:38 PM that LVN A needed the assistance of the DON or someone. As LVN A was attempting again to forcefully push the inner cannula into the outer cannula upside down and not stabilizing the outer cannula, the surveyor intervened and questioned LVN A on which way the tip of the inner cannula was pointed. LVN A paused and looked at the tracheostomy and tried to forcefully push the inner cannula upside down again, without stabilizing the outer cannula, as Resident #5 continued to violently cough and large amounts of secretions were being expelled through the tracheostomy tube. At approximately 1:40 PM, the surveyor intervened and asked LVN A to stop and remove the inner cannula and questioned LVN A about how the tracheostomy was positioned in the resident's neck. LVN A then turned the inner cannula over with the tip pointing down and the inner cannula went into the outer cannula easily and it was clicked in place. Resident #5 quit coughing after LVN A had securely inserted the inner cannula. LVN A said, Oh my. I feel awful. I feel so dumb. I should have thought about the anatomy. The DON entered Resident #5's room at 1:50 PM and was informed LVN A had pushed the call light at 1:17 PM for assistance and no one had come. The DON donned a gown and gloves and came into the room and asked LVN A what she needed and LVN A told the DON she needed to suction the resident, and she did not have any suction tubes. The DON left to get supplies. While waiting for the DON to return, LVN A said today (2/25/26) was her first time to work in the facility. LVN A said she worked for a nurse staffing agency. LVN A said, I really feel dumb right now. LVN A said everywhere she had worked before had a respiratory therapist to provide tracheostomy care. At 1:59 PM, Resident #5's oxygen saturation was reading 99% and the resident was asleep. LVN A said she did not think she would suction Resident #5 at that time, since she was resting and her oxygen level was good. LVN A said it had been years since she had done tracheostomy care, and she knew she failed this care miserably. LVN A said she knew Resident #5 was her patient and she should be able to perform all care for her. When the DON returned with supplies, LVN A told her she decided not to suction the resident and let her rest. During an interview on 2/25/26 at 2:15 PM, LVN A said she had received report from the night shift nurse this morning (2/25/26) and she knew she had a resident with a tracheostomy. LVN A said she did not know that she would be the one to do tracheostomy care or suction the resident. LVN A said she had been trained on performing tracheostomy care, but it had been years, a long time. LVN A said the last time she had a resident with a tracheostomy was about a year ago and the facility had a 24-hour respiratory therapist that managed all the tracheostomy care. LVN A said intratracheal suctioning should be a sterile procedure. LVN A said it had probably been at least six years since donning (putting on) sterile gloves. LVN A said she knew she cross-contaminated when putting on her sterile gloves and then did the care before thinking about it. LVN A said she knew she lost her sterile field and contaminated her gloves and the suction catheter. LVN A said using contaminated gloves and a contaminated suction catheter to do intratracheal suctioning could cause bacteria build up and infection in the resident. LVN A said Resident #5 probably felt like she was going to choke when she was trying to push the inner cannula back in upside down and did not stabilize her outer tracheostomy cannula. LVN A said, Then you asked about the curvature of the cannula and how the tracheostomy was positioned in the neck and then I turned it over and it went right in. LVN A said she felt dumb. LVN A said she thought she was just meeting resistance. The surveyor asked LVN A how the care she provided to Resident #5 during tracheostomy care and intratracheal suctioning could have affected Resident #5 and she responded, It's not good.During an interview on 2/25/26 at 5:24 PM, the DON said the staffing agency profile should be set up to say what skills were needed to work at the facility when the account was created. The DON said all she could see in the staffing agency software when choosing nursing staff to work was if they had long-term care experience, their date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of birth , name, and a phone number. The DON said she could look at the staff profile in the staffing agency software and see what assessments the potential staff had done in the agency software. The DON said she looked at the potential agency staff's years of experience and whether they had long-term care experience when choosing agency staff. The DON said she was responsible for the facility staff's competencies, and they did them annually and on hire. The DON said she had instructed her staff to make sure that facility staff would do all the skills the surveyors needed to see during the survey. The DON said she had told LVN M to perform the tracheostomy care and she did not know why the agency staff nurse did the tracheostomy care. The DON said she did not even know LVN A was the one doing the tracheostomy care. The DON said LVN A should have gotten someone if she did not know how to perform tracheostomy care. The DON said when she walked into Resident #5's room while LVN A was in there, along with surveyor, she could not hide her eyes because she was not pleased with what she saw when she walked in. The DON said she would not have set the sterile supplies on top of the resident while performing tracheostomy care. The DON said if staff attempted to perform tracheostomy care and were not knowledgeable of tracheostomy care and did not perform the tracheostomy care and suctioning using sterile technique, it could set up the resident for infections. The DON said trying to force the inner cannula of the tracheostomy back in upside down could cause trauma to the airway of Resident #5 and trying to force anything could be detrimental to the resident. The DON said intratracheal suctioning should be a sterile procedure. The DON said the resident could get an infection and overall compromise the respiratory system because you have put something directly into the airway. During an interview on 2/26/26 at 9:27 AM, RN L said she worked 2/23/26 and was Resident #5's nurse on the day shift. RN L said she did not recall seeing a red suction catheter on the floor 2/23/26. RN L said suctioning a tracheostomy was a sterile procedure and she used a new suction catheter each time she suctioned Resident #5. RN L said if a contaminated suction catheter was used to suction a tracheostomy, it could cause a terrible infection. RN L said tracheostomy care started with washing hands and gathering supplies. RN L said the inner cannula had to be rotated in a downward motion until it clicked into place when reinserting the inner cannula. RN L said if she was in the middle of tracheostomy care and the resident went into respiratory distress she would have to yell out for help and do the best she could until help arrived on Hall 600. RN L said if the inner cannula was forcefully pushed back into the outer cannula upside down, it could cause the resident to aspirate (when liquid, food, or other materials accidentally enter the airway and lungs) or cause the resident to go into respiratory distress.Record review of nursing competencies for all nursing staff that performed tracheostomy care for Resident #5 since she admitted to the facility on [DATE] through 2/25/26 indicated all facility nursing staff had been checked off as had met the performance requirements for Tracheostomy Care and Tracheal Suctioning on 8/27/25.A request for LVN A's nursing competencies was made on 2/25/26 at 3:00 PM and 4:15 PM from the Regional Nurse and was not provided with the requested documentation prior to exiting the facility.On 2/25/26 at 11:22 AM, requested a policy related to respiratory care-storage of suction equipment from the Regional Nurse.Interview on 2/26/26 at 2:30 PM, the Regional Nurse said they did not have a policy related to storage of suction equipment.Record review of the facility's policy titled Tracheostomy Care dated reviewed March 2, 2023, indicated . Staff will provide care for residents with a tracheostomy in accordance with standard practice guidelines . Procedure . perform hand hygiene and apply clean gloves . observe for the need of tracheostomy care due to secretions at the stoma site or in the tube . observe the skin around the tracheal stoma, under the tracheal tube, and under tracheal ties for skin breakdown . validate peripheral capillary oxygen saturation (Sp02) through pulse oximetry preoxygenate the resident for 30 seconds . provide suctioning per practice guidelines . use sterile kit for suctioning . emergency sterile tracheostomy equipment of the correct size will be kept at the bedside . replacement inner cannula . suction catheters (tracheal and oral) .Record review of the National Library of Medicine website article titled, Tracheal Trauma - StatPearls - NCBI Bookshelf accessed on 3/04/26 indicated . Tracheal Trauma was uncommon but (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was typically caused by iatrogenic (adverse, unintended health outcomes caused by medical treatment, errors, or negligence) . most experts believe the incidence of tracheal trauma was underestimated as iatrogenic injuries were underreported . suspicion resulting in early detection of tracheal trauma was one of the most crucial factors for reducing morbidity and mortality . clinical presentation of tracheal trauma may vary depending on the mechanism of injury and involvement of adjacent structures . symptoms included blood-tinged sputum, shortness of breath, . most iatrogenic tracheal injuries tend to occur in the posterior (back) membranous portion of the trachea .This was determined to be an Immediate Jeopardy (IJ) on 2/25/26 at 5:28 PM. The ADM, DON, and the Regional Nurse were notified 2/25/26 at 5:52 PM and provided the IJ template on 2/25/26 at 6:00 PM. The ADM, DON, and Regional Nurse expressed understanding of the Immediate Jeopardy and a Plan of Removal was requested.The following plan of removal submitted by the facility was accepted on 2/26/26 at 10:35 AM:How other residents with the potential to be affected by the same deficient practice would be identified:Any resident with a tracheostomy had the potential to be affected by the deficient practice.What measures would be put in place or what systemic changes would be made to ensure that the deficit practice does not recur:Trach care was completed by LVN A on 2/25/2026. DON performed an assessment at 1:50 PM on 2/25/2026 and resident #5 did not require additional suctioning.DON again assessed Resident#5 for signs and symptoms of respiratory distress on 02/25/2026 at 17:30 with no adverse effects noted. Resident #5 had an order placed by DON/designee to check oxygen saturation hourly for 24 hours for continued monitoring. Regional nurse verified order in place on 2/25/26. DON/Designee notified NP of changes on 2/25/2026. Competency check-off to include sterile technique for suctioning and replacement of inner cannula was performed with LVN A on 2/25/2026.Trach care will be performed on 2/26/26 at 10:30 AM with inner cannula replacement.LVN A (Agency nurse) removed from facility schedule, with last shift being worked on 2/25/2026.Regional Nurse verified DON competency in trach care and sterile technique on suctioning on 2/25/26. Education will be provided to all staff regarding answering call lights in a timely manner by Administrator/designee by 11:59 PM on 2/25/2026. No employee will be allowed to work until education is received.Education and competencies with return demonstration will be provided by DON/Designee to all nursing staff prior to next scheduled shift regarding tracheostomy care. DON/Designee that have had competency verification, will perform competency with return demonstration and education to include sterile technique for suctioning and trach care prior to contract staff working in the facility. DON/designee will maintain list of contract staff that have completed the above competencies and verify competencies are completed prior to starting shift.How the corrective action(s) will be monitored to ensure the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the system changes):Beginning 2/26/2026, DON/designee will observe trach care and sterile technique twice weekly on random nursing staff for 30 days then weekly for three months. Beginning 2/26/2026, DON/designee will do rounds throughout the facility to observe for call light response randomly five times weekly for two weeks then randomly for 30 days.Involvement of Medical Director:Medical Director notified by DON on 2/25/2026. Involvement of QA (Quality Assurance):An Ad Hoc QAPI meeting (created immediately to address a specific, urgent, temporary need) held with the Medical Director, Regional Director of Operations, Director of Nursing, and Regional Nurse Consultant on 2/25/2026. ˆ Administrator will forward results of audits monthly to the QAPI Committee for review and/or action.Who is responsible for implementation of process:The Director of Nursing/designee will be responsible for implementation of New Process for monitoring respiratory care. The New Process/ system for respiratory care will be started on 2/25/26 and no employee will be able to return to work until they complete the Inservice. ˆ Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 2/25/26.The surveyor verification of the Plan of Removal from 2/26/26 was as follows:Record review of the Interdisciplinary Progress Note dated 2/25/26 at 1:50 PM indicated the DON assessed Resident #5 and resident was stable and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had no signs of respiratory distress, respirations were even, nonlabored, and no secretions were noted at the trach site.Record review of the Interdisciplinary Progress Note dated 2/25/26 at 5:30 PM indicated the DON assessed Resident #5 and her breaths were even and nonlabored. Respirations were 18 with slightly diminished breath sounds to her left upper lobe of lung and clear all other areas. Resident #5's oxygen saturation was 92 % on oxygen. The DON instructed the assigned floor staff to administer scheduled breathing treatment and reassess breath sounds promptly.Record review of the Active Orders Report for Resident #5 revealed an order for oxygen saturation checks hourly for 24 hours with a start date and time of 2/25/26 at 4:00 PM.Record review of the Interdisciplinary Progress Notes documentation indicated the facility NP was notified of the events during trach care and suctioning, and resident status on 2/25/26 at 3:35 PM.Record review of Respiratory Competency Evaluations for Tracheal Suctioning and Tracheostomy Care revealed LVN A completed it with a Pass circled on 2/25/26 by the Regional Nurse.Observation and interview revealed tracheostomy care was provided on 2/26/26 at 10:30 AM for Resident #5 by LVN AA and the DON. LVN AA knocked, disinfected her hands by washing, set up a clean work area, rewashed her hands, and explained the procedure to the resident. LVN AA took the resident's vitals and listened to her lung sounds stating her lungs were clear. LVN AA rewashed her hands. LVN AA removed the inner cannula and disposed of it. Oxygen saturation was monitored by the DON, by speaking out the oxygen saturation throughout procedure. LVN AA was able to answer questions about sterile procedure. LVN AA donned sterile gloves. LVN AA suctioned and cleaned outer cannula and surrounding tissue and changed tracheostomy tie. LVN AA disposed of her gloves, washed her hands, and applied sterile gloves. LVN AA then inserted a new inner cannula. LVN AA reassessed Resident #5's vital signs including her lung sounds and reapplied her oxygen. Resident #5 was repositioned for comfort. Oxygen Saturation was between 99% and 91% during the procedure. LVN AA was interviewed, and she stated she was in-serviced with return demonstration for tracheostomy care. LVN AA stated she was taught, depending on the resident, she may need to have someone assist to add supplemental oxygen. LVN AA stated she was taught the procedure for suctioning and inner cannula changing was sterile. LVN AA said she was taught about the anatomy of the trachea and not forcing the cannula in. LVN AA stated she was taught to answer all call lights even if there was a staff member in the room.Record review of documentation LVN A (agency nurse) was removed from the facility schedule 2/25/26 and was marked in the agency staffing software as Do Not Return by the ADM related to an issue with tracheostomy care during shift on 2/26/26.Record review of a Respiratory Competency Evaluations for Tracheal Suctioning and Tracheostomy Care were completed with a Pass circled for the DON completed 2/25/26 by the Regional Nurse.Record review of Respiratory Competency Evaluations for Tracheal Suctioning and Tracheostomy Care were completed with a Pass circled for 14 nursing staff (including LVN A and the DON) completed 2/25/26 by the Regional Nurse.Record review of the QAPI Meeting sign-in sheet dated 2/25/26 indicated there were 4 staff members in attendance, including the Regional Nurse, the ADM, the DON, and the MD via phone.Record Review of a Training In-service Form indicated an in-service was held on 2/25/26 with In-service Topics of Call lights: policy and Procedure presented by the DON. The in-service stated . All staff members, both clinical and non-clinical, are responsible for answering call lights to help ensure they are addressed in a timely manner . if non-clinical staff members answer call light and resident requires physical assistance or clinical intervention, the staff member should immediately locate nearest clinical staff member and report need . if a staff member is already in resident's room and call light is on, another staff member should knock on and enter room to check if assistance is needed . if you are in a resident's room and require assistance . if residents are stable, ensure the residents are safe, step out briefly, and locate the nearest available staff member for assistance . if resident is unstable (actively falling, loss of consciousness, respiratory distress, sudden change of condition) remain with the resident and verbally call out/yell for help immediately . The in-service indicated 43 staff had signed the in-service.Record Review of a Training In-service Form indicated an in-service was held on 2/25/26 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with In-service Topics of Trach Care, Trach Suctioning; Policy and Procedure with demonstration and returned demonstration presented by the Regional Nurse. The in-service included Respiratory Competency Evaluations for Tracheal Suctioning and Tracheostomy Care were completed with a Pass circled for 14 nurses including the DON and LVN A.During interviews with staff from all departments and across all shifts on 2/26/26 between 10:50 AM and 12:29 PM, with Housekeeper X, Housekeeper EE, Housekeeper ZZ, Laundry BBB, [NAME] XX, DA Y, DA MM, DM, CNA Z, CNA CC, CNA GG, CNA HH, CNA KK, CNA WW, CNA YY, CNA CCC, LVN T, LVN AA, LVN UU, LVN TT, LVN M, LVN AA, MA VV, RN K, RN FF, PT/OT Technician BB, OTA DD, Activity Director, Social Worker, HR Coordinator, Maintenance Supervisor, AC J, BOM AAA, Medical Records/Supply Coordinator Q, and the DON were able to verbalize call lights were everyone's responsibility to answer. They stated if a call light was on, it should have been answered as soon as it was noticed. If they were unable to assist the residents, then they were instructed to find someone who could have assisted the residents, after making sure the resident was safe and stable. They verbalized if they were unable to leave the resident, then they were to call out or use their cell phone to get help.During interview with nurses across all shifts on 2/26/26 between 10:50 AM and 12:29 PM, with LVN T, LVN AA, LVN TT, LVN UU, LVN M, RN K, RN FF, and the DON revealed they were able to verbalize the policy and procedure for tracheostomy care and suctioning. The nurses stated sterile technique was required for tracheostomy suctioning and the inner tracheostomy cannula was to be re-inserted with the tip facing downward. They verbalized they were required to perform tracheostomy care and suctioning check offs by performing a return demonstration.During an interview on 2/26/26 at 12:16 PM, NP DDD said she was notified of Resident #5 having lower oxygen saturation during tracheostomy care. NP DDD said she asked about how Resident #5's current oxygen saturations were, and she was back to her baseline. NP DDD said tracheal suctioning should be a sterile procedure. NP DDD said if tracheal suctioning was not performed sterilely, it could give the resident pneumonia, could lead to multiple organ failure with sepsis (life threating infection in the blood), it could be really bad. NP DDD said the inner cannula of the tracheostomy should have gone back in at an angle and twisted to point down until it clicked securely and the outer cannula should be stabilized to prevent dislodgement while inserting the inner cannula. NP DDD said if the outer cannula was not held securely and the staff member was trying to forcefully push the inner cannula into the tracheostomy upside down, it could cause stretching of the stoma site, causing a leak around the tracheostomy, and could cause damage to the trachea. NP DDD said tracheostomy care should be performed as a sterile procedure to prevent introducing any new bacteria into the resident's airway and causing an infection in the resident.During an interview on 2/26/2026 at 12:42 PM, the MD said intratracheal suctioning had to be done sterile because it could cause a bacterial infection in the resident. The MD said trying to forcefully put the inner tracheal cannula in upside down could cause some soft tissue trauma to the trachea, cause the resident pain, discomfort, and bleeding. The MD said that he did not feel that it would be life threatening. The MD said he was notified of the incident related to Resident #5's tracheostomy care and suctioning and participated in the QAPI meeting last night (2/25/26) and believed they now have a plan in place to prevent further incidents with tracheostomy care.During an interview on 2/26/26 at 2:26 PM, LVN M said she was the Staffing Coordinator. LVN M said she had communicated with DON and the Regional Nurse and told them she did not want to do the tracheostomy care on Resident #5 on 2/25/26 because she was nervous after performing the IV care with a surveyor. LVN M said the Regional Nurse asked LVN A if she was comfortable doing the tracheostomy care and had asked her how long it had been since she had performed tracheostomy care. LVN M said LVN A said it had been some time since she had performed tracheostomy care but did verbalize how to perform the care. LVN M said she even asked LVN A again if she was okay and comfortable with performing the tracheostomy care and LVN A said she would just go ahead and do it. During an interview on 2/26/26 at 2:42 PM, the DON said respiratory care was being re-in-serviced to the nursing staff on tracheostomy care/suctioning before working their next shift. The DON said the agency nurse was DNR (Do Not Return) in the agency staffing software, and hopefully, after next week they would no longer need

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pain management was provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 resident reviewed for pain management. (Resident #21) The facility failed to ensure Resident #21 had effective pain management by failing to administer routine pain medication timely. This failure could place residents at risk for increased pain and decreased quality of life.Findings included: Record review of an undated face sheet revealed Resident #21 was a [AGE] year-old male admitted on [DATE] with diagnoses of diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), blindness to one eye, and chronic pain. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #21 had a BIMS score of 15 which indicated no cognitive impairment. It revealed he had no behavior and had not refused care. Resident #21 was independent for ADLs. He was taking high risk medications from the following drug classes; antianxiety, antidepressant, hypnotic, diuretic, opioid, hypoglycemic, and anticonvulsants. Record review of the care plan dated 06/30/2025 revealed Resident #21 had a history of verbally aggressive behavior regarding medication. He has a history of becoming upset/angry when the nurse was not present to give the next pain pill at the exact time it was due to be given again. He has a known history of cursing staff. No care plan was noted for chronic pain, opioid use, or opioid dependence. Record review of ?Physician Orders' dated 06/24/2025 revealed Resident #21 had an order for Oxycodone Hcl 15mg orally every 4 hours for pain. To be administered at 3 a.m., 7 a.m., 11 a.m., 3 p.m., 7 p.m., and 11 p.m. Record review of EHR medication administration times for Resident #21 on 02/23/2026 revealed the following medication due and medication administration times: Oxycodone Hcl 15mg orally every 4 hours: Date: Time Due: Time Administered: Pain Level: Nurse: 02/22/2026 7 a.m. 9:41 a.m. 4 DON02/22/2026 11 a.m. 1:03 p.m. 7 LVN SS02/22/2026 3 p.m. 4:10 p.m. 6 LVN SS02/22/2026 7 p.m. 7:16 p.m. 0 LVN RR During an interview on 02/23/2026 at 11:10 a.m., Resident #21 stated he was extremely upset by the way he was treated over needing pain medication that past weekend. He stated because there was such a staffing shortage, the facility had no nurse show up for the day shift on 02/22/2026 and his pain medication was due at 7:00 a.m. Resident #21 stated he had been dependent on opioids for over 20 years to control his pain, and they must be taken routinely to maintain an acceptable level of pain relief. He stated that when one was missed or administered late his pain level increases rapidly, and it is hard to bring it back under control. He stated the DON was called to work the floor on his hall, but she did not make it to the facility until 8:30 a.m. He stated that when she came into the nurse's station, he approached her and asked if he could have his pain medication that was missed because he was beginning to hurt. Resident #21 stated an acceptable level of pain for him was 3 or less on a scale of 1-10. He stated at that point he was at a 4 or 5. He stated the DON told him she would get to him when she could, but she had to get organized and figure out a way to get back into time compliance with medications for all residents. He stated he waited until 9:00 a.m. and approached her again, this time, on the hall pushing the medication cart. He stated when he asked for his pain medication again, the DON told him she was going by the list in order of room number, and he would get his pain medication when she got to his name on the list. Resident #21 stated he was at a ?5 or 6' at the time and it was not unbearable, but he feared it would be by the time she made it to the next to the last room on the hall (Resident #21's room). He stated at 9:30 a.m., he approached her again and she stated she was two rooms from his room, and she would be with him in a few minutes. He stated his pain remained ?5 or 6' at this time. Resident #21 stated at 9:40 a.m., the DON approached him with pain medication. He stated he was very upset and cursed at her, but he felt like his pain made him act out of character. He stated he then questioned the DON about the next pain pill that was due in 1 hour and 20 minutes. Resident #21 stated the DON stated he would have to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0697 Level of Harm - Actual harm Residents Affected - Few	wait as late as possible to take that medication because it would be too close to the oxycodone he took at 9:40 a.m. Resident #21 stated he could not understand why he was treated like his pain did not matter. He stated he stayed in pain for the remainder of the day. He stated he did not miss any more oxycodone, but they were given late to try and get his schedule back on track. He stated his 11 a.m. dose was administered at after 1:00 p.m. and his 3 p.m. dose was late, as well. He stated he did not lose sleep, but felt it unnecessary to make a person in pain, remain in pain, because it was more convenient for the staff to go by room number. He stated he came to her, so she would not have to walk down the hall to him, and she still ignored his pain. During an interview on 02/23/2026 at 3:30 p.m., the DON stated she was called into work on 02/22/2026 and was late arriving. She stated someone called in at the last minute and she did not arrive at the facility until around 8:30 a.m. She stated she started late and Resident #21 was waiting at the nurses' station wanting his pain medication as soon as she arrived. She stated he told her he was in pain and that it was a ?4' on a scale of 1-10 and she told him she was going to go down the hall and get all the residents back in time compliance with their medications. She stated he did approach her a few more times wanting his pain medication because he was concerned, he would not get his 11 a.m. dose. The DON stated that pain was an important condition that should be monitored and taken care of by the nurse in a timely manner. She stated she did not feel Resident #21 was in enough pain to cause him any distress by waiting an extra hour to receive his pain medication. She stated she realized pain was subjective. The DON stated pain could cause some people to act aggressively or angrily. She stated he cursed her multiple times, but that had no bearing on when she delivered his pain medication. The DON stated someone came in and took the floor from her around noon on 02/22/2026, and all the medication was in time compliance when she counted the medication cart down with the oncoming nurse. She stated she did not notify the MD of the late administration of medication. During an interview on 02/25/2026 at 9:20 a.m., LVN RR stated Resident #21 told her she should have given his pain medication before she left shift her 02/21/2026 night shift on 02/22/2026 morning. She stated she had not given it to him because he was not up at the nurse's station when she left at 8:00 a.m. She stated she gave him his medication on 02/22/2026 at 7 p.m., and his pain level was a 0. She stated she had to wake him to administer the medication and he was in no distress. During an interview on 02/25/2026 at 10:00 a.m., LVN SS stated she came in to relieve the DON on 02/22/2026. She stated she arrived around 11:50 a.m. and started on the floor a little after noon. She stated she administered Resident #21's 11 a.m. dose of oxycodone around 1:00 p.m. She stated she realized it was late, but she was trying to spread out the time and get his medication back in time compliance without giving him too much medication. She stated she had not notified the MD of the late medication administration. She stated Resident #21 rated his pain 7 on a scale of 1-10, but it was relieved when she followed up with him around 2 p.m. During an interview on 02/25/2026 at 4:00 p.m., the Administrator stated it was the expectation that pain be treated seriously and pain medication be administered timely. She stated late pain medication administration could lead to pain and decreased quality of life. Review of the facility's policy titled ?Pain Management and Basic Comfort Measures' dated 03/27/2023, revealed the staff was to evaluate pain and provide basic comfort measures in accordance with standard practice guidelines.utilize pain level scale to determine acceptable level of pain. No pain-0, Mild 1-3, Moderate 4-6, Severe 7-10, determine intensity.provide pain medication as prescribed by an authorized prescriber.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population for 7 (Resident #4,#2,#47,#77,#78,#90 and #104) of 16 residents reviewed for nursing services. The facility failed to have sufficient staff available to provide resident ADL care routinely. This failure could put residents at risk of not receiving necessary care and supervision to maintain their highest practicable physical, mental, and psychosocial wellbeing. Findings Included: 1. Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old male admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and vascular ulcers (slow-healing, painful, and often recurring open sores, typically forming around the ankles due to chronic vein disease, such as poor circulation or faulty valves). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 15 which indicated no cognitive impairment. It revealed he had no behavior and had not refused care. Resident #4 required partial assistance (helper does less than half the work) for bed mobility, personal hygiene, dressing, and transfer. Record review of the care plan dated 01/15/2026 revealed Resident #4 had a venous stasis ulcer on his right lateral ankle, right medial calf, and a non-pressure ulcer to his right buttock. Record review of the February 2026 ADL sheet reviewed on 02/25/2026, revealed Resident #4 had not been bathed since 02/06/2026 when he received a shower on day shift. No other showers were shown for February 2026. During an observation and interview on 02/23/2026 at 9:30 a.m., Resident #4 stated he had several concerns with his care. He pointed out that he was 6'8 tall and his bed was uncomfortable. Resident #4's feet were hanging over the footboard of the bed. He stated the remote that let the head and feet up and down, had a short in it and had the short for over 2 months. He stated he talked with the maintenance man several times about replacing it, but it had not happened yet, so he was stuck in the position he was in with his head at about 45 degrees. Resident #4 stated that he leaned to the right side and is often left that way for hours before someone comes in and repositioned him. He stated he could reposition himself if he could let the bed up and down, but the remote does not work. Resident #4 was noted to be leaning to the right side lying on his paralyzed arm and hand and his right foot was dropped to the right side. Resident #4 stated he had not received a bath or shower in over 10 days. He stated there was a COVID outbreak in the building and the facility had less than a skeleton crew working and multiple different staff members including the DON told him they did not have time to bathe him. Resident #4 stated he understood he could not leave his room and would settle for a bed bath. He voiced concern over his body odor and stated it was embarrassing to smell like shit and musk. He also stated he requested a shave but not in bed. There was a strong smell of body odor present and overgrown facial hair. Resident #4 was dressed in a burnt orange T shirt with several white and brown stains on the front. Resident #4's sheets were soiled and covered in brown and red stains. Resident #4 stated he had not received his medication over the weekend. He stated the nurse was new and came in and told him she was not going to make it to him in time to give him his medications. He stated this was upsetting to him because he felt the doctor prescribed the medication because they were important to his health. During an observation and interview on 02/23/2025 at 11:00 a.m., Resident #4 stated the food was not edible. He stated it was always very cold like it had been sitting out for hours or days when it was served to him at the end of the hallway. He stated he wasn't sure if they were running out of food or not, but he seemed to get small portions and sometimes the items were burnt or clumped together like they were stuck to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the bottom of the pot. Resident #4 continued to be positioned on his right side lying on his right arm and hand. Resident #4 attempted to let his head and feet up or down, but remote would not function. During an observation and interview on 02/23/2025 at 1:20 p.m., Resident #4 continued to be positioned on his right side lying on his paralyzed right arm and hand. Resident #4 stated at least he could not feel the arm and hand, but he would like to be turned and pulled up in the bed because his heel was starting to hurt from resting on the footrest. During an observation on 02/23/2025 at 3:40 p.m., Resident #4 continued to be positioned on his right side lying on his paralyzed right arm and hand. Resident #4's heels were resting on the footboard, and he stated he needed to be pulled up in the bed. He stated he asked the people that brought his lunch tray to pull him up in bed, but they said they were not nurses or aides. During an observation on 02/24/2026 at 9:00 a.m., Resident #4 had on the same burnt orange shirt with food stains covering it and the smell of his body odor was strong throughout the room. Resident #4's sheets had not been changed and were covered with food . During an interview on 02/24/2026 at 2:10 p.m., Resident #4 stated he requested a bed bath that morning and was told he was ascheduled for baths on Monday, Wednesday, Friday. During an observation and interview on 02/25/2026 at 10:10 a.m., Resident #4 stated he had still not gotten a bath. Resident #4 remained in the same burnt orange shirt with stains, and his sheets were the same stained sheets from the previous 2 days. The foul odor of feces and body odor was present upon entering the room. Resident #4 stated now I know if I can smell my sour-ass you can smell me. He stated he really would like to be cleaned up and he was having trouble sleeping with all the crumbs in his bed. During an interview on 02/25/2026 at 11:00 a.m., CNA B stated she was the aide for Resident #4 and was aware it was his bath day. She stated she was the aide for Resident #4 the previous day and she told him it was not his bath day. She stated she knew he needed a bath, but she had several others to do, and she could not physically get all of them done with everything else she had to do. She stated she did not have time to do everything required of her on her shift. CNA B stated she had 22 residents to care for and half of them were COVID positive. She stated she was to feed them 2 meals, keep them clean and dry, turn them every 2 hours, bathe 6-8 of them a day, and chart. She stated that it was an impossible task even if there was no COVID. CNA B stated she did her best to care for the residents. During an interview on 02/25/2026 at 11:45 a.m., LVN C stated she worked as the charge nurse for half of 200, 300, and all of 400 on 02/21/2026 day shift and 02/22/2026 night shift. She stated she would never return to the facility again after the two shifts because it was unsafe for the residents and her nursing license. She stated on 02/21/2026 she gave about 5 of the 39 residents their medications on time, because she was busy answering call lights and assisting the CNA on the hall. She stated there were residents that she did not provide medications because the medications were ordered multiple times daily and she felt it would be dangerous to give the medications too close together. She stated she notified the MD of the medications held. LVN C stated on Sunday night for about 4 hours, there were 4 staff members in the building caring for 88 residents,; included nurses and CNAs. 2. Record review of an undated face sheet revealed Resident #2 was [AGE] years old and admitted to the facility on [DATE] with diagnoses including diabetes, lack of coordination, and age-related physical disability. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #2 was understood and understood others. The MDS indicated Resident #2 had a BIMs of 15 which indicated his cognition was intact. The MDS indicated Resident #2 required substantial to maximal assistance with showers or baths. Record review of Care Plan last revised 12/29/25 indicated Resident #2 had impaired mobility and required assistance with ADLs. There was an intervention to assist the residents with daily living activities as needed. Record review of a CNA Flow Sheet dated 02/01/26 - 02/25/26 indicated Resident #2 had only received a bath on 02/01/26. There were no other baths documented. There was a refusal documented on 02/09/26. During an interview on 02/23/26 at 2:50 p.m., Resident #2 said he had not had a bath in a week. He said he had asked staff for a bath and they told him they did not have time. 3. Record review of the face sheet, dated 02/25/2026, reflected Resident #47 was a [AGE] year-old male who admitted to the facility on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE] with diagnoses of chronic obstructive pulmonary disorder (COPD) (a progressive lung condition that makes it difficult to breath), and brain and lung cancer. Record review of the admission MDS assessment, dated 01/21/2026, reflected Resident #47 had unclear speech, was understood, and was able to understand others. Resident #47 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS reflected Resident #47 had inattention and disorganized thinking that fluctuated. Resident #47 had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #47 had a functional limitation in range of motion that interfered with daily functions or placed him at risk for injury to one side of his lower extremities, and he used a wheelchair. Resident #47 usually required partial/moderate assistance with showering, which reflected the helper completed less than half of the effort. Record review of the comprehensive care plan, dated 01/20/2026, reflected Resident #47 required assistance with ADLs. The interventions included: assist with daily care needs and daily living tasks and encourage to do as much as possible for self. Record review of the CNA Flow Sheet reviewed on 02/24/2026, dated 02/02/2026 to 02/24/2026, reflected Resident #47 received only one shower on 02/06/2026. During an observation and interview on 02/23/2026 at 9:26 a.m., Resident #47 was lying in bed with the head of his bed elevated slightly. His hair was cut short, and he had white and gray stubble around his mouth, on his cheeks, and his neck. He was wearing an black and yellow shirt. Resident #47 reported he did not always get his scheduled showers. He said he has only received a handful since being admitted to the facility. Resident #47 stated his shower days were Tuesday, Thursday, and Saturday. He said he did not receive his shower on Saturday. During an observation and interview on 02/24/2026 at 10:44 a.m., Resident #47 asked LVN O for a shower. He stated it had been days since he received a shower and he had been asking for it. LVN O said his shower was scheduled for 2 p.m. Resident #47 stated he preferred his showers in the morning time. He was wearing the same clothing from 02/23/2026. During an interview on 02/25/2026 at 2:09 p.m., CNA N stated she worked for agency and had been assigned to Resident #47's hallway. CNA N stated she had only been assigned to the right side of 100 hall, but ended up with all the residents on 100 hall, because staff had called in. CNA N stated it was impossible for her to complete all her assigned tasks including showers. CNA N was unable to remember if Resident #47 received his shower. CNA N said it was important to ensure showers were completed to prevent skin issues. CNA N stated it was important to maintain good hygiene. 4. Record review of an undated face sheet revealed Resident #77 was a [AGE] year-old female admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and bipolar disorder (a mental health condition characterized by intense mood swings, alternating between high-energy manic or hypomanic episodes and low-energy depressive episodes). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #77 had a BIMS score of 99 which indicated severe cognitive impairment. She had short- and long-term memory impairment and had moderately impaired decision-making ability. It revealed he had no behavior and had not refused care. Resident #77 required dependent assistance for bed mobility, bathing, personal hygiene, dressing, and transfer. Resident #77 was incontinent of bowel and bladder. Record review of the care plan dated 11/07/2025 revealed Resident #77 was dependent for ADLs and required complete staff assistance for personal hygiene and bathing. Record review of the February 2026 ADL sheet, reviewed on 02/25/2026, printed 02/25/2026 revealed Resident #77 had not been bathed in February of 2026. Resident #77 was scheduled to have a shower on Monday, Wednesday, and Friday. She received 0 of 11 scheduled showers in February. Resident #77's last recorded shower was 01/27/2026 During an observation on 02/23/2025 at 9:40 a.m., Resident #77 had a foul odor of ammonia and body odor. Resident #77 was unable to communicate her last bath. 5. Record review of an undated face sheet revealed Resident #78 was [AGE] years old and admitted to the facility on [DATE] with diagnoses which including quadriplegia (paralysis affecting all four limbs and the torso, typically caused by cervical spinal cord injury), seizures, and high blood pressure. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #78 was sometimes understood and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sometimes understood others. The MDS indicated Resident #78 was unable to complete the BIMS interview. The MDS indicated Resident #78 was dependent on staff for all ADLs. Record review of Care Plan last revised 01/07/26 indicated Resident #78 was dependent on staff for all ADLs. There was an intervention to assist the resident with daily care needs and daily living tasks. The care plan indicated the resident had a diagnosis of quadriplegia with an intervention to provide assistance with ADLs. Record review of a CNA Flow Sheet dated 02/01/26 - 02/25/26 did not indicate any baths were given during that time period. The flow sheet did not indicate any refusals from the resident. Record review of an undated photo provided by Resident #78's family member revealed brown rings were on the pad under Resident #78 in his room. During an interview on 02/23/26 at 11:21 a.m., a family member for Resident #78 said he did not always get his baths. The family member said he was not gotten out of bed for showers. During an interview on 02/25/26 at 10:18 a.m., a family member for Resident #78 said the facility was not showering him. The family member said they had to come to the facility to wash and bathe him. The family member said his bottom was not being cleaned good and when she washed him, he was still dirty. The family member said they also had to do his oral care. The family member said they had come to the facility, and his eyes were crusty. The family member said there was dry stuff on his face and boogers coming out of his nose. She said she found brown rings on the pads that were under his bottom. During an interview on 02/25/26 at 11:53 a.m., CNA QQ said they did not have enough staff. She said there were residents that did not get baths because she could not get to them. She said they used to have a shower aide, but she left. She said she had never seen Resident #78 up in the shower. She said she had only known him to get bed baths. She said he had not missed any baths that she was aware of. 6. Record review of an undated face sheet revealed Resident #90 was a [AGE] year-old female admitted on [DATE] with diagnoses of heart failure, obesity, and hypothyroidism (abnormally low activity of the thyroid gland). Record review of an annual MDS assessment dated [DATE] revealed Resident #90 had a BIMS score of 14 indicating intact cognition. She required dependent assistance with ADLs. Resident #90 was incontinent of bowel and bladder. Record review of the February 2026 ADL sheet reviewed 02/25/2026 revealed Resident #90 had not been bathed in February of 2026. Resident #90 was scheduled to have a shower on Monday, Wednesday, and Friday. He received 0 of 11 scheduled showers in February. Record review of the January and February 2026 ADL sheet reviewed 02/25/2026 revealed the following documented number of times incontinent care was performed by staff for Resident #90: January 2026 ˆ February 2026-Day shift- 3 times -Day shift- 0 times-Evening shift-13 times -Evening shift-4 times-Night shift- 18 times -Night shift- 18 times During an observation and interview on 02/23/2026 at 9:30 a.m., Resident #90 stated she had not been bathed this month. She stated the facility was short on staff, and one aide cannot bathe all the people on the hall. She stated she knows she smells and her vagina was raw from urine and not getting a bath. She stated it was embarrassing to smell of urine and feel so dirty. Resident #90 stated she would report to the administrator, but he was out sick, and she never got to have a care plan meeting. She stated she had called the ombudsman for advice. Resident #90 stated she was out of things to do to make sure she was getting a bath and she felt defeated. Resident #90 stated she was having a major problem with the staff keeping her clean and dry. She stated on average she was cleaned and dried (incontinent care) once per shift. She stated on 2 occasions, this month, she had gone more than an entire day without being cleaned. She stated the CNAs often put blankets under her to catch the urine and keep the sheets dry. She stated she allowed them to do so because it was better than lying on a wet mattress. Resident #90 stated it had gotten so bad she reached out to the ombudsman because the social worker and DON were not doing anything to remedy the situation. She stated she felt it was her right to be cleaned and dry. She stated she understood that she was a bigger lady, and it took more than one person to perform pericare on her, but she still had the right to be clean and dry. During an observation and interview on 02/24/2026 at 10:45 a.m., CNA B and CNA D entered the room of Resident #90 to perform pericare. CNA B began pericare. During removal of the brief for Resident #90 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	it was noted the brief was completely saturated and urine visibly leaked from it as it was tucked under the resident to remove it, saturating the sheets. The strong smell of ammonia was present. CNA B stated this was the first time I touched her (Resident #90) today. She stated night shift had to have put the two blankets under her, because she did not double pad people. Resident #90 stated it was the first time she had been changed since around 2:00 a.m. and skin was sore on her thighs, buttock and vagina from being wet so long. During a phone interview on 02/24/2026 at 11:20 a.m., CNA E stated she worked the 2-10 shift. She stated it was hit or miss on having enough staff to get everything done in a shift. She stated the facility paid a $2.00 per hour shift differential to work 2-10 so it was the best staffed shift in the building. CNA E stated, since the beginning of February because of tax season and people receiving their tax returns, staffing had been short at least 2-3 shifts she worked per week to the point she could not bathe the residents she was assigned to bathe. She stated even with enough staff, there were care needs that are left unmet (oral care, hair care, denture cleaning, clipping nails) because it was too much to handle. She stated until about 2 months ago, the facility had a person designated as a shower aide and that took a lot of pressure off the CNAs trying to do all the care for each resident. Since the showers or baths were the responsibility of the floor CNAs, it was not always possible to complete baths, and she rarely was able to chart. During a phone interview on 02/24/2026 at 11:40 a.m., CNA F stated she worked all shifts. She stated the staffing coordinator was constantly asking for her to work over or another shift. She stated day shift was short and night shift was short. She stated the 2-10 shift was staffed well. CNA F stated during night shift, it was impossible to keep everyone clean and dry, and turned. CNA F stated she knew the residents are upset by the amount of time it takes to answer the call light, but when they are in a room, we cannot stop what we are doing to answer the light. She stated, at most, there were 4 CNAs, and nurses did not do CNA work because they had more than enough work of their own to complete. She stated, at best, 2 rounds would be done on each resident. She started her last round around 2:30 a.m. to ensure she got through everyone by 5:30 a.m. She stated it was possible that when day shift came on, the resident had not had incontinent care since 2:30 a.m. CNA F stated not getting incontinent care timely can lead to skin breakdown. During an interview on 02/25/2026 at 2:00 p.m., the Ombudsman stated she had visited Resident #90 and reported her care concerns of not being changed and bathed timely, due to not enough staff, to the DON and Administrator. She stated she told Resident #90 to contact the state and make a complaint against the facility if the care did not improve after letting them know the issues. 7. Record review of an undated face sheet revealed Resident #104 was [AGE] years old and admitted to the facility on [DATE] diagnoses including high blood pressure, malignant neoplasm of larynx (a common head and neck cancer, predominantly squamous cell carcinoma, that affects the voice box), and pain. Record review of Resident #104's electronic medical record accessed on 02/25/26 did not indicate a complete MDS. Record review of a baseline care plan for Resident #104 dated 02/20/26 indicated was independent with decision making skills. No indication of ADL status was noted. Record review on 02/25/2026 of a CNA Flow Sheet for Resident #104 dated 02/20/26 - 02/25/26 did not indicate any baths were given. The flow sheet did not indicate any refusals from the resident. During an interview on 02/25/26 at 10:56 a.m., Resident #104 said he had not had a bath since he was admitted to the facility on [DATE]. He said he had only had a light wipe down. He said at the very least a bed bath would feel good. He said he could not walk so a shower would be hard to do. During an interview on 02/25/2026 at 2:00 p.m., the Staffing Coordinator stated it was her responsibility to schedule CNAs, nurses and medication aides. She stated CNA staffing had been a challenge over the last few months. She stated she often worked as a nurse on the floor or a CNA and that all department heads had a call rotation that required them to work the floor if no one else could be found to work the shift. She stated she was instructed to staff 7 CNAs on day shift, 7 CNAs on evening shift, and 4 CNAs on night shift to stay in budget. She was not familiar with the facility assessment and stated she has never had permission to staff with 9 CNAs on days and evenings. She stated with so many residents in isolation the facility really needed the 9 CNAs on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	days and evenings. During an interview on 02/25/2026 at 3:00 p.m., the DON stated she was directed by corporate to staff 7 CNAs on days, 7 CNAs on evenings, and 4 CNAs on night shift. She stated she understood those numbers were not met several days in February 2026. She stated there were some vacancies, but corporations were allowing them to use agency to assist with staffing. She stated the acuity of the residents went up drastically over the last couple of weeks related to the COVID outbreak. She stated most of them were not acutely ill, but they still require full PPE isolation, and that is time consuming. She stated there are ads on employment sites with sign on bonuses, they pay shift differential, they are using agency as of 3 days ago, and they have a referral program to assist with getting staff. The DON stated that the census has grown rapidly in the past 2 months and she was not able to hire people fast enough to fill the positions. She stated she felt much of the missed ADL care was related to mismanagement of time. During an interview on 02/25/2026 at 4 p.m., the Administrator stated the facility did not have any written policies or procedures related to staffing levels. She stated the facility went by the acuity level of the residents and census number to determine how many CNAs were assigned each shift. The Administrator stated the facility had 3 CNA vacancies and several staff out with COVID, but they had sign on bonuses and were using staffing (agency) as of 02/21/2026 to supplement the staff. The Administrator stated she was unaware of the facility assessment numbers because she was interim and had not reviewed the data. Record review of the PBJ staffing Data Report indicated the facility triggered for a one-star staff rating (a one-star staffing rating from the Center for Medicare and Medicaid Services [CMS] indicates much below average nursing home staffing levels, based on 6 key measures including RN hours, total nurse hours, weekend staff, and staff turnover. This rating often results from low staffing levels below 155 points, poor retention, and high turnover) for quarter 4 of 2025. Record review of the facility assessment dated [DATE] revealed the following information:The facility typically hadhas the following average number of staff in the departments listed in the table below, in order to meet the staffing requirements and acuity level of residents/patients for the current census. Adjustments are made when the census or acuity levels increase to continue to meet the requirements and the acuity level of the residents. The average census range is 88-96. Certified Nurses' Aide (CNA): Ratio may vary due to resident needs: 9 Per Day shift 9 Per Evening shift 4 Per Night shift Record review of the ?COVID Positive Resident Log' printed on 02/24/2026 revealed 34 active COVID infections requiring isolation. Record review of the ?Detailed Punch Sheet' printed on 02/24/2026 revealed the following numbers of CNAs that worked each shift each day: Date Day Shift Evening Shift Night Shift02/14/26 4 3.5 302/15/26 4 3.5 302/16/26 4 6.5 3.502/17/26 4 8 202/18/26 7 6.5 1.502/19/26 5 3 302/20/26 4 5.5 302/21/26 6 8.5 4.502/22/26 4 4 402/23/26 5 7 2.5 Record review of the daily census on 02/25/2026 revealed an average census of 87 residents for the dates of 02/14/206- 02/23/2026. Requested ?Staffing Policy' from Administrator on 02/25/2026 at 11:00 a.m., and she stated there was not a policy specifically for staffing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements.1. The facility failed to label and securely store a large white opened bag containing tan/brown granulated particles (identified as breadcrumbs by [NAME] LL) on 2/23/26.2. The facility failed to ensure DA MM wore a beard covering to cover facial hair while in the kitchen or a mask on 2/23/26 and 2/24/26.3. The facility failed to ensure [NAME] NN performed hand hygiene after pulling up her mask multiple times while preparing pureed (smooth pudding-like) foods on 2/24/26.4. The facility failed to ensure DA OO and DA PP performed hand hygiene after taking a meal ticket from a resident and a meal ticket from a staff member back into the kitchen on 2/24/26.5. The facility failed to ensure DA OO performed hand hygiene after pulling up his mask twice while prepping meal trays during meal service on 2/24/26.These failures could place residents at risk of food contamination and spread of illness.Findings included:During initial tour observations and interviews in the kitchen on 2/23/26 beginning at 9:10 AM, there was a large white paper bag of tan/brown granulated particles in a plastic trash bag lying flat on the bottom shelf of the dry pantry. The bag was not labeled or securely closed and was open to air with a piece of blue tape, with 1/4/26 wrote on it. [NAME] LL said it was breadcrumbs and the bag should have been tied up or the contents of the bag placed in a container. [NAME] LL said she had been off the weekend and did not know when the last time the bag had been used to feed the residents. [NAME] LL said with the bag of breadcrumbs being left open, anything such as bugs could get in it and it could make the residents sick. The DM entered the dry pantry, and he said the date on the bag was the date the bag was opened. The DM said the bag of breadcrumbs should be in a storage container or at least tied up securely to keep bugs out because it could make the residents sick. All staff in the kitchen were wearing masks, except DA MM. DA MM also was not wearing any facial covering to cover his approximately 1/2-inch mustache or sideburns. DA MM was preparing/pouring glasses of tea and water and placing on meal trays. Surveyor asked DA MM why everyone else was wearing a mask in the kitchen, he said he should be wearing a mask also due to the COVID outbreak to not spread germs or COVID. DA MM said if they were not in a COVID outbreak, he should have been wearing a beard cover to keep hair out of the residents' food. DA MM said not wearing a mask or not wearing a beard cover could make the residents' sick.During an observation and interviews on 2/24/26 beginning at 10:34 AM, [NAME] NN prepared pureed foods. [NAME] NN dipped noodles from a pot on the stove into a pan to bring to the blender. [NAME] NN used her right hand three times to pull up her mask and then proceeded to dip the noodles into the blender. [NAME] NN then placed the scoop inside the pan of noodles, and the scoop handle fell into the noodles when she left to go get milk. [NAME] NN microwaved the milk, and said the recipe required the milk to be warm. [NAME] NN then blended the noodles and milk; then [NAME] NN said the consistency was too thin. [NAME] NN then used the same scoop to add more noodles to the mixture. [NAME] NN washed her hands after washing the blender. [NAME] NN used her bare right hand to pull up her mask over her nose, then got the clean blender bowl, set it on the blender, and placed the blade inside the bowl with her same right bare hand.During on observation on 2/24/26 at 11:52 AM, DA MM came from the back of the kitchen and walked through the kitchen, out the doors into the dining area, and walked to the front area of the facility and without wearing a mask or a beard cover. DA MM then came back to the kitchen and put on a mask. DA MM had approximately 1/2-inch mustache and sideburns.During an observation on 2/24/26 at 12:00 PM, DA OO wrapped silverware and placed it on meal trays, added condiments, placed the cover over the food, and placed the meal trays on the meal cart on the opposite side of the food line. A resident came to the kitchen door and requested an alternate meal and handed her meal ticket to DA OO. and he handed the meal ticket to DA PP, who was setting up the meal trays with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	drinks and desserts, and placed the meal trays on the food line. DA PP handed the meal ticket to the DM. DA OO and DA PP did not wash or sanitize their hands after handling the meal ticket, continued to set up the meal trays, and placed them on the meal cart to be delivered to the other residents.During an observation on 12/24/26 at 12:17 PM, DA OO pulled his mask up twice, did not wash or sanitize his hands, continued setting up meal trays, wrapping silverware, adding condiments, covering the food, and placing the meal trays on the meal cart.During an observation on 12/24/26 at 12:37 PM, a staff member brought another resident's meal ticket to the kitchen and handed it to DA OO, and he handed it to DA PP. DA PP placed the meal ticket on a wire shelf in front of her. DA OO and DA PP did not wash or sanitize their hands after handling the meal ticket brought in from outside the kitchen and continued prepping meal trays for other residents.During an interview on 2/26/26 at 10:20 AM, the DM said he had worked at the facility for four months. The DM said the cook on Monday had opened the breadcrumbs to make pureed bread and forgot to close it back. The DM said the bag of breadcrumbs should have been tied up securely and labeled with an expiration date as well as an open date. The DM said staff should wash their hands after touching their face or anything. The DM not washing your hands after touching your face or mask would be cross-contamination and could make residents sick. The DM said when kitchen staff took a meal ticket from a resident or staff from outside the kitchen, it was cross-contamination and staff should have washed or sanitized their hands or let him know to help after touching the meal ticket. The DM said DA MM had worked at the facility for two months and DA MM did not know he could get a beard cover from his office when they were out where the beard covers were normally kept outside the kitchen. The DM said DA MM should have been wearing a mask in the kitchen, and the DM said he was supposed to have gotten DA MM one, but he had forgotten. The DM said if staff were not wearing masks during the COVID outbreak, it could make residents sick along with his staff as well. The DM said he would discuss the issues with DA MM.During an interview on 2/26/26 at 12:47 PM, DA PP said she had worked at the facility for about a year. DA PP said handling a meal ticket given back to them from a resident or staff member from outside the kitchen and not washing or sanitizing their hands during meal service was cross-contamination and could spread infection, especially with this COVID outbreak. DA PP said she knew not to accept a meal tray back into the kitchen, and she did not think about a piece of paper but could see where that was also cross-contamination. DA PP said staff should always wash or sanitize hands after touching their face, especially with this COVID now with the mask.An attempt was made to contact DA OO on 2/26/26 at 12:50 PM by phone. There was no answer and inability to leave a voicemail due to the mailbox being full. A detailed text message was sent, requesting a returned call. DA OO did not respond prior to exiting the facility.During an interview on 2/26/26 at 1:21 PM, [NAME] NN said she was aware she pulled up her mask multiple times and tried to wash her hands every time, but knew that she failed that too. [NAME] NN said she had been tested for COVID the last day she worked and it was negative. [NAME] NN said she had been sick and feeling bad all week. [NAME] NN said not washing or sanitizing hands after pulling her mask up caused cross-contamination and could make residents sick.During an interview on 2/26/26 at 1:52 PM, the [NAME] President of Nutrition said she did not observe the staff handling their masks and meal tickets from outside the kitchen and not washing or sanitizing their hands. The [NAME] President of Nutrition said their policy was anytime staff touch their face; they should wash their hands and change gloves. The [NAME] President of Nutrition said to refer to the ADON in regard to staff wearing masks in the kitchen. The [NAME] President of Nutrition said their policy said all facial hair should be covered with a restraint. The [NAME] President of Nutrition said staff should wash their hands anytime they changed tasks or washed anything to prevent cross-contamination.During an interview on 2/26/26 at 2:42 PM, the DON said she was responsible for ensuring Infection Prevention was being done in the absence of the ADON. The DON said at that time, all staff should be wearing masks, including kitchen staff. The DON said all staff were wearing masks to protect other staff and the residents. The DON said COVID was like a wildfire in the facility because a lot of the positive cases did not have any symptoms.During an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675444	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview on 2/26/26 at 3:03 PM, the ADM said she would expect staff to follow the policies of the facility in the kitchen. The ADM said not following proper sanitation in the kitchen could cross-contaminate and spread germs and illness. The ADM said they recommended staff to wear masks in the facility during the COVID outbreak, but they were not required.Record review of the facility's policy titled Food Storage dated revised February 6, 2024, indicated . Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination . 1. Storeroom: . Air-tight containers or bags are used for all opened packages of food . All containers are accurately labeled with the item and the date opened .Record review of the facility's policy titled General Food Preparation and Handling dated revised February 6, 2024, indicated . Food items are prepared to conserve maximum nutritive value, develop and enhance flavor and to be free of harmful organisms and substances . 4. Food is prepared with clean tongs, scoops . to avoid manual contact of prepared foods .Record review of the facility's Nutrition Services policy titled Employee Infection Control dated revised April 8, 2025, indicated . All local, state, and federal standards and regulations are followed to ensure a safe and sanitary Nutrition Service Department . 1. Employees that have symptoms of communicable diseases . are not permitted to work in the kitchen . 5. Anyone who enters the kitchen will have all hair restrained using mesh or net bouffant caps and beard guards (as needed) . 7. Employees will wash their hands before handling food in preparation .Record review of the facility's Infection Control policy titled Coronavirus 2-2019;SARS-CoV-2; COVID-19 dated revised March 2025, did not address the use of masks as source control (prevention) during COVID outbreak.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 13 of 34 residents (Resident's #7, #17, #18, #22, #26, #29, #31, #41, #51, #66, #71, #83, and #85) reviewed for infection control practices.1. The facility failed to ensure facility staff followed infection control protocol during a COVID-19 outbreak at the facility.2. The facility failed to ensure the staff had access to the required PPE supplies for COVID positive rooms on 100 hall, on 02/23/2026, 02/24/2026, and 02/25/2026.3. The facility failed to ensure CNA N wore the required PPE while delivering meal trays to Resident's #7, #17, #18, #22, #26, #51, #66, #71, and #83, who were COVID positive and on droplet/respiratory isolation on 02/23/2026.4. The facility failed to ensure admission Coordinator (AC) J wore the required PPE while delivering a meal tray to Resident #29, who was COVID positive and on droplet/respiratory isolation on 02/23/26.5. The facility failed to ensure admission Coordinator (AC) J washed and sanitized hands after existing Resident 29's room, who was on droplet/respiratory isolation, prior to opening the ice chest on 400 hall and using the ice scoop to get ice in two cups then placed the ice scoop back in the storage area on 02/23/26.6. The facility failed to ensure the Dietary Manager (DM) wore the required PPE while delivering meal trays to Resident #41 and Resident #85 in room [ROOM NUMBER], who were COVID positive and on droplet/respiratory isolation on 02/23/26.7. The facility failed to ensure LVN T wore an N-95 mask and face shield or googles while performing Resident #26's blood sugar check, who was COVID positive, on 02/25/2026.8. The facility failed to ensure LVN T wore an N-95 mask, isolation gown, gloves, and a face shield or googles while in Resident #22's room, who was COVID positive, on 02/25/2026.9. The facility failed to ensure LVN O changed his gloves and performed hand hygiene after checking Resident #31's blood sugar and before administering her enteral tube medication on 02/24/2026.These failures could place residents and staff at risk for cross contamination, the spread of infections, and complications from the spread of COVID-19; an infectious disease.The findings included: 1. Record review of the face sheet, dated 02/25/2026, reflected Resident #7 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (a progressive lung condition that makes it difficult to breath). Record review of the quarterly MDS assessment, dated 02/21/2026, reflected Resident #7 had unclear speech, was sometimes understood, and was usually able to understand others. Resident #7 had a BIMS score of 5, which indicated severe cognitive impairment. He had no shortness of breath during the look-back period. The MDS reflected he was on isolation precautions for an active infection disease. Record review of the comprehensive care plan, dated 02/17/2026, reflected Resident #7 was on isolation precautions related to COVID. The interventions included: Respiratory/droplet isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of Resident #7's active orders report, dated 02/26/2026, reflected an order which started 02/18/2026 for Isolation: Droplet/Respiratory. 2. Record review of the face sheet, dated 02/25/2026, reflected Resident #17 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of personal history of COVID-19 and cancer with neutropenia (too few white blood cells). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the quarterly MDS assessment, dated 01/15/2026, reflected Resident #17 had clear speech, was understood, and was usually able to understand others. Resident #17 had a BIMS score of 7, which indicated severe cognitive impairment. Resident #17 had no shortness of breath during the look-back period. Record review of the comprehensive care plan, dated 02/20/2026, reflected Resident #17 was on isolation related to COVID. The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #17 had no order for isolation precautions. 3. Record review of the face sheet, dated 02/25/2026, reflected Resident #18 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of non-ST elevation heart attack and neutropenia (too few white blood cells). Record review of the admission MDS assessment, dated 02/102/2026, reflected Resident #18 had clear speech, was understood, and was able to understand others. Resident #18 had a BIMS score of 13, which indicated no cognitive impairment. Resident #18 had no shortness of breath during the look-back period. Record review of the comprehensive care plan, dated 02/17/2026, reflected Resident #18 was on isolation precautions related to COVID. The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #18 had an order, which started on 02/18/2026, for Isolation: Droplet/Respiratory. 4. Record review of the face sheet, dated 02/25/2026, reflected Resident #22 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Non-Hodgkin lymphoma (blood cancer), cancer of the larynx, and COVID-19. Record review of the quarterly MDS assessment, dated 02/23/2026, reflected Resident #22 had clear speech, was understood, and was able to understand others. Resident #22 had a BIMS score of 6, which indicated severe cognitive impairment. Resident #22 had no shortness of breath during the look-back period. The MDS reflected Resident #22 was on isolation precautions for an active infectious disease. Record review of the comprehensive care plan, dated 02/25/2026, reflected 02/25/2026, reflected Resident #22 was on isolation precautions related to COVID. The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #22 had an order, which started on 02/18/2026, for Isolation: Droplet/Respiratory. 5. Record review of the face sheet, dated 02/25/2026, reflected Resident #26 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (a progressive lung condition that makes it difficult to breath). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the quarterly MDS assessment, dated 02/20/2026, reflected Resident #26 had clear speech, was understood, and was able to understand others. Resident #26 had a BIMS score of 15, which indicated no cognitive impairment. Resident #26 had shortness of breath while lying flat and was on isolations precautions for an active infectious disease. Record review of the comprehensive care plan, dated 02/17/2026, reflected Resident #26 was on isolation precautions related to COVID. The interventions included: The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #26 had an order, which started on 02/16/2026 for Isolation: Respiratory/Droplet. 6. Record review of Resident #29's face sheet dated 02/25/2026 indicated he was [AGE] years old and was admitted to the facility on [DATE] and re-admitted [DATE]. Resident #29 had diagnoses which included non-progressive motor disorder resulting in involuntary, slow, and writhing (twisting) or jerky movements. Record review of Resident #29's annual MDS assessment dated [DATE] indicated he was usually understood and usually understood others. Resident #29 had a BIMS score of 00, which indicated he had severe cognitive impairment. Resident #29 was required set-up or clean-up assistance with eating. Resident #29 required substantial assistance to dependent on staff for most other ADLs. Record review of Resident #29's Care Plan dated 02/25/2026 indicated he was on isolation related to COVID positive with interventions of isolation per physician order, post signs at resident's door informing visitors to check in with licensed staff prior to entering, and protective personal equipment to be worn. Record review of Resident #29's Order Summary Report dated 02/25/2026 indicated an order for droplet/respiratory isolation with a start date of 02/18/2026. Record review of Resident #29's Interdisciplinary progress notes dated 02/18/2026 indicated he had tested positive for COVID-19. 7. Record review of Resident #41's face sheet dated 2/26/26 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #41 had diagnoses which included cerebral palsy (permanent, non-progressive neurological-brain disorder appearing in infancy that affects movement, posture, and muscle tone). Record review of Resident #41's annual MDS assessment dated [DATE] indicated she had a BIMS score of 7, which indicated she had severe cognitive impairment. Resident #41 was independent with eating. Record review of Resident #41's Care Plan dated 2/25/26 indicated she was on isolation related to COVID positive with interventions of droplet/respiratory isolation per physician order, post signs at resident's door informing visitors to check in with licensed staff prior to entering, and protective personal equipment to be worn. Record review of Resident #41's Order Summary Report dated 2/25/26 indicated an order for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	droplet/respiratory isolation with a start date of 2/18/26. Record review of Resident #41's Interdisciplinary progress notes dated 2/24/26 indicated she was positive for COVID-19. 8. Record review of the face sheet, dated 02/25/2026, reflected Resident #51 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of cerebral palsy (group of permanent, non-progressive neurological disorders appearing in infancy or early childhood that affects body movement, muscle tone, balance, and posture). Record review of the quarterly MDS assessment, dated 11/27/2025, reflected Resident #51 had no speech, was rarely/never understood by staff, and was sometimes able to understand others. Resident #51's BIMS was unable to be assessed. The staff assessment for mental status reflected Resident #51's long-term and short-term memory was okay. She was able to recall the location of her own room and staff names and faces. Resident #51 had severely impaired decision-making ability. Resident #51 had no shortness of breath during the look-back period. Record review of the comprehensive care plan, dated 02/20/2026, reflected Resident #51 was on isolation precautions related to COVID. The interventions included: The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #51 had no order for isolation precautions. 9. Record review of the face sheet, dated 02/25/2026, reflected Resident #66 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of COVID. Record review of the quarterly MDS assessment, dated 01/23/2026, reflected Resident #66 had clear speech, was understood, and was able to understand others. Resident #66 had a BIMS score of 12, which indicated moderately impaired cognition. Resident #66 had no shortness of breath during the look-back period. Record review of the comprehensive care plan, dated 02/17/2026, reflected Resident #66 was on isolation precautions related to COVID. The interventions included: The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #66 had an order, which started on 02/18/2026 for Isolation: Respiratory/Droplet. 10. Record review of the face sheet, dated 02/25/2026, reflected Resident #71 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of fractures to her back and ribs and COVID. Record review of the quarterly MDS assessment, dated 12/04/2025, reflected Resident #71 had clear speech, was understood, and was able to understand others. Resident #71's BIMS assessment was not assessed. Resident #71's short-term and long-term memory was okay. She was able to recall the current season, location of own room, and that she was in a nursing home. She had independent (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	decision-making ability. Resident #71 had no shortness of breath during the look-back period. Record review of the comprehensive care plan, dated 02/20/2026, reflected Resident #71 was on isolation precautions related to COVID. The interventions included: The interventions included: droplet/respiratory isolation, protective personal equipment to be worn, and infection control practices as indicated. Record review of the active orders report, dated 02/26/2026, reflected Resident #71 had no order for isolation precautions. 11. Record review of Resident #85's face sheet dated 02/25/2026 indicated she was [AGE] years old and was admitted to the facility on [DATE] initially and re-admitted on [DATE]. Resident #85 had diagnoses which included hemiplegia (unable to move one side of body) and hemiparesis (weakness of one side of body) following cerebral infarction (stroke-brain tissue damage caused by block blood flow to brain). Record review of Resident #85's reentry MDS assessment dated [DATE] indicated she had a BIMS score of 14, which indicated she was cognitively intact. Resident #85 was independent with eating. Record review of Resident #85's Care Plan dated 02/25/2026 indicated she was on isolation related to COVID positive with interventions of droplet/respiratory isolation per physician order, post signs at resident's door informing visitors to check in with licensed staff prior to entering, and protective personal equipment to be worn. Record review of Resident #85's Order Summary Report dated 02/25/2026 indicated an order for droplet/respiratory isolation with a start date of 02/18/2026. Record review of Resident #85's Interdisciplinary progress notes dated 02/18/2026 indicated she tested positive for COVID-19. During an observation on 02/23/2026 between 12:48 p.m., and 1:10 p.m., CNA N passed meal trays to every room on hall 100 without the use of PPE (gown, gloves, N95 mask, or face shield or goggles) on the COVID positive rooms. CNA N went from COVID positive rooms to COVID negative rooms. Residents #7, #17, #18, #22, #26, #51, #66, and #71 were COVID positive and the use of PPE was required for each room. During an observation on 02/23/2026 beginning at 1:12 p.m., staff were passing meal trays on hall 400. The Dietary Manager (DM) was assisting in passing meal trays and he entered room [ROOM NUMBER]. The room had a sign on the door that read Droplet Precautions - STOP-EVERYONE MUST: CLEAN THEIR HANDS, INCLUDING BEFORE ENTERING AND WHEN LEAVING THE ROOM-Make sure eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. The DM only wore a KN95 mask (high-efficiency, disposable respirators) and did not wear gloves, gown, or face shield/goggles. The DM took a meal tray into room [ROOM NUMBER] and then carried out a meal tray and then touched the meal cart with his fingers of right hand looking at meal labels and then carried the meal tray down the hallway toward the kitchen. The DM did not sanitize his hands when he came out of room [ROOM NUMBER]. Then at 1:17 PM, the DM returned carrying a meal tray and re-entered room [ROOM NUMBER], only wearing a KN95 mask, no gloves, gown, or face shield/goggles and delivered a meal tray to Resident #85. The DM then exited the room and sanitized his hands. The DM then re-entered room [ROOM NUMBER] wearing only a KN95 mask, no gloves, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gown, or face shield/goggles, and delivered a meal tray to Resident #41 and set up items on the bedside table and then brought a cup out of the room and carried it down the hallway toward the kitchen. The DM did not sanitize his hands when he came out of the room. Then at 1:23 PM, the DM went back into room [ROOM NUMBER] wearing only a KN95 mask, no gloves, gown, or face shield/goggles, with another cup, delivered it to Resident #41, and came out and sanitized his hands. At 1:25 PM, AC J was assisting in passing meal trays on hall 400. AC J took a meal tray into room [ROOM NUMBER] (Resident #29) and placed on his bedside table, wearing only a surgical mask, no gloves, gown, or face shield/goggles. There was a sign on the door of room [ROOM NUMBER] that read Droplet Precautions - STOP-EVERYONE MUST: CLEAN THEIR HANDS, INCLUDING BEFORE ENTERING AND WHEN LEAVING THE ROOM-Make sure eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit. Then LVN G donned required PPE and pulled the meal cart with the roommate's tray to the doorway of room [ROOM NUMBER] and met AC J as she was exiting the room. LVN G then handed AC J two cups off the meal tray and asked AC J to put ice in the cups. AC J took the cups without sanitizing her hands after exiting the room. AC J then went to the ice chest on the 400 hall, pulled the ice scoop from the side pocket and proceeded to fill both cups with ice. AC J placed the scoop back in the storage area and returned the cups to LVN G. AC J then sanitized her hands. At 1:27 PM, the DM returned and took a cup of water into room [ROOM NUMBER], only wearing a KN95 mask; no gown, gloves, or face shield/goggles. The DM then came out of room [ROOM NUMBER] and sanitized his hands. During an observation on 02/23/2026 between 2:15 p.m., and 3:30 p.m., the following was observed: Resident #22, who was COVID positive, had no gloves or N-95 masks inside the PPE supply cart in his room. Resident #51, who was COVID positive, had no face shield or goggles, or N-95 masks inside the PPE supply cart in her room. Resident #17 and Resident #83, who were COVID positive, had no face shield or goggles, or N-95 masks inside the PPE supply cart in the hallway. Resident #7, who was COVID positive, had no gloves, face shield or goggles, or N-95 masks inside the PPE supply cart in the hallway. During an observation and interview on 02/25/2026 at 6:23 a.m., LVN T entered Resident #26's room wearing a KN-95 mask with no face shield or goggles. LVN T stated a KN-95 mask was appropriate to wear inside a COVID positive room and a face shield or goggles were optional. She stated there was no difference between the N-95 mask or the KN-95 mask. During an observation on 02/26/2026 at 10:00 a.m., LVN T was in Resident #22's room with a surgical mask, no isolation gown, no gloves, no face shield or goggles. She was assisting him with items on his bedside table. 12. Record review of the face sheet, dated 02/25/2026, reflected Resident #31 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of gastrointestinal hemorrhage (bleeding in the stomach or intestinal tract), dysphagia (difficulty swallowing), and gastrostomy status (surgically created opening in the stomach wall). Record review of the quarterly MDS assessment, dated 07/14/2026, reflected Resident #31 had clear speech, was usually understood, and was sometimes able to understand others. Resident #31 had a BIMS score of 03, which indicated severe cognitive impairment. The MDS reflected Resident #31 had a feeding tube and received 51% or greater total calories through the feeding tube. Record review of the comprehensive care plan, dated 10/17/3025, reflected Resident #31 had a feeding tube necessary for nutritional needs due to dysphagia. The interventions included: monitor for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tube dislodgment, blockage, or leakage; monitor feeding tube site for redness or signs of infection; and observed tube placement before each feeding. Record review of Resident #31's active orders report, dated 02/26/2026, reflected an order which started 09/05/2025 for lorazepam 0.5 mg tablet via enteral tube three times a day, hold for sedation. Record review of the MAR, dated February 2026, reflected Resident #31 received lorazepam 0.5 mg via enteral tube three times a day. During an observation on 02/24/2026 at 11:28 a.m., LVN O checked Resident #31's blood sugar. After he was finished checking Resident #31's blood sugar, he continued proving care. LVN O administered Resident #31's medications with the same gloves used to check her blood sugar. During an interview on 02/24/2026 at 11:43 a.m., LVN O stated he normally changes gloves after checking Resident #31's blood sugar, but he was nervous with the surveyor watching him. LVN O stated it was important to ensure he changed his gloves and performed hand hygiene to prevent the spread of germs. LVN O stated gown, gloves, and an N-95 mask were required in COVID positive rooms. He said the face shield or goggles were optional. He stated he was unsure why there were no PPE supplies available on the 100 hall. He was unsure where to get PPE supplies or who stocked them. LVN O stated he was unsure if it was okay to take meal trays inside a room with no PPE. He stated it was important to wear the required PPE inside a COVID positive room to keep the residents safe and not bring any germs back out of the room. During an interview on 02/25/2026 at 11:48 a.m., AC J said she had worked at the facility for 5-6 years. AC J said she had not received any formal training on passing meal trays. AC J said she had received training on what PPE was required to go into COVID positive rooms, but it had been a while. AC J said staff must wear a gown, gloves, and a mask to go into a COVID positive rooms. AC J said she knew she had messed up and did not wear the appropriate PPE into Resident #29's room. AC J said she knew residents were COVID positive because there was a sign on the door of the residents. AC J said she took Resident #29's meal tray in and sat it on the over bed table and left the room. AC J said she realized she was not wearing the appropriate PPE when the LVN G came in the room with all the PPE on. AC J said she did not sanitize her hands when she went to the ice chest and filled the cups with ice. AC J said by not wearing the appropriate PPE or sanitizing her hands, she could have transferred germs to the ice chest/scoop and anything she touched. During an interview of 02/25/2026 at 11:58 a.m., RN K said she had worked at the facility for eight months. RN K said suction tubing/catheters should definitely not be in the floor. RN K said the red catheter should have been discarded if it was on the floor and not placed in the drawer with her clean supplies. RN K said by placing it in the drawer uncovered contaminated everything in the drawer. RN K said if someone did use the suction catheter that had been on the floor and placed uncovered in the drawer to suction Resident #5's tracheostomy, it could have introduced microorganisms and placed the resident at risk for infection. RN K said gloves, gowns, masks (N95), eye shield or goggles were required to enter a room with COVID positive residents. RN K said the required PPE was for droplet precautions so if the resident sneezed or coughed, it kept the droplets from getting on the staff's clothes, in their mucus membranes, and their hands. RN K said not wearing proper PPE could potentially spread the disease to other residents, the staff could get sick, and they could carry disease outside the building. During an interview on 02/25/2026 at 2:09 p.m., CNA N stated she was from agency staffing and did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not believe she had to wear PPE inside a COVID positive room anymore, while passing meal trays. She stated she was passing meals trays again at the facility on 02/24/2026 and sought clarification from two different staff members, and each one told her something different. She said she ended up wearing PPE to pass trays on the second day. She stated the required PPE was a gown, KN-95 mask, and gloves. She said a regular surgical mask could have been worn. She stated she did not wear a face shield or goggles because they were not available. During an interview on 02/26/2026 at 10:20 a.m., the DM said he had worked at the facility for four months. The DM said to go into COVID positive rooms, staff were supposed to wear a gown, gloves, and whatever was in the bucket, and they should change their mask when coming out of the room and wash/sanitize their hands. The DM said he did not recall seeing the sign on room [ROOM NUMBER]'s door of being on isolation. The DM said not wearing appropriate PPE in rooms with COVID positive residents could make other residents sick as well. During an interview on 02/26/2026 at 12:53 p.m., the ADON said he was the Infection Preventionist. The ADON said staff should wear a gown, gloves, face shield or goggles, and an N95 mask when entering a room with COVID positive residents on Droplet/respiratory isolation. The ADON said he did not know the difference between KN95 or N95 masks. The ADON said, as the Infection Preventionist, he made sure signs were on the doors, isolation carts were outside the room or nearby, because they did not have enough for all the COVID positive rooms, and for testing staff and residents. The ADON said he was currently out sick with COVID. The ADON said the DON was doing the Infection Preventionist duties in his absence. The ADON said it had been all hands-on deck because they had so many staff out sick. The ADON said it was everyone's responsibility to ensure the isolation carts were stocked with required PPE and if items were needed to let someone know. The ADON said he did an in-service with all staff at shift change at the beginning of the COVID outbreak related to COVID. The ADON said not wearing proper PPE in COVID rooms and going from positive rooms to negative rooms would spread the infection and cross-contaminated rooms. During an interview on 02/26/2026 at 1:28 p.m., the DON stated she expected the staff to ensure infection control protocol was being followed according to the policy and procedures. She stated she expected the staff to ensure they were changing gloves and performing hand hygiene. She stated if the staff were unsure about what PPE to wear inside a COVID positive room, they should have asked. She stated the staff should have had access to the PPE supplies, but if they did not, she expected them to ask her. She stated she expected to be notified if PPE supplies were unavailable. She stated the required PPE inside a COVID positive room was a gown, gloves, N-95 mask, and a face shield or goggles. She stated she was unsure if there was a difference between a KN-95 mask or an N-95 mask. The DON said it was important to ensure infection control practices were followed to protect the staff and other residents from the spread of infection. She said the infection control preventionist was responsible for monitoring to ensure infection control practices were followed. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated she expected the staff to ensure infection control policies and procedures were followed. She stated clinical management was responsible for monitoring to ensure infection control policies were followed. She said it was important to ensure infection control policies were followed to minimize the spread of infection. During an interview on 02/26/2026 at 2:26 p.m., LVN M said she was the staffing coordinator. LVN M said goggles/face shield, gown, gloves, mask or N95 should be worn in a room with COVID positive residents and then trash the mask when coming out of the room. LVN M said staff should (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wash/sanitize their hands prior to getting ice from the ice chest on the hall. LVN M said staff should have dumped the ice and sanitized the ice chest once it was determined it was contaminated. LVN M said not wearing appropriate PPE and not sanitizing hands after entering a COVID positive room, was an infection control issue and could spread COVID to other residents. During an interview on 02/26/2026 at 2:42 p.m., the DON said, at that time, during the COVID outbreak, all staff should be wearing a mask, including kitchen staff. The DON said all staff were wearing masks to protect other staff and residents. The DON said COVID spread like wildfire in the facility because a lot of the positive cases did not have any symptoms. During an interview on 02/26/2026 at 3:03 p.m., the Regional Administrator said she would expect staff to follow the policies of the facility. The Regional Administrator said if staff were not wearing appropriate PPE in COVID positive rooms, it could spread illness. Record review of the resident COVID testing log, dated 02/17/2026, 02/20/2206, and 02/24/2026, reflected 34 residents were COVID positive. Record review of the Coronavirus policy, dated March 2025, reflected .PPE.N95 along with goggles or face shield will be used for all COVID isolations residents.KN95s with goggles or face shield may be used for source control in all other rooms/areas not containing COVID-19.the required PPE for COVID-19 isolation rooms or when providing care or services to a COVID-19 positive resident or a resident suspected of having COVID-19, staff should wear an N95 mask, face shield or googles, gown, and gloves. Record review of the Isolation Precautions policy, dated February 2025, reflected Modified Isolation Precautions: Intended to prevent the transmission of novel or high consequence pathogens that could be easily disseminated or transmitted from person to person, for which methods of transmission are still under investigation, and/or for which there may be potential for high morbidity/mortality. This could include pathogens such as COVID-19.Modified Isolation Precautions. all personnel entering the room must wear isolation downs, gloves, N95/KN95 mask, and eye protection. Record review of the Infection Prevention, Control, and Surveillance policy, dated February 2025, reflected .handwashing is monitored by direct surveillance of persons performing their normal job functions.Appendix B Hand Hygiene. activity included: . After performing personal care for residents . after handling soiled items.after removing gloves. before handling medication. before handling food.between dirty and clean procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the residents and/or representatives had the right to participate in the development and implementation of his or her person-centered plan of care, and to ensure that the planning process facilitated the inclusion of the residents and/or representatives for 5 (Resident #4,Resident #21, Resident #51, Resident # 81, and Resident #90) of 18 residents reviewed for care plans. The facility failed to ensure the IDT, Resident #4, Resident #21, Resident #51, Resident #81, and Resident #90, were involved in the review of the comprehensive assessment and were able to discuss their individualized care needs for services to include their need for medical and nursing care, medications, therapy, psychological and dietary needs. This failure could affect residents by placing them at risk for not receiving adequate or individualized care. Findings include: 1. Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old male admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and vascular ulcers (slow-healing, painful, and often recurring open sores, typically forming around the ankles due to chronic vein disease, such as poor circulation or faulty valves). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS of 15 which indicated no cognitive impairment. The MDS revealed he had no behavior and had not refused care. Resident #4 required partial (helper does less than half the work) for bed mobility, personal hygiene, dressing, and transfer. Record review of the last recorded care plan conference for Resident #4 was dated 03/26/2025. There was no record located for care plan meetings for June 2025, September 2025, or December of 2025. No other care plan conference meeting information was located. During an interview on 02/23/2026 at 11:00 a.m., Resident #4 stated he would like to participate in his care plan meetings so the facility could listen to ideas to improve how they cared for residents. He stated he had not been invited to nor participated in a care plan meeting since about a week after he was admitted around a year ago. He stated not being a part of his care planning process made him feel lost and left out. 2. Record review of an undated face sheet revealed Resident #21 was a [AGE] year-old male admitted on [DATE] with diagnoses of diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), blindness to one eye, and chronic pain. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #21 had a BIMS of 15 which indicated no cognitive impairment. The MDS revealed he had no behavior and had not refused care. Resident #21 was independent for ADLs. He was taking high risk medications from the following drug classes; antianxiety, antidepressant, hypnotic, diuretic, opioid, hypoglycemic, and anticonvulsants. Record review of the last recorded care plan conference for Resident #21 was dated 11/20/2024. There were no records found for February 2025, May 2025, August 2025, November 2025, or February 2026. No other care plan conference documentation was located. During an interview on 02/23/2026 at 11:20 a.m., Resident #21 stated he used to go to his care plan meetings each time the social worker scheduled one. He said that was the time when he could ask questions about his medication, ask for appointments, tell the facility his likes and dislikes on food and how the CNAs treated people. Resident #21 stated the facility had a high turnover rate for social workers and he didn't think the one the facility currently had cared about how the residents felt. He stated any problem he had ever brought to her she brushed off as insignificant. 3. Record review of an undated face sheet revealed Resident #51 was a [AGE] year-old female admitted on [DATE] with diagnoses of cerebral palsy (a group of permanent, non-progressive neurological disorders appearing in infancy that affect movement, posture, and muscle tone), dysphagia (difficulty swallowing, ranging from mild discomfort to total inability to swallow, often caused by neurological conditions [stroke, Parkinson's], esophageal blockage, or muscular disorders), and atrophic neurodermitis (chronic, itchy, inflammatory (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skin conditions). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #51 was able to recognize the location of her room, staff faces, and her cognitive skills for decision making were moderately impaired. Resident #51 required substantial (helper does more than half the work) assistance with ADLs. Record review of the last recorded care plan conference for Resident #51 was dated 04/17/2025. There was no record located for care plan meetings for July 2025, October 2025, or January of 2026. No other care plan conference meeting information was located. 4. Record review of an undated face sheet revealed Resident #81 was a [AGE] year-old female admitted on [DATE] with diagnoses of parkinsonism (a clinical syndrome characterized by a combination of movement-related symptoms, most notably bradykinesia [slowness of movement], rigidity [stiffness], resting tremors, and postural instability, orthopnea (shortness of breath or difficulty breathing), and anemia. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #81 had a BIMS of 15 indicating no cognitive impairment. She required set up with ADLs. Record review of the last recorded care plan conference for Resident #81 was dated 04/17/2025. There was no record located for care plan meetings for July 2025, October 2025, or January of 2026. No other care plan conference meeting information was located. During an interview on 02/23/2026 at 2:00 p.m., Resident #81 stated they had not received an invitation to a care plan meeting in about 1 year. Resident #51 stated they would like to be involved in decisions bout their care. 5. Record review of an undated face sheet revealed Resident #90 was a [AGE] year-old female admitted on [DATE] with diagnoses of heart failure, obesity, and hypothyroidism (abnormally low activity of the thyroid gland). Record review of an annual MDS assessment dated [DATE] revealed Resident #90 had a BIMS of 14 indicating no cognitive impairment. She required dependent assistance with ADLs. Record review of the last recorded care plan conference for Resident #90 was dated 07/23/2025. There was no record located for care plan meetings for October 2025 or January of 2026. No other care plan conference meeting information was located. During an interview on 02/23/2026 at 10:15 a.m., Resident #90 stated she was very upset that they were not including her in the planning of her care. She stated she was stuck in the bed or her chair and unable to visit all the nurses, aides, and people that cared for her. She stated it was unfair they discussed her without her present or worse yet, no at all. Resident #90 stated she had things to discuss about the pitiful care she has been receiving the last several months. During an interview on 02/25/2026 at 3:15 p.m., the Social Worker stated it was her job to keep a calendar and ensure the residents had a care plan meeting at least quarterly. She stated she sent letters out to the family to invite them to the care conferences. The Social Worker stated the IDT met 2 days a week to discuss care plans with the residents. The Social Worker stated the residents did not always attend their care plan meetings. She stated in a perfect world the care plan meeting schedule would align with the MDS schedule, but she had not gotten everyone on that schedule, yet. The Social Worker stated if the care plan conference form was not located in the EHR, the care plan conference had no taken place. She stated she knew the residents had a right to attend their care conferences, but it was not always possible to get to everyone each time they had a conference due. The Social Worker stated the residents could feel like they do not matter by not attending their own care plan meeting. During an interview on 02/25/2026 at 3:30 p.m., the DON stated it was the responsibility of the Social Worker to coordinate care conferences for all residents. She stated they should be done quarterly at the least and all departments should be represented, such as nursing, dietary, activities, therapy, and social services. The DON stated she was unaware this was not happening quarterly and stated it was her responsibility as the DON to ensure all systems were functioning properly in the building. She stated no residents or family members had complained to her about not having care plan meetings. The DON stated it could make the residents feel ignored and neglected to not be a part of their own care planning. During an interview on 02/25/2026 at 4:00 p.m., the Administrator stated it was absolutely the responsibility of the Social Worker and all department heads to ensure that the residents and all IDT members are present at resident care plan meetings. The Administrator stated Resident #4 had many concerns that could have been resolved (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the care planning process. On 02/24/2026 at 4:00 p.m., 02/25/2026 at 10:00 a.m., and 02/26/2026 at 10:00 a.m. a policy for Care Planning Meeting/ Care Conferences was requested from the Regional DON. No policy was received prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for 6 out of 6 anonymous residents during a confidential meeting. The facility failed to ensure the resident council grievances for call light timing and showers were promptly resolved. This failure could place residents at risk for a decreased quality of life and feeling as their voice was not heard.The findings included: Record review of the resident council meeting minutes, dated 09/30/2025, reflected the residents shared a concern regarding .CNA's respond to call light and tell them that the next shift will take care of needs and that it's time to get off. Record review of the resident council meeting minutes, dated 10/27/2025, reflected old business: .showers remain a concern and Nursing: Showers are not being given as scheduled. Record review of the resident council meeting minutes, dated 11/24/2025, reflected .Nursing: Nurse aides turning call lights off and do not respond to needs. Record review of the resident council meeting minutes, dated 12/30/2025, reflected Old business. showers not being. The nursing section was blank. Record review of the resident council meeting minutes, dated 01/28/2026, reflected .Nursing: residents stated that aides are not making rounds to check on them. Aides are turning off lights and not responding to needs. During a confidential interview with 6 anonymous residents reflected anonymous residents agreed they felt like their grievances on call light timing and showers were not resolved. The residents agreed that it would only get better for a few days but would return to the same issues. They agreed that call lights were not answered timely. Anonymous Resident #1 said on one occasion, she had to wait 3 hours and 42 minutes for her call light to be answered. The anonymous residents agreed that at times, only 2 CNAs for the entire building were scheduled. The residents said it was all shifts that were working short. The anonymous residents agreed that medications were given late and showers were not given as scheduled because of the staffing concerns. The residents stated they felt ignored and neglected. During an interview on 02/26/2026 at 9:55 a.m., the Activity Director stated she helped facilitate the resident council meetings. She said normally she attended the beginning of the meetings and then left so the meeting was conducted without the presence of staff. She said the residents usually recorded their own meeting minutes. The Activity Director stated the residents expressed ongoing concerns about the showers and call lights. She said when the residents started complaining about certain things, like showers or call lights, the complaints usually did not stop. She said when the residents complained about things during the resident council meeting, she wrote it up as a grievance and then took the concerns to the morning meetings with the department heads. The Activity Director stated nursing concerns were given to the DON. She said the DON was responsible for addressing and resolving the grievances for the nursing department. She said it was important to ensure that grievances were resolved to give the residents a sense of independence and it gave them a voice. During an interview on 02/26/2026 at 1:28 p.m., the DON stated she was aware of the ongoing grievances of the resident council regarding showers and call lights. The DON stated she had completed in-service education with the staff regarding showers and answering call lights, but the cause of the concerns fell back to staffing. She stated after completing in-service education with the staff, she followed up with the residents who said the issues were resolved. She said there was no on-going monitoring, after the in-service education. She said she did not always have time to follow back up. The DON stated it was important to ensure grievances were resolved for the residents' quality of life and so they felt heard. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated she was sitting in the building while the Administrator was out. She said she expected the department heads to address the grievances of resident council and follow up with the next resident council to ensure the grievances were resolved. She stated management staff were responsible for monitoring to ensure grievances were resolved. She said it was important to ensure resident concerns were resolved because the facility was their home. Record review of the Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Council policy, undated, reflected the policy was To aid the facility's sense of community, quality of life for the residents and meet the requirements of F565, the wellness department will assist, as required, to oversee the facility's Resident Council as assigned.concerns noted on the minutes should be group concerns. ask for clarification to assist department heads in solving issues appropriately.the recorded minutes will be provided to the facility Administrator to provide as needed facility department head team to address any concerns or suggestions within 48 hours of the meeting concluding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for 7 of 18 residents dependent on staff reviewed for ADLs. (Resident #2, Resident #4, Resident #47, Resident #77, Resident #78, Resident #90, and Resident #104) 1.The facility failed to ensure Resident #2, Resident #4, Resident #77, Resident #78, Resident #90, and Resident #104 received scheduled baths in February of 2026. 2.The facility failed to ensure Resident #4, and Resident #47 were groomed and shaved. These failures could place residents at risk of not receiving care or services, decreased quality of life, embarrassment, and decreased self-esteem. The findings included: 1. Record review of an undated face sheet revealed Resident #2 was [AGE] years old and admitted to the facility on [DATE] with diagnoses including diabetes, lack of coordination, and age-related physical disability. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #2 was understood and understood others. The MDS indicated Resident #2 had a BIMs of 15 which indicated his cognition was intact. The MDS indicated Resident #2 required substantial to maximal assistance with showers or baths. Record review of Care Plan last revised 12/29/25 indicated Resident #2 had impaired mobility and required assistance with ADLs. There was an intervention to assist the resident with daily living activities as needed. Record review of a CNA Flow Sheet dated 02/01/26 - 02/25/26 indicated Resident #2 had only received a bath on 02/01/26. There were no other baths documented. There was a refusal documented on 02/09/26. During an interview on 02/23/26 at 2:50 p.m., Resident #2 said he had not had a bath in a week. He said he had asked staff for a bath and they told him they did not have time. 2. Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old male admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and vascular ulcers (slow-healing, painful, and often recurring open sores, typically forming around the ankles due to chronic vein disease, such as poor circulation or faulty valves). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS of 15 which indicated no cognitive impairment. The MDS revealed he had no behavior and had not refused care. Resident #4 required substantial (helper does more than half the work) for bed mobility, personal hygiene, dressing, and transfer. Record review of the care plan dated 01/15/2026 revealed Resident #4 had a venous stasis ulcer (slow-healing, chronic, and often painful open sores that typically form on the lower legs, usually near the ankle, due to poor blood flow and high pressure in the veins) on his right lateral (side of) ankle, right medial (mid) calf, and a non-pressure ulcer to his right buttock. There was no care plan for ADLs for Resident #4. Record review of the February 2026 ADL sheet printed 02/25/2026 revealed no documented evidence Resident #4 had been bathed since 02/06/2026 when he received a shower on the day shift. No other showers were reflected for February 2026. Resident #4 was scheduled to have a shower on Monday, Wednesday, and Friday. He received 1 of 11 scheduled showers in February. During an interview and observation on 02/23/2026 at 9:30 a.m., Resident #4 stated he had not received a bath or shower in over 10 days. He stated there was a COVID outbreak in the building and the facility had less than a skeleton crew working and multiple different staff members including the DON told him they did not have time to bathe him. Resident #4 stated he understood he could not leave his room and would settle for a bed bath. He voiced concern over his body odor and stated it was embarrassing to smell like shit and musk. He also stated he requested a shave but not in bed. There was a strong smell of body odor present and overgrown facial hair (growing an unwanted beard). Resident #4 was dressed in a burnt orange T shirt with several white and brown stains on the front. Resident #4's sheets were soiled and covered in (3 areas about quarter size) brown and (2 smeared areas about 1.5 inches wide by 6-8 inches long) red food stains. During an observation and interview on 02/24/2026 at 9:00 a.m., revealed Resident #4 had on the same burnt orange shirt with food stains covering it and the smell of his body odor was strong (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	throughout the room. Resident #4's sheets had not been changed and were covered in food. Resident #4 stated he had not received a bath on 02/23/2026. During an observation and interview on 02/25/2026 at 10:10 a.m., Resident #4 stated he had still not gotten a bath. Resident #4 remained in the same burnt orange shirt with stains, and his sheets were the same stained sheets from the previous 2 days. The foul odor of feces and body odor was present upon entering the room. Resident #4 stated Now I know if I can smell my sour-ass you can smell me. He stated he really would like to be cleaned up and he was having trouble sleeping with all the crumbs in his bed. 3. Record review of the face sheet, dated 02/25/2026, reflected Resident #47 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disorder (COPD) (a progressive lung condition that makes it difficult to breath), and brain and lung cancer. Record review of the admission MDS assessment, dated 01/21/2026, reflected Resident #47 had unclear speech, was understood, and was able to understand others. Resident #47 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS reflected Resident #47 had inattention and disorganized thinking that fluctuated. Resident #47 had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #47 had a functional limitation in range of motion that interfered with daily functions or placed him at risk for injury to one side of his lower extremities and he used a wheelchair. Resident #47 usually required partial/moderate assistance with showering, which reflected the helper completed less than half of the effort. Record review of the comprehensive care plan, dated 01/20/2026, reflected Resident #47 required assistance with ADLs. The interventions included: assist with daily care needs and daily living tasks and encourage to do as much as possible for self. Record review of the CNA Flow Sheet, dated 02/02/2026 to 02/24/2026, reflected Resident #47 received only one shower. During an observation and interview on 02/23/2026 at 9:26 a.m., revealed Resident #47 was lying in bed with the head of his bed elevated slightly. His hair was cut short, and he had white and gray stubble around his mouth, on his cheeks, and his neck. He was wearing a black and yellow shirt. Resident #47 reported he did not always get his scheduled showers. He said he had only received a handful since being admitted to the facility. Resident #47 stated his shower days were Tuesday, Thursday, and Saturday. He said he did not receive his shower on Saturday. During an observation on 02/24/2026 at 10:44 a.m., revealed Resident #47 asked LVN O for a shower. He stated it had been days since he received a shower and he had been asking for it. LVN O said his shower was scheduled for 2 p.m. Resident #47 stated he preferred his showers in the morning time. He was wearing the same clothing from 02/23/2026. During an interview on 02/25/2026 at 2:09 p.m., CNA N stated she worked for agency and had been assigned to Resident #47's hallway. CNA N stated she had only been assigned to the right side of 100 hall, but ended up with all the residents on 100 hall, because staff had called in. CNA N stated it was impossible for her to complete all her assigned tasks including showers. CNA N was unable to remember if Resident #47 received his shower. CNA N said it was important to ensure showers were completed to prevent skin issues. CNA N stated it was important to maintain good hygiene. 4. Record review of an undated face sheet revealed Resident #77 was a [AGE] year-old female admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and bipolar disorder (a mental health condition characterized by intense mood swings, alternating between high-energy manic or hypomanic episodes and low-energy depressive episodes). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #77 had a BIMS of 99 which indicated severe cognitive impairment. She had short- and long-term memory impairment and had moderately impaired decision-making ability. It revealed he had no behavior and had not refused care. Resident #77 required dependent assistance for bed mobility, bathing, personal hygiene, dressing, and transfer. Resident #77 was incontinent of bowel and bladder. Record review of the care plan dated 11/07/2025 revealed Resident #77 was dependent for ADLs and required complete staff assistance for personal hygiene and bathing. Record review of the February 2026 ADL sheet printed 02/25/2026 revealed no documented evidence that Resident #77 had been bathed in February of 2026. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #77 was scheduled to have a shower on Monday, Wednesday, and Friday. He received 0 of 11 scheduled showers in February. During an observation on 02/23/2025 at 9:40 a.m., revealed Resident #77 had a foul odor of ammonia and body odor. Resident #77 was unable to communicate her last bath. 5. Record review of an undated face sheet revealed Resident #78 was [AGE] years old and admitted to the facility on [DATE] with diagnoses which including quadriplegia (paralysis affecting all four limbs and the torso, typically caused by cervical spinal cord injury), seizures, and high blood pressure. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #78 was sometimes understood and sometimes understood others. The MDS indicated Resident #78 was unable to complete the BIMS interview. The MDS indicated Resident #78 was dependent on staff for all ADLs. Record review of the care plan last revised 01/07/26 indicated Resident #78 was dependent on staff for all ADLs. There was an intervention to assist the resident with daily care needs and daily living tasks. The care plan indicated the resident had a diagnosis of quadriplegia with an intervention to provide assistance with ADLs. Record review of a CNA Flow Sheet for Resident #78 dated 02/01/26 - 02/25/26 did not indicate any baths. The flow sheet did not indicate any refusals from the resident. During an interview on 02/23/26 at 11:21 a.m., a family member for Resident #78 said he did not always get his baths. The family member said he was not gotten out of bed for showers. During an interview on 02/25/26 at 10:18 a.m., a family member for Resident #78 said the facility was not showering him. The family member said they had to come to the facility to wash and bathe him. The family member said his bottom was not being cleaned good and when she washed him, he was still dirty. The family member said they also had to do his oral care. The family member said they had come to the facility, and his eyes were crusty. The family member said there was dry stuff on his face and boogers coming out of his nose. She said she had seen brown rings on the pads that were under him. Record review of an undated photo provided by Resident #78's family member revealed brown rings on the pad under Resident #78. 6. Record review of an undated face sheet revealed Resident #90 was a [AGE] year-old female admitted on [DATE] with diagnoses of heart failure, obesity, and hypothyroidism (abnormally low activity of the thyroid gland). Record review of an annual MDS assessment dated [DATE] revealed Resident #90 had a BIMS of 14 indicating no cognitive impairment. She required dependent assistance with ADLs. Resident #90 was incontinent of bowel and bladder. Record review of the February 2026 ADL sheet printed 02/25/2026 revealed no documented evidence Resident #90 had been bathed in February of 2026. Resident #90 was scheduled to have a shower on Monday, Wednesday, and Friday. He received 0 of 11 scheduled showers in February. During an interview on 02/23/2026 at 9:30 a.m., Resident #90 stated she had not been bathed this month. She stated the facility was short on staff and one aide could not bath all the people on the hall. She stated she knew she smells and her vagina was raw from urine and not getting a bath. She stated it was embarrassing to smell of urine and feel so dirty. Resident #90 stated she would report to the Administrator, but he was out sick, and she never got to have a care plan meeting. She stated she had called the Ombudsman for advice. Resident #90 stated she was out of things to do to make sure she was getting a bath and she felt defeated. During an observation on 02/24/2026 at 11:00 a.m., revealed when Resident #90 was receiving incontinent care when she asked CNA B and CNA D when she would receive her bath. CNA B responded, It is not your bath day today, but I will give you a quick wash down. Resident #90 received a partial (extremities and hair not washed and bed linen not changed) bed bath. During an interview on 02/24/2026 at 11:00 a.m., CNA B stated she was the aide for Resident #4, Resident #77, and Resident #90 and was aware it was their bath days. She stated she did not have time to do everything required of her on her shift. CNA B stated she had 22 residents to care for and half of them were COVID positive. She stated she was to feed them 2 meals, keep them clean and dry, turn them every 2 hours, bathe 6-8 of them a day, and chart. She stated that it was an impossible task even if there was no COVID. CNA B stated she did her best to care for the residents. She stated she had to make sure the residents were fed and dry and that was about all she had time for. CNA B stated not getting a bath could make the residents feel dirty and uncared for. 7. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an undated face sheet revealed Resident #104 was [AGE] years old and admitted to the facility on [DATE] diagnoses including high blood pressure, malignant neoplasm of larynx (a common head and neck cancer, predominantly squamous cell carcinoma, that affects the voice box), and pain. Record review of Resident #104's electronic medical record accessed on 02/25/26 did not indicate a complete MDS. Record review of a baseline care plan for Resident #104 dated 02/20/26 indicated the residents were independent with decision making skills. Record review of a CNA Flow Sheet for Resident #104 dated 02/20/26 - 02/25/26 did not indicate any baths were documented as provided. The flow sheet did not indicate any refusals from the resident. During an interview on 02/25/26 at 10:56 a.m., Resident #104 said he had not had a bath since he was admitted to the facility on [DATE]. He said he had only had a light wipe down. He said at the very least a bed bath would feel good. He said he could not walk so a shower would be hard to do. During an interview on 02/25/26 at 11:53 a.m., CNA QQ said they did not have enough staff. She said there were residents that did not get baths because she could not get to them. She said they used to have a shower aide, but she left. She said she had never seen Resident #104 up in the shower. She said she had only known him to get bed baths. She said he had not missed any baths that she was aware of. During an interview on 02/25/2026 at 3:00 p.m., the DON stated it was the responsibility of the CNAs to provide baths to all residents on their scheduled bath days. She stated every resident had a bath schedule in the system the CNAs charted in. She stated any refusals were to be recorded and reported to the charge nurse. She stated if the resident refused several times the family would be notified to attempt to intervene. The DON stated she was aware there had been some missed baths because staffing had been an issue with half of her staff out with COVID. She stated COVID had been going through the building for about 10 days. The DON stated the facility started using agency staff on 02/21/2026 to try and supplement the staff out with COVID and they did have a few vacancies in the schedule, as well. The DON stated there was no excuse for the CNA not giving a bath related to their time management. She stated she had worked on the floor as a CNA several times in the last few months and she was able to provide all care including baths. She stated she was the CNA on the 400 hall on 02/23/2026 and she did all the baths assigned that day. The DON stated Resident #4 refused his bath on 02/23/2026 and she failed to document his refusal. The DON stated bathing was important for health and keeping the residents feeling good about themselves. The DON stated not getting a bath for several days could make the residents feel neglected and uncared for. During an interview on 02/25/2026 at 4:00 p.m., the Administrator stated she was unaware of the issue the residents were having receiving their baths. She stated it was more than likely due to the number of staff that was out with COVID, but the residents still must be bathed. She stated it was the DON and ADON that monitored baths and were to ensure they were happening. The Administrator stated it could make the residents feel disgusting and like they don't matter when they are not cared for properly. Record review of the Activities of Daily Living (ADL), supporting policy, dated February 2025, reflected Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with. hygiene (bathing, dressing, grooming, and oral care).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to refrain from utilizing the DON as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents for reviewed for nursing services. 1. The DON worked as a charge nurse or CNA 6 times in January 2026 2. The DON worked as a charge nurse or CNA 4 times in February 2026 This failure could place residents at risk by leaving nursing staff without supervisory coverage and leaving essential DON functions undone. Findings included: During observation and interview on 02/23/2026 at 10:00 a.m., the DON was changing linen on a bed in a resident room and stated she had to work the floor several nights as a charge nurse, be a CNA on the floor when the facility was short staffed. The DON stated she knew she was not supposed to work the floor in a building of more than 60 average residents. The DON stated she would take the citation because she was not leaving the residents with no care. The DON stated she was the monitor for the weight system, the skin system, the antibiotic stewardship system, and the gradual dose reduction system. The DON stated she had ADONs to assist her, but ultimately the responsibilities were hers. The DON stated she had not had time to keep up with all the systems because she was working the floor. The DON stated she was responsible for checking behind the nurses for clean oxygen equipment, making sure admission orders were checked, making sure admission assessments were done, making sure everyone was on the correct antibiotic, and making sure interventions were in place for weight loss and falls. The DON listed the dates she had worked on the floor totaling 6 shifts in January 2026 and 4 shifts in February of 2026. Record review of sign in sheets for January2026 had not listed the DON as the floor nurse or CNA on any of the days. February showed the DON as the charge nurse on 02/22/2026 and the CNA on 400 hall 02/23/2026. Record review of the staffing sheets on 02/25/2026 indicated an average daily census of 86 for January and February of 2026. During an interview with the Administrator on 02/25/2026 at 3:00 p.m., the Administrator stated the DON had worked the floor several shifts. The Administrator stated the DON was salary, and she did not have to clock in and out when working the floor, so there was no way to track what days and hours she actually worked the floor. The Administrator stated she was sure working shifts on the floor, away from her work, would put the DON a little behind because she had many systems she oversaw, but a lot can be done in the downtime during the shift. The Administrator stated all the department head nurses took turns working the floor when someone called in. She said they each had responsibilities to keep the facility functioning well and it was her expectation that they keep up with their work. A relevant policy was requested from the Regional RN on 02/25/2026 at 10:00 a.m. and 02/26/2026 at 10:00 a.m., but none was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, and dispensing of routine drugs and biologicals to meet the needs of each resident for 1 of 7 resident's reviewed for pharmacy services. (Resident #1) The facility failed to administer Resident #1's physician ordered Debrox ear drops from 02/24/2026 to 02/26/2026. This failure could place residents at risk for medication errors and adverse effects from medication.The findings included: 1. Record review of face sheet, dated 02/25/2026, reflected Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis chronic obstructive pulmonary disease (chronic, progressive lung disease that makes it hard to breathe). Record review of the quarterly MDS assessment, dated 02/24/2026, reflected Resident #1 had clear speech, was understood, and was able to understand others. Resident #1 had a BIMS score of 12, which indicated moderately impaired cognition. Resident #1 had no behaviors or refusal of care. Record review of Resident #1 comprehensive care plan, dated 10/17/2025, did not reflect the new order for Debrox ear drops or acute hearing loss. Record review of the active orders report, dated 02/26/2026, reflected an order, which started on 02/24/2026 for Debrox 6.5% solution - 5 drops to both ears twice a day x 4 days for impacted cerumen (earwax). Record review of the MAR, dated February 2026, reflected Resident #1's order for Debrox ear drops was not given on 02/24/2026, 02/25/2026, and 02/26/2026. During an interview on 02/26/2026 at 9:45 a.m., LVN T stated Resident #1's order for Debrox ear drops was placed in the charting system on 02/24/2026. LVN T stated Resident #1's Debrox ear drops had not been delivered from the pharmacy, so they had not been started yet. She said she was going to call and follow up with the pharmacy when she had a chance. LVN T stated it was important to ensure medications were started timely after they were ordered so the acute problems did not become worse. During an interview on 02/26/2026 at 1:28 p.m., the DON stated Debrox ear drops were an over-the-counter medication that was not required to be sent from the pharmacy. She stated the medications were stocked in the medication room. She said she expected the nursing staff to communicate promptly when medications were running low or unavailable. The DON stated she expected the nursing staff to follow the MAR and administer medications by the physician orders. She said new staff or agency staff should be triple checking the MAR against the card to ensure the correct medication, the correct dose, and the correct medication route was administered. She said it was important to ensure medications were given promptly when ordered and were administered according to the physician orders because the medications were prescribed for a reason. She stated it was vital to receive medications to improve or maintain their health status. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated she expected the nursing staff to ensure physician orders were followed. She stated nursing management was responsible for monitoring to ensure medications were administered as ordered by the physician. She stated it was important to ensure medications were administered according to the physician orders to ensure proper treatment was given. Record review of the facility's Medication Administration policy, dated January 2024, reflected Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. compare the medication and dosage schedule on the resident's MAR with the medication label.medications are administered in accordance with written orders of the prescriber.the person who prepares the dose from administration is the person who administers the dose.verify medication is correct three times before administering the medication.when pulling medication package from med cart. when dose is prepared. before dose is administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 7 of 19 residents (Resident #2, Resident #4, Resident #9, Resident #21, Resident #33, Resident #61, Resident #81) and 7 anonymous residents reviewed palatable food. 1. The facility failed to ensure residents received food that was palatable. 2. The facility failed to ensure residents received food with an appetizing appearance, texture, and appropriate temperature.These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life.Record review of a Resident Council Meeting Form dated 09/30/25 indicated, .Food sometimes served cold on the halls.1. Record review of an undated face sheet revealed Resident #2 was an [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses including mild protein-calorie malnutrition (a severe, potentially life-threatening condition caused by inadequate intake of calories, protein, and essential nutrients, leading to muscle wasting, weakened immunity, and tissue degeneration), diabetes, and weakness.Record review of a quarterly MDS assessment dated [DATE] revealed Resident #2 was understood and was understood others. The MDS revealed Resident #2 had a BIMS score of 15, which indicated intact cognition.During an interview on 02/23/26 at 2:50 p.m., Resident #2 said the food did not taste good at all. He said it was very bland. He said it was not worth eating.2. Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old male and was admitted to the facility originally on 10/13/23 with diagnoses including diabetes, weakness, depression, and Vitamin B deficiency.Record review of a quarterly MDS assessment dated [DATE] revealed Resident #4 was understood and understood others. The MDS revealed Resident #20 had a BIMS score of 15 which indicated the resident had intact cognition.During an interview on 02/23/26 at 11:00 a.m., Resident #4 said the food was not edible. He said it was always very cold like it had been sitting out for hours or days when it is served to him at the end of the hallway. He stated he was not sure if they were running out of food or not, but he seemed to get small portions and sometimes the items were burnt or clumped together like they were stuck to the bottom of the pot.During an interview on 02/24/26 at 2:10 p.m., Resident #4 said he was sadly disappointed in his lunch meal today (02/24/26). He said he got about 4 lima beans and a carrot as his mixed vegetables and some rubber things that were supposed to be noodles. He stated it looked and tasted a little like Playdough. He stated he had no way to get outside food, and the alternative was chicken nuggets that were hard to chew so he was forced to try and swallow it down.3. Record review of an undated face sheet revealed Resident #9 was a [AGE] year-old female and was originally admitted to the facility on [DATE] with diagnoses including heart failure, high blood pressure, and diabetes.Record review of a MDS assessment dated [DATE] revealed Resident #9 was understood and understood others. The MDS revealed Resident #21 had a BIMS score of 15 which indicated the resident had intact cognition.During an interview on 02/23/26 at 11:42 a.m., Resident #9 said the food was always lukewarm and bland. She said they did not get a lot of choices and were served chicken and hamburgers a lot of the time.4. Record review of an undated face sheet revealed Resident #21 was a [AGE] year-old male and was originally admitted to the facility on [DATE] with diagnoses including major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and loss of interest in activities lasting at least two weeks), vitamin deficiency, and generalized anxiety disorder.Record review of a quarterly MDS assessment dated [DATE] revealed Resident #21 was understood and understood others. The MDS revealed Resident #21 had a BIMS score of 15 which indicated the resident had intact cognition.During an interview on 02/23/26 at 11:17 a.m., Resident #21 said the food at the facility was not good enough to feed to a stray dog. He said it was always cold and the portions were not enough to keep a mouse alive. He stated his family [NAME] him snacks or he would starve to death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He said the worse part of the meals was the hashbrown casserole that had all breakfast foods mixed together and served in this ball like they scooped it out with the smallest ice cream scoop they could find. He said it had about 1/2 a sausage link and 1/2 scrambled egg mixed in shredded potatoes, and it was very bland and was always ice cold. He said there was not enough staff to ask anyone to go warm it up.During an interview on 02/25/26 at 1:01 p.m., Resident #21 said the potatoes in the soup for lunch today (02/25/26) were not done and were hard. He said he was concerned someone might choke5. Record review of an undated face sheet revealed Resident #33 was a [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses including chronic obstruction pulmonary disease (chronic lung disease), depression, and anxiety.Record review of a quarterly MDS assessment dated [DATE] revealed Resident #33 was understood and understood others. The MDS revealed Resident #33 had a BIMS score of 15 which indicated the resident had intact cognition.During an interview on 02/23/26 at 3:10 p.m., Resident #22 said the food was terrible. He said it was cold and bland.6. Record review of an undated face sheet revealed Resident #61 was a [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses including muscular dystrophy (a disease characterized by progressive muscle weakness, degeneration, and fat replacement, often resulting in lost mobility), weakness, and heart failure.Record review of a quarterly MDS assessment dated [DATE] for revealed Resident #61 was understood and understood others. The MDS revealed Resident #61 had a BIMS score of 15 which indicated the resident had intact cognition.During an interview on 02/23/26 at 11:05 a.m., Resident #61 said the food was not seasoned and did not taste good.7. Record review of an undated face sheet revealed Resident #81 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and loss of interest in activities lasting at least two weeks), chronic obstructive pulmonary disease (chronic lung disease), and lack of coordination.Record review of a quarterly MDS assessment dated [DATE] for revealed Resident #81 was understood and understood others. The MDS revealed Resident #81 had a BIMS score of 15 which indicated the resident had intact cognition.During an observation on 02/24/26 at 12:00 p.m., Resident #81 came to the kitchen to request chicken strips and potatoes. She requested the chicken strips be chopped up. During an observation on 02/24/26 at 1:00 p.m. Resident #81 was served a tray with chopped chicken strips and potatoes. The chicken strips were so chopped they looked like breadcrumbs.During an observation and interview on 02/24/26 at 3:36 p.m., Resident #81 said her chicken strips at lunch were pulverized. She said her food was supposed to be chopped. She said everything on her lunch tray was ice cold. She said it took them over 45 minutes to make her tray. She said she had to go to the kitchen to see what was taking so long. Her tray was still at bedside. The chicken strips on the plate looked like breadcrumbs. She said the chicken strips did not taste like chicken. She said they tasted like breadcrumbs. She said the potatoes were cold. She said some of them were hard and she could not eat them. She said they had a food committee once a month and the DM attends. She said he did listen. She said they have to ask for condiments.During an observation and interview on 02/24/26 at 1:15 p.m., a lunch tray was sampled by three surveyors and the Dietary Manager. The food tray consisted of baked fish, mixed vegetables, parmesan noodles, hushpuppies, and apple cobbler. The baked fish was bland and cold. The parmesan noodles were chewy, cold, and had no flavor. The hushpuppies were cold. The apple cobbler was cold. There was only fruit and no crust in the cobbler. The Dietary Manager said the cobbler should have had crust and was cold. He said it should have been served warm. He said the fish was bland and cold. He said the noodles were bland, cold, and chewy.8. During a confidential interview with 6 anonymous residents on 02/24/26 at 3:00 p.m., it was reported that the food was a concern. The anonymous residents agreed that the food was served cold most of the time. The residents said the portions served were small and the flavor was bland. Anonymous Resident #2 stated the food has been brought up during resident council meetings. Anonymous Resident #2 said the flavor of the food has improved some but still needed more (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	improvement.During an interview on 02/25/26 at 11:53 a.m., CNA QQ said she heard a lot of food complaints concerning portion size, same meals over and over, and that the food was cold. She said when the food was cold, she warmed it up in the employee break room. She said she had never reported food complaints to the nurse or the kitchen staff.During an interview on 02/25/26 at 1:57 p.m., Dietary Manager said there was a food committee that met on Mondays and Wednesdays. He said the committee usually consisted of himself and approximately 7 residents. He said the last time they met was 02/18/26, and the only complaint the residents had were that the residents wanted more fruit. He said they also discussed their likes and dislikes. He said no one has complained to him about the food being cold. He said he had been told the food was bland. He said they had worked on it, and the residents had told him that it was better. He said lunch on 02/24/26 was a little off. He said he was just rushing to get everything together. He said he did hear that the potatoes in the soup today (02/25/26) were under cooked. He said he went to the resident to offer him something else, and the resident refused. He said residents who do not like their food could cause them to not want to eat, and they could lose weight.During an interview on 02/26/26 at 12:54 p.m., the DON said she heard food complaints. She said she always passed the complaints on to the Administrator. She said she heard complaints that food was cold, the coffee was cold and watered down, and some people say the food was bland. She said she would expect the kitchen to serve food the residents liked, and that was appealing to them. She said if someone did not like what you were eating, it could cause someone to lose weight. She said a resident might feel like their preferences were not being honored.During an interview on 02/26/26 at 1:14 p.m., the Administrator said she expected the kitchen staff to follow the recipes and the food to be palatable for the residents. She said residents who did not like their food could lead to weight loss and other problems.Record review of a Hot and Cold Food Temperatures facility policy last revised 02/06/24 indicated, .The temperatures of the food items will be managed to conserve maximum nutritive value and flavor and to be free of harmful organisms and substances.all hot food items must be served to the resident at a palatable temperature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote resident self-determination through support of family choice for 1 of 19 residents reviewed for resident rights. (Resident #78)The facility failed to place Resident #78's shoes on his feet daily as requested by family.The facility failed to get Resident #78 up out of bed daily as requested by family. These failures could place dependent residents at risk for feelings of depression, lack self-determination and decreased quality of life.Record review of an undated face sheet revealed Resident #78 was [AGE] years old and admitted to the facility on [DATE] with diagnoses which including quadriplegia (paralysis affecting all four limbs and the torso, typically caused by cervical spinal cord injury), seizures, and high blood pressure.Record review of a quarterly MDS assessment dated [DATE] indicated Resident #78 was sometimes understood and sometimes understood others. The MDS indicated Resident #78 was unable to complete the BIMS interview. The MDS indicated Resident #78 was dependent on staff for all ADLs. Record review of Care Plan last revised 01/07/26 indicated Resident #78 was dependent on staff for all ADLs. There was an intervention to assist the resident with daily care needs and daily living tasks. The care plan indicated the resident had a diagnosis of quadriplegia with an intervention to provide assistance with ADLs. Record review of a CNA Flow Sheet for Resident #78 dated 02/01/26 - 02/24/26 did not indicate any refusals for putting on and taking off socks and shoe or other footwear that was appropriate. The flow sheet did not indicate any refusals of the resident being transferred from a bed to a wheelchair.Record review of Interdisciplinary Progress Notes for Resident #78 dated 02/20/26 - 02/24/26 did not indicate the resident had refused to get up out of bed or wear his shoes.During an observation and interview on 02/23/26 at 11:21 a.m., revealed Resident #78 was in bed. He had socks on his feet. There was a sign hanging on the curtain near his bed that indicated, (Resident #78) needs his shoes on from 2 - 4.). Resident #78's family member said he was supposed to be out of bed with shoes on his feet for a few hours each day.During an observation on 02/23/26 at 3:41 p.m., revealed Resident #78 was in bed asleep. The resident did not have on shoes, only socks.During an observation on 02/24/26 at 10:32 a.m., revealed Resident #78 was in bed awake. There were only socks on his feet.During an observation on 02/24/26 at 11:29 a.m., revealed Resident #78 was in bed. There were only socks on his feet.During an observation on 02/24/26 at 12:37 p.m., revealed Resident #78 was in bed. There were only socks on his feet.During an observation on 02/24/26 at 2:31 p.m., revealed Resident #78 was in bed. There were only socks on his feet.During an observation on 02/24/26 at 3:29 p.m., revealed Resident #78 was in bed. There were only socks on his feet.During an interview on 02/25/26 at 10:18 a.m., Resident #78's family member said during care plan meetings it was discussed Resident #78 being out of bed every day for at least 2 hours a day and his shoes on his feet. The family member said Resident #78 had drop foot (the inability to lift the front part of the foot due to muscle weakness or paralysis) and they wanted him up. The family member said they wanted the facility to do what they had discussed.During an observation on 02/25/26 at 11:00 a.m., revealed Resident #78 was in bed. There were only socks on his feet.During an interview on 02/25/26 at 11:53 a.m., CNA QQ said she was not sure if Resident #78 was to be gotten up daily. She said she had never seen him up out of bed and she had worked at the facility since August 2025. She said she had never offered to get him up out of bed. She said she did not know the family wanted him to have on shoes or noticed the sign in his room. She said she had never seen him with shoes on his feet.During an interview on 02/25/26 at 1:44 p.m., LVN T said if a family member or a resident requested to be out of bed and have shoes on, she would expect staff to do so, unless the resident did not want to be gotten up or not have shoes on. She said she had not worked with Resident #78 and had only worked at the facility five days.During an interview on 02/26/26 at 8:30 a.m., the Social Worker said the last care plan meeting for Resident #78 was in June 2025. She said she could not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remember if him being gotten out of bed and having shoes on for a few hours a day was discussed. She said if the family had wanted these things to be done, she would have expected for staff to have been getting him up and putting his shoes on.During an interview on 02/26/26 at 12:54 p.m., the DON said she was aware that Resident #78 was supposed to be out of bed every day and have shoes on during the day. She said he required a mechanical lift and he was a two-man job. She said he had not been out of the bed. She said it was Resident #78's right to refuse. She said she could not say if any refusals were documented. She said she would expect for staff to be getting him up daily and putting him in his chair daily. She said she would expect for any refusals to be documented. She said CNAs should report refusals to the nurse so that they can make a note in the progress note. She said it should also be reflected on his Kardex. She said not being gotten up and not having shoes on could be a dignity thing. She said the family saw it as he could develop foot drop. She said Resident #78 could verbalize if he wanted to get up but was able refuse or agree to get up.During an interview on 02/26/26 at 1:14 p.m., the Administrator said if Resident #78 was willing she would have expected for him to have been gotten up daily with shoes on his feet. She said if he did refuse, she would have expected it to have been documented. She said a resident who was not being gotten up could lead to depression and further decline.Record review of a Resident Rights facility policy last revised 08/14/22 indicated, .The staff will abide by and protect resident rights in accordance with state and federal guidelines.Staff will abide by resident rights as outlined within CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the resident access personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically, or, if not, in a readable hard copy from such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays) and allow the resident to obtain a copy of the records or any portions thereof upon request and 2 working days advance notice to the facility for 1 of 7 residents (Resident #105) reviewed for access of records. The facility failed to provide Resident #105's legal representative copies of medical records after a request was submitted to the facility on [DATE]. This failure could place residents at risk of violation of their rights by not receiving copies of their medical records.The findings included: Record review of the face sheet, dated 02/26/2026, reflected Resident #105 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (progressive, irreversible brain disorder in which it causes the slow destruction of nerved cells leading to a decline in memory, thinking, language, and behavior that severely impacts daily functioning). Record review of the discharge MDS assessment, dated 11/24/2025, reflected Resident #105 had an unplanned discharge from the facility with the anticipation of return. Record review of Resident #105's Attorney's office letter, dated 11/26/2026, reflected Resident #105's legal representative requested all correspondence with Texas Health and Human Services Commission from the last two years related to Resident #105's Medicaid for Nursing Resident benefits by 12/01/2025 so renewal of benefits could have been obtained. The letter also requested the daily plan of care, nursing logs, medication logs, incident reports, and any and all emails, letters, and notes related to Resident #105. Record review of HIPAA Authorization to Disclose Protected Health Information signed and dated on 11/25/2025 by Resident #105's legal representative, reflected [Attorney office] is permitted to receive the information and is hereby authorized to receive any and all information the releasing persons or organization may have concerning treatment or services rendered to [Resident #105] for any reason, whether inpatient or outpatient. During an interview on 02/24/2026 at 4:02 p.m., Attorney W stated she had still not received the records that were requested on 11/26/2025. Attorney W stated she had verified with Medical Records and the Administrator that the request had been received. Attorney W stated Resident #105's legal representative had signed the HIPAA release of information form which was sent with the letter. She said the delay in receiving Resident #105's medical records have caused her Medicaid benefits to lapse. During an interview on 02/24/2026 at 4:13 p.m., Medical Records stated if an attorney requested medical records, the request was sent to the corporate office and the facility's attorney, Attorney S. Medical Records stated the request was not handled at the facility. Medical Records said she was aware of Resident #105's record request from Attorney W. She said the request was sent to the Administrator, before he was out on leave. During an attempted phone interview on 02/24/2026 at 4:19 p.m., Attorney S did not answer the phone. A brief message was left with a call back number that was not returned upon exit from the facility. During an interview on 02/24/2026 at 5:03 p.m., the facility's attorney Chief Operating Officer stated Resident #105's record request was overlooked and missed. He stated that they were working on gathering the documents and would have them sent by the end of the week. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated she was aware of the records request for Resident #105's attorney. She said the records request was sent directly to the attorney and the not the records request email. She stated there was not a process in place to monitor the request after it was sent to the attorney. She stated it was important to ensure residents and their representatives had access to medical records because it was the rules. Record review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Release of Information Protocol, undated, reflected .2. *Send the signed HIPAA Authorization form to Medical Records Request [email]. 3. *Legal/Personal requests send to Medical Records Request [email]. After receiving the above documentation, a review will be completed and presented to Attorney S. He will determine the direction in which the facility should take.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident quarterly (every 3 months) using the MDS form specified by the state and approved by CMS for 1 of 19 residents (Resident #20) reviewed for assessments. The facility failed to ensure Residents #20's quarterly MDS assessment was completed within 3 months from the previous assessment. This failure could place residents at risk of not receiving necessary care or receiving inappropriate care for their conditions.The findings included: Record review of the face sheet, dated 02/25/2026, reflected Resident #20 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of osteomyelitis (bone infection) and dementia (decrease in memory and thinking ability that interferes with daily living). Record review of Resident #20's quarterly MDS assessment, dated 10/25/2026, reflected it was completed within 14 days of the ARD date. Record review of Resident #20's quarterly MDS assessment, dated 01/22/2026, reflected it was completed on 02/26/2026, which was 35 days after the ARD date. During an interview on 02/26/2026 at 12:40 p.m., the MDS Coordinator stated Resident #20's quarterly MDS assessment with the ARD of 01/22/2026 had not been completed yet. She stated it was late and she had no reasons for why it was not completed. She said she was responsible for making sure the MDS assessments were completed timely. She stated it was important to ensure MDS assessments were completed timely because it was regulatory compliance. During an interview on 02/26/2026 at 2:33 p.m., the Regional Administrator stated she expected MDS assessments to be completed according to the required timeframes within the RAI manual. She stated the MDS Coordinator was responsible for ensuring the MDS assessments were completed. She said it was important to ensure MDS assessments were completed timely because it was a regulatory requirement. Record review of the Resident Assessment policy, dated 09/13/2020, reflected .quarterly assessments will be conducted not less often than once every 3 months (92) days. Record review of the RAI Manual, updated October 2025, reflected .Quarterly (non-comprehensive) must be completed no later than the ARD date + 14 calendar days .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a Baseline Care Plan that included the instructions for resident care needed to provide effective and person-centered care for 3 of 12 residents reviewed for new admissions. (Resident #100, Resident #101, and Resident #103).The facility failed to develop a Baseline Care Plan for Resident #100's urinary catheter (tube inserted into the bladder to drain urine) within 48 hours of admission.The facility failed to develop a Baseline Care Plan for Resident #101 and Resident #103 within 48 hours of admission.This failure could place residents at risk of not receiving care and services to meet their needs.Findings included:1. Record review of Resident #100's face sheet dated [DATE] indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), cerebral infarction (stroke-blockage of blood vessels in the brain resulting in brain tissue death due to lack of oxygen), hemiplegia (severe or total loss of motor function on one side of the body due to brain damage), visual disturbances, and muscle spasms (sudden involuntary and often painful contractions of one or more muscles).Record review of Resident #100's admission MDS assessment indicated it had not been completed.During an observation and interview on [DATE] at 12:19 PM, revealed Resident #100 had a urinary catheter hanging on the side of her bed.Record review of Resident #100's Baseline Care Plan dated [DATE] revealed her Baseline Care Plan did not include a urinary catheter and interventions.2. Record review of Resident #101's face sheet dated [DATE] indicated he was [AGE] years old and admitted to the facility on [DATE] with diagnoses including acute hematogenous osteomyelitis (bone infection), diabetes (high blood sugar), and polyneuropathy (nerve pain in multiple areas).Record review of Resident #101's admission MDS assessment indicated it had not been completed.Record review or Resident #101's Active Orders Report dated [DATE] indicated he received insulin for diabetes, gabapentin for polyneuropathy, and he was receiving two different IV antibiotics (used to treat infections) for osteomyelitis. During an observation and interview on [DATE] at 3:45 PM, Resident #101 was lying in bed, and he said everything had been good. Resident #101 had a PICC (peripherally inserted central catheter into a vein in the upper arm and guided to a large vein near the heart) to right upper extremity dated [DATE]. Resident #101 said he was receiving IV antibiotics for osteomyelitis of his foot. Resident #1 said he had surgery to remove some toes on his foot and had a dressing to his right foot.Record review of Resident #101's Baseline Care Plan revealed it had been initiated on [DATE] but only listed his diagnoses and allergies at the top of the form with no other items or interventions marked and it was not signed as being completed.3. Record review of Resident #103's face sheet dated [DATE] indicated he was [AGE] years old and admitted to the facility [DATE] with diagnoses including fracture of greater trochanter (top part of upper leg bone), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), heart disease, and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath).Record review of Resident #103's admission MDS assessment indicated it had not been completed.Record review or Resident #103's Active Orders Report dated [DATE] indicated he received aspirin for heart disease, wound treatment to a skin tear to his right lower extremity, hydrocodone for pain of greater trochanter fracture, lorazepam for major depressive disorder, midodrine to treat heart disease, glipizide for diabetes, atorvastatin for hyperlipidemia (high fat in blood), and escitalopram for major depressive disorder.During an observation and interview on [DATE] at 11:14 AM, revealed Resident #103 was lying in bed and said he had just got back from therapy. Resident #103 had a urinary catheter hanging on the side of the bed. Resident #103 said his wife died last month and he fell four days after she died and broke his leg.Record review of Resident #103's Baseline Care Plan revealed there was not a Baseline Care Plan completed within 48 hours of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER: Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 Hampton Rd Texarkana, TX 75503	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #103's admission to the facility.During an interview on [DATE] at 11:58 AM, RN K said she had worked at the facility for eight months. RN K said she had not had to do an admission, but they had a manual to refer to when/if she did. RN K said the admission nurse should complete the Baseline Care Plan. RN K said the Baseline Care Plan was a baseline of what care the resident needed and they would build from that. RN K said she would need to look to see what all should be included on the Baseline Care Plan; she referred to her computer. RN K then said the Baseline Care Plan should include medications, diagnoses, allergies, advance directives, social status, smoking, alcohol use, skin issues, feeding tubes (tube inserted into stomach for nutrition administration), tracheostomy (surgical procedure creating an opening (stoma) in the neck into the trachea (tube that allows air to pass to and from lungs) to establish an airway)), wounds, urinary catheters, and IVs. RN K said if the Baseline Care Plan was not completed, the resident may not receive the care/services needed, receive proper care, or could receive delayed care.During an interview on [DATE] at 9:27 AM, RN L said the MDS nurse did all the care plans. RN L said she did admissions but did not do the Baseline Care Plans. RN L said she assumed the MDS nurse did the Baseline Care Plan.During an interview on [DATE] at 12:53 PM, the ADON said the admitting RN was responsible for completing the Baseline Care Plan within 24 hours of admission. The ADON said they wanted the Baseline Care Plan completed within 24 hours, but the process started immediately on admission. The ADON said the Baseline Care Plans should include the resident's functional abilities, assistance needed, preferences, pain, disease processes, urinary catheters, tracheostomy, and IVs. The ADON said the purpose of the Baseline Care Plans was to build a process to care for the resident to have better outcomes and for the autonomy (self-governance, independence, and freedom to make own decisions) of the resident.During an interview [DATE] at 2:26 PM, LVN M said she did admissions when she worked on the floor. LVN M said she thought the admission nurse started the Baseline Care Plan and the MDS nurse finished it. LVN M said the Baseline Care Plan's purpose was to plan the care of how they would care for the resident. LVN M said the Baseline Care Plan should be completed within 24 hours of admission. LVN M said the residents may not get the proper care if the Baseline Care Plan was not completed with all the care areas.During an interview [DATE] at 2:42 PM, the DON said during the admission process they had a list of tasks to complete. The DON said the Baseline Care Plan should be initiated by the admission nurse. The DON said the Baseline Care Plan was to provide the basis for the care to be provided. The DON said she would expect the Baseline Care Plan to be followed and completed within 24-48 hours of admission. The DON said she did not know how the Baseline Care Plan not being completed would directly affect the residents other than reviewing everything with residents. The DON said if the Baseline Care Plan was not completed then it could not be given to the resident or their responsible party.During an interview on [DATE] at 3:03 PM, the ADM said the purpose of the Baseline Care Plan was to show the basics that the resident needed, such as their basic needs and diet. The ADM said she would expect the Baseline Care Plan policy to be followed. The AMD said not having the Baseline Care Plan completed could cause them to miss the residents' basic needs.Record review of the facility's policy titled Care Plan-Process dated reviewed [DATE], indicated . the interdisciplinary team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required timeframes . 1. Initiate a Baseline Care Plan and complete within forty-eight (48) hours of admission based on the physician's orders and nursing evaluation. 2. The Baseline Plan of Care facilitates care until the comprehensive Care Plan is developed within the first fourteen days after admission . 5. The team directs care planning toward attaining and maintaining the highest optimal physical, psychosocial, functional status including Advanced Directives, and signs the approved Plan of Care .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 treatment and care in accordance with professional standards of practice for 1 of 13 (Resident #91) residents reviewed for quality of care. The facility failed to ensure a neurology referral was implemented for Resident #91, when it was ordered on 12/10/2025. These failures could place residents at an increased risk for a decreased quality of care, neglect, and decreased self-esteem.The finding included: Record review of the face sheet, dated 02/25/2026, reflected Resident #91 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of seizures (sudden, uncontrolled, and temporary burst of abnormal electrical activity in the brain, causing disturbances in awareness, behavior, sensation, or muscle function) and chronic migraine with aura, intractable (severe, recurrent headache preceded or accompanied by temporary neurological symptoms lasting over 72 hours). Record review of the quarterly MDS assessment, dated 01/17/2026, reflected Resident #91 had clear speech, was understood, and was able to understand others. Resident #91 had a BIMS score of 12, which indicated moderately impaired cognition. He had no behaviors or refusal of care. Record review of Resident #91's comprehensive care plan, dated 10/31/2025, did not reflect Resident #91's chronic migraines. Record review of the nurse practitioner's note, dated 12/10/2025, reflected Resident #91 reported he was continuing to have migraines and the medications he was taking were not helping. The assessment and plan reflected a referral order was given for neurology for migraines. The note was signed by Nurse Practitioner V. Record review of the nurse practitioner's note, dated 02/03/2026, reflected Will follow up with staff on neurology appointment. During an observation and interview on 02/23/2026 at 10:04 a.m., Resident #91 was sitting up in a chair inside his room. Resident #91 said he was in the nursing facility because he had several strokes and heart attacks. He said that he recurrent migraines and the medications were not helping him. He said Nurse Practitioner V came to the facility and was supposed to send a referral to a neurologist, but he had not seen one yet. He stated he was able to function with his headaches because he was used to them. During an interview on 02/25/2026 at 11:42 a.m., LVN O stated he normally worked 100 hall. LVN O stated Nurse Practitioner V gave orders verbally or as a text message on the phone. LVN O stated he did not recall any order given for Resident #91's neurology referral. During an interview on 02/25/2026 at 12:01 p.m., Nurse Practitioner V stated the facility was supposed to have put in the referral for a neurologist for Resident #91. She was unable to remember who she gave the order to. She said she had just returned to work from vacation and had not followed up with the nursing staff. She stated she expected the facility to ensure referrals were made when she ordered them. She stated it was important to ensure the referral for Resident #91 was made so his issues with migraines could have been addressed. She stated Resident #91 had told her he was on a medication for his migraines that helped before he came to the facility and had not been getting it at the facility. She said she made the referral so they could have restarted his medications. During an interview on 02/26/2026 at 9:45 a.m., LVN T stated she had only worked at the facility for approximately 5 days and had not received an order for a referral on Resident #91. She stated when she received orders from Nurse Practitioner V in a text message. She stated she had not experienced Nurse Practitioner V making rounds so was unsure how those orders were given. She stated it was important to ensure orders or referrals were implemented and followed up on to maintain residents' quality of care. During an interview on 02/26/2026 at 1:28 p.m., the DON stated when Nurse Practitioner V gave orders or referrals, she expected the nursing staff to immediately place the orders in the computer system and implement them. She stated referrals were made for a reason. She said it was important to initiate the referral when it was ordered so the residents could get the care and treatment they needed. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated she expected the nursing staff to ensure physician orders or referrals were followed and implemented. She stated nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675444	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management was responsible for monitoring to ensure medications or referrals were administered or implemented as ordered by the physician. She stated it was important to ensure medications were administered and referrals were initiated according to the physician orders to ensure proper treatment was given. During an interview on 02/26/2026 at 2:33 p.m. with the Regional Compliance Nurse, the policy for quality of care was requested and not provided upon exit of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #90) of 12 residents reviewed for incontinent care. The facility failed to provide timely incontinent care for Resident #90 using appropriate techniques. This failure could place residents at risk for urinary tract infections, pain, and skin breakdown.Findings include: Record review of an undated face sheet revealed Resident #90 was a [AGE] year-old female admitted on [DATE] with diagnoses of heart failure, obesity, and hypothyroidism (abnormally low activity of the thyroid gland). Record review of an annual MDS assessment dated [DATE] revealed Resident #90 had a BIMS of 14 indicating no cognitive impairment. She required dependent assistance with ADLs. Resident #90 was incontinent of bowel and bladder. Record review of the January and February 2026 ADL sheet printed 02/25/2026 revealed the following documented number of times incontinent care was performed by staff for Resident #90. January 2026 ˆ February 2026-Day shift- 3 times -Day shift- 0 times-Evening shift-13 times -Evening shift-4 times-Night shift- 18 times -Night shift- 18 times During a record review of the Grievance log dated 09/2025 to 02/2026 revealed no grievances were noted related to Resident #90 or incontinent care. During a record review of Staff Perineal Care Checkoff on 02/25/2026 for CNA B revealed all areas were completed as proficient. During an interview on 02/23/2026 at 9:15 a.m., Resident #90 stated she was having a major problem with the staff keeping her clean and dry. She stated on average she was cleaned and dried once per shift. She stated on 2 occasions this month she had gone more than an entire day without being cleaned. She stated the CNA often put blankets under her to catch the urine and keep the sheets dry. She stated she allowed them to do so because it was better than lying on a wet mattress. Resident #90 stated it had gotten so bad she reached out to the Ombudsman because the Social Worker and DON were not doing anything to remedy the situation. She stated she felt it was her right to be cleaned and dry. She stated she understood that she was a bigger lady and it took more than one person to perform pericare on her, but she still had the right to be clean and dry. During an observation and interview on 02/24/2026 at 10:45 a.m., revealed CNA B and CNA D entered the room of Resident #90 to perform pericare. CNA B washed her hands prior to beginning pericare and not again until she left the room. CNA D did not wash her hands prior to beginning pericare. CNA B stated, I do not have hand sanitizer, and the facility does not provide it, so I am going to just do the pericare like I always do. CNA B began pericare. During removal of the brief for Resident #90 it was noted the brief was completely saturated and urine leaked from it as it was tucked under the resident to remove it, saturating the sheets. The strong smell of ammonia was present. CNA B stated this was the first time I touched her (Resident #90) today. She stated night shift had to have put the two blankets under her, because she did not double pad people. Resident #90 stated it was the first time she had been changed since around 2:00 a.m. and her skin was sore on her thighs, buttock and vagina from being wet so long. CNA B changed gloves, did not wash her hands, and continued with incontinent care. CNA B wiped from the top of the buttocks toward the vagina 4 times using the same wipe and BM was noted on the wipe when it was disposed of. CNA B stated she felt that because of Resident #90's smell she should give her a bed bath even though it was not Resident #90's day to receive a bath. During an interview on 02/24/2026 at 11:30 a.m., CNA B stated she knew she had not done well on pericare because she did not have hand sanitizer and she wiped from butt to vagina and that could cause infection. She stated she was nervous. CNA B stated there was not enough staff to keep all the residents clean and dry like they deserved to be. CNA B stated she felt very bad about not being able to get to everyone's incontinent care and baths like they deserved. During an interview on 02/25/2026 at 2:00 p.m., the Ombudsman stated she had visited Resident #90 and reported her care concerns of not being changed and bathed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timely to the DON and Administrator. She stated she told Resident #90 to contact the state and make a complaint against the facility if the care did not improve after letting them know the issues. During an interview on 02/25/2026 at 3:00 p.m., the DON stated the facility would provide hand sanitizer if the CNAs let them know they did not have any. She stated she expected hand sanitizer and hand washing to be done multiple times during each episode of pericare. The DON stated not sanitizing hands and wiping from back to front introduced bacteria to the urinary tract and could lead to urinary tract infections. The DON stated there were two CNAs on hall 400 on 02/24/2026 day shift and there was no reason that pericare was not done in a reasonable time. She stated reasonable times depend on the resident and that Resident #90 was not a heavy wetter, so she may not be wet every 2 hours. The DON stated the facility had a big problem with documentation. She believed more care was provided to the residents than was seen in the medical record. The DON stated she and her ADON monitored CNA proficiency by watching care for each CNA at least annually. She stated CNA B had a proficiency checkoff on hire and she had only been employed for a few months. During an interview on 02/25/2026 at 4:00 p.m., the Administrator stated she expected the CNAs to perform perineal care by the book. She stated perineal care had to be performed timely and using techniques to prevent infection. The Administrator stated there was enough staff in the building on 02/24/2026 and no care should have been delivered untimely. The Administrator stated she was unaware of the problems Resident #90 was having with care because she was an interim administrator for the facility while the other administrator was out. She stated if the resident complained to the staff, she expected a grievance to be written and followed up in to remedy care issues. Review of a policy titled ?Perineal Care' dated 2025 revealed the following steps for perineal care of a female. Staff will provide cleanliness of genitalia to avoid skin breakdown and infection. Staff will perform perineal/incontinent care with each bath and after each incontinent episode.Clean anal area by first wiping off fecal material with toilet tissue. (For females, wash by wiping from vagina toward anus with one stroke). Discard washcloth. Change bath water as indicated when discolored or soapy. Repeat with clean cloth until skin is clear of fecal material.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #31) reviewed for enteral tube management. The facility failed to ensure LVN O did not push Resident #31's medications by gastrostomy tube during medication administration on 02/24/2026. This failure could place residents with gastrostomy tube at risk for complications from medication administration such as stomach cramping or damage to the tube lining.The findings included: Record review of the face sheet, dated 02/25/2026, reflected Resident #31 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of gastrointestinal hemorrhage (bleeding in the stomach or intestinal tract), dysphagia (difficulty swallowing), and gastrostomy status (surgically created opening in the stomach wall). Record review of the quarterly MDS assessment, dated 07/14/2026, reflected Resident #31 had clear speech, was usually understood, and was sometimes able to understand others. Resident #31 had a BIMS score of 03, which indicated severe cognitive impairment. The MDS reflected Resident #31 had a feeding tube and received 51% or greater total calories through the feeding tube. Record review of the comprehensive care plan, dated 10/17/3025, reflected Resident #31 had a feeding tube necessary for nutritional needs due to dysphagia. The interventions included: monitor for tube dislodgment, blockage, or leakage; monitor feeding tube site for redness or signs of infection; and observed tube placement before each feeding. Record review of Resident #31's active orders report, dated 02/26/2026, reflected an order which started 09/05/2025 for lorazepam 0.5 mg tablet via enteral tube three times a day, hold for sedation. Record review of the MAR, dated February 2026, reflected Resident #31 received lorazepam 0.5 mg via enteral tube three times a day. During an observation on 02/24/2026 at 11:28 a.m., LVN O used a 60 mL feeding tube syringe to push Resident #31's scheduled lorazepam (antianxiety medication) into her gastrostomy tube. He also pushed the flushes before and after the medication administration. During an interview on 02/24/2026 at 11:43 a.m., LVN O stated he normally pushed Resident #31's flushes and medications because the gastrostomy tube stopped up frequently. He said he was provided with a skills check off for medication administration through the feeding tube when he was hired. He was unable to remember who performed the check off. LVN O stated he knew he was supposed to flush before and after the medication administration, but stated he was not told he should not have pushed the liquids through the tubing. He stated the medication probably should have been given by gravity. He said pushing medications through the gastrostomy tube could have caused air in Resident #31's abdomen which could have caused bloating and gas pain. During an interview on 02/26/2026 at 1:28 p.m., the DON stated pushing medications or flushes through a gastrostomy tube was not the proper way to administer medications. She stated the flushes and medications should have been given to via gravity. She said nursing management provided skills check offs annually and upon hire. She said the skills check offs were completed by a preceptor (seasoned staff member). She was unsure who performed LVN O's skills check off. The DON stated it was important to ensure proper technique was used for gastrostomy tube medication administration to prevent trauma or distress to the resident. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated she expected the clinical staff to follow the best practices for gastrostomy tube management. She stated the clinical staff were responsible for monitoring to ensure the best practices were used for medication administration through the gastrostomy tube. She stated Iit was important to ensure the proper technique was used during medication administration through the gastrostomy tube to minimize the risk of injuries. Record review of the Enteral Nutrition policy, dated 05/19/2023, reflected Enteral nutrition therapy will be performed in a safe manner by qualified licensed nurses according to standard practice guidelines. The policy did not address medication administration through the feeding tube.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 7 errors out of 32 opportunities, resulting in a 21.88 percent medication error rate for 2 of 7 residents reviewed for medication error. (Resident's #20, #34) The facility did not ensure the following:1. Resident #20's Vitamin D3, magnesium oxide, multivitamin with minerals, B-12 methyl, and Vitamin C were administered on 02/24/2026.2. Resident #34's esomeprazole magnesium (for indigestion) and Bisacodyl suppository 10 mg was administered on 02/25/2026. These failures could place residents at risk for adverse reactions or ineffective dosage related to inaccurate drug administration. The findings included: 1. During an observation on 02/24/2026 beginning at 8:07 a.m., LVN O prepared Resident #20's medication for administration. LVN O prepared four pills, crushed them, mixed them with a small amount of apple sauce and administered them to Resident #20. LVN O did not include Resident #20's scheduled vitamin C, B-12 methyl, magnesium oxide, multivitamin with minerals, and Vitamin D3. Record review of the active orders report, dated 02/26/2026, reflected Resident #20 had an order for the following:1. Vitamin C 500 mg - 1 tablet by mouth twice a day for skin changes; started on 09/16/2025.2. B12 methyl 1000 mcg - 1 tablet by mouth once a day for vitamin D deficiency; started on 08/28/2025.3. magnesium oxide 400 mg - 1 tablet by mouth once a day for magnesium deficiency; started on 06/28/2025.4. multivitamin with minerals - 1 tablet by mouth once day for prophylactic; started on 06/16/2025.5. Vitamin D3 - 1 tablet by mouth twice a day; started on 06/16/2025. Record review of the MAR, dated February 2026, reflected Resident #20's vitamin C, B-12 methyl, magnesium oxide, multivitamin with minerals, and vitamin D3 was signed out as administered on 02/24/2026. 2. During an observation on 02/25/2026 beginning at 7:34 a.m., LVN U prepared Resident #34's medications for administration. LVN U placed 8 tablets into the medication cup, including one Bisacodyl 5 mg tablet. LVN U did not include or administer Resident #34's scheduled esomeprazole magnesium. Record review of the active orders report, dated 02/26/2026, reflected Resident #34 had the following orders:1. esomeprazole magnesium 20 mg - 1 capsule by mouth once time a day for gastroesophageal reflux disease, which started on 08/19/2025.2. Bisacodyl 10 mg suppository - 1 suppository rectally one time a day for constipation, which started on 06/16/2025. Record review of Resident #34's MAR, dated February 2026, reflected the bisacodyl 10 mg suppository and esomeprazole magnesium 20 mg was signed out as given. During an interview on 02/25/2026 at 11:42 a.m., LVN O stated he was only responsible for administering certain medications that required blood pressure, or assessment, or monitoring. LVN O stated he was not responsible for administering Resident #20's vitamins. He said that the medication aides were responsible for giving those types of medications. He stated MA P gave Resident #20 her vitamins. During an interview on 02/25/2026 at 4:58 p.m., LVN U stated today was her first day working at the facility. She stated she worked with agency. LVN U stated Resident #34 was not given his esomeprazole magnesium because it needed to be reordered from the pharmacy. LVN U stated she did not realize Resident #34's Bisacodyl was supposed to have been given in the suppository form. She stated she must have just overlooked the order dosage amount and the route or form it should have been given because she was nervous and new to the charting system and facility. She said it was important to ensure the correct dosage and route was administered to prevent medication errors or side effects from missing or incorrect medications. During an interview on 02/26/2026 at 1:28 p.m., the DON stated esomeprazole magnesium was an over-the-counter medication that was not required to be sent from the pharmacy. She stated the medications were stocked in the medication room. She said she expected the nursing staff to communicate promptly when medications were running low or unavailable. The DON stated she expected the nursing staff to follow the MAR and administer medications by the physician orders. She said new staff or agency staff should be triple checking the MAR against the card to ensure the correct medication, the correct dose, and the correct medication route was administered. She stated the person who administered the medication should have been the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one signing out the medication on the MAR. She said it was important to ensure medications were given promptly when ordered and were administered according to the physician orders because the medications were prescribed for a reason. She stated it was vital to receive medications to improve or maintain their health status. During an interview on 02/26/2026 at 2:03 p.m., the Regional Administrator stated expected the nursing staff to ensure physician orders were followed. She stated she expected the person administering the medications should have signed it out. She stated nursing management was responsible for monitoring to ensure medications were administered as ordered by the physician. She stated it was important to ensure medications were administered according to the physician orders to ensure proper treatment was given. During an interview on 02/26/2026 at 2:39 p.m., MA P stated LVN O was responsible for giving Resident #20 all her medications. MA P stated she had not given Resident #20 medications for a while now and she would not even know what she took. Record review of the Medication Administration policy, dated January 2024, reflected Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. compare the medication and dosage schedule on the resident's MAR with the medication label.medications are administered in accordance with written orders of the prescriber.the person who prepares the dose from administration is the person who administers the dose.verify medication is correct three times before administering the medication.when pulling medication package from med cart. when dose is prepared. before dose is administered. Record review of the Medication Error: Reporting and Management policy, dated 01/10/2023, reflected .Administration Error - Wrong: .b. dose.e. route. Omissions - the failure to administer an ordered medication to a patient before the next scheduled dose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 8 resident reviewed for physical environment (Resident #4). Resident #4's electrical bed remote had a short and would only let the head up. The remote would not let the head down or control the foot of the bed or the bed height. This deficient practice could result in decreased comfort, pain, the resident developing skin issues or deterioration of current wounds. Findings included: Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old male admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and vascular ulcers (slow-healing, painful, and often recurring open sores, typically forming around the ankles due to chronic vein disease, such as poor circulation or faulty valves). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS score of 15 which indicated no cognitive impairment. It revealed he had no behavior and had not refused care. Resident #4 required partial (helper does less than half the work) for bed mobility, personal hygiene, dressing, and transfer. Record review of the care plan dated 01/15/2026 revealed Resident #4 had a venous stasis ulcer (slow-healing, chronic, and often painful open sores that typically form on the lower legs, usually near the ankle, due to poor blood flow and high pressure in the veins)on his right lateral (outside) ankle, right medial (mid) calf, and a non-pressure ulcer to his right buttock. Record review of the maintenance request log dated November 2025 to February 2026 revealed a request from 12/09/2025 that indicated the bed remote in Resident #4's room was not working consistently. The Maintenance Director replied on the form, checked out ok and signed the form as completed. No other maintenance requests were noted related to bed remotes. During an observation and interview on 02/23/2026 at 9:30 a.m., Resident #4 stated he had several concerns with his care. He pointed out that he was 6'8 tall and his bed was uncomfortable. Resident #4's feet were hanging over the footboard of the bed. He stated the remote that let the head and feet up and down had a short in it and had the short for over 2 months. He stated he had talked with the maintenance man several times about replacing it, but it had not happened yet, so he was stuck in the position he was in with his head at about 45 degrees. Resident #4 stated that he leans to the right side and is often left that way for hours before someone comes in and repositioned him. He stated he could reposition himself if he could let the bed up and down, but the remote does not work. Resident #4 was noted to be leaning to the right side lying on his paralyzed arm and hand and his right foot was dropped to the right side. During an observation and interview on 02/23/2025 at 11:00 a.m., Resident #4 continued to be positioned on his right side lying on his right arm and hand. Resident #4 attempted to let his head and feet up or down and remote would not function. During an observation and interview on 02/23/2025 at 1:20 p.m., Resident #4 continued to be positioned on his right side lying on his paralyzed right arm and hand. Resident #4 stated at least he could not feel the arm and hand, but he would like to be turned and pulled up in the bed because his heel was starting to hurt from resting on the footrest. He said it hurt when the staff pulled him up in bed with the head of the bed elevated like it was, but he had no choice since his remote was not working. During an observation on 02/23/2025 at 3:40 p.m., Resident #4 continued to be positioned on his right side lying on his paralyzed right arm and hand. Resident #4's heels were resting on the footboard, and he stated he needed to be pulled up in the bed. He stated he asked the people that brought his lunch tray to pull him up in bed, but they said they were not nurses or aides.During an observation on 02/24/2026 at 9:00 a.m., Resident #4 was up in bed, but the remote was not functioning to let his head up and down. During an observation and interview on 02/24/2026 at 11:00 a.m., Resident #4's wound care was performed by the treatment nurse with the wound NP H assisting. Wound care was carried out in a professional manner. The wound care NP H stated he was concerned about Resident #4's heels resting on the footboard and the fact that his bed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remote had not worked in the last 6-8 weeks. He stated he alerted the nurse that it was not functioning, and she said she would put it in a work order. During an interview on 02/25/2025 at 1:50 p.m., the Maintenance Director stated he was unaware Resident #4's remote for his bed was not functioning properly. He stated, more than likely, it had short in the cord because that was the cause of most malfunctions with the beds. The maintenance man stated he had not been informed about Resident #4's bed remote functioning. During an interview on 02/25/2025 at 2:05 p.m., the Maintenance Director stated he remembered the work order for Resident #4's bed remote and he ordered a new one that had not arrived yet. He stated he was able to remove a remote from an unoccupied bed and replace Resident #4's remote. During an interview on 02/25/2026 at 3:00 p.m., the DON stated it was important for all residents to have functioning bed remotes. The DON stated non-functioning bed remotes could result in discomfort for the resident, skin breakdown, and injury to the resident or staff. The DON stated the Maintenance Director was responsible for making monthly checks on all equipment as well as completing any work orders regarding bed malfunctions. During an interview on 02/25/2025 at 3:00 p.m., the Administrator stated it was the Maintenance Director's responsibility to maintain all equipment in the facility. The Administrator stated the maintenance director was responsible for checking equipment such as beds and wheelchairs at least monthly and completing work orders daily. The Administrator stated it was important to have functioning equipment for all residents for safety. The Administrator stated they had no policy on the functioning of essential equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #4, Resident #21, Resident #23 and Resident #34) of 18 residents reviewed for care plans. 1. The facility failed to ensure Resident #4 had a complete comprehensive care plan.2. The facility failed to ensure Resident #21 had a care plan for high-risk medications (antianxiety, antidepressant, and opioid).3. The facility failed to ensure Resident #23 had a complete comprehensive care plan.4. The facility failed to ensure Resident #34 had a complete comprehensive care plan. These failures could place residents at risk of not having their individualized needs met, falls, decreased range of motion and a decline in their quality of care and life.Findings included: 1. Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old male admitted on [DATE] with diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and vascular ulcers (slow-healing, painful, and often recurring open sores, typically forming around the ankles due to chronic vein disease, such as poor circulation or faulty valves). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS of 15 which indicated no cognitive impairment. The MDS revealed he had no behavior and had not refused care. Resident #4 required partial (helper does less than half the work) for bed mobility, personal hygiene, dressing, and transfer. Resident #4 had the potential for falls, pressure ulcers, high-risk medication usage (insulin, antidepressant and hypnotics). Record review of the care plan dated 01/15/2026 revealed Resident #4 had no care plans for ADLs, potential for falls, psychotropic medication, high-risk medication (insulin) usage. 2. Record review of an undated face sheet revealed Resident #21 was a [AGE] year-old male admitted on [DATE] with diagnoses of diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), blindness to one eye, and chronic pain. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #21 had a BIMS of 15 which indicated no cognitive impairment. The MDS revealed he had no behavior and had not refused care. Resident #21 was independent for ADLs. He was taking high risk medications from the following drug classes; antianxiety, antidepressant, hypnotic, diuretic, opioid, hypoglycemic, and anticonvulsants. Record review of the care plans dated 10/01/2025 revealed Resident #21 had no care plans for antianxiety medication, antidepressant, hypnotic, diuretic, hypoglycemic, anticonvulsant and opioid usage. 3. Record review of an undated face sheet revealed Resident #23 was a [AGE] year-old female admitted on [DATE] with diagnoses of diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar), depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, and, if untreated, can last for weeks or years), and peripheral vascular disease (refers to the restriction of blood flow in blood vessels outside the heart and brain, commonly caused by atherosclerosis [plaque buildup] in the arteries). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #23 had a BIMS of 15 which indicated no cognitive impairment. Resident #23 required partial (helper does less than half the work) assistance with ADLs. Resident #23 had a diagnosis of depression and seizure disorder, and diabetes. Resident #23 took antidepressant medication and opioid use. Resident #23 had multiple falls with no injury. Record review of a care plan dated 10/27/2025 revealed Resident #23 had no care plan for depression, antidepressant use, seizure disorder, opioid use, diabetes and multiple falls. 4. Record review of an undated face sheet revealed Resident #34 was a [AGE] year-old male admitted on [DATE] with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	

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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	diagnoses of CVA (cerebral vascular accident [stroke], hemiplegia to right side (paralysis to single side of the body), and seizure disorder (a sudden, uncontrolled burst of electrical activity in the brain that causes temporary, involuntary changes in movement, sensation, behavior, or awareness). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #34 had a BIMS of 06 which indicated severe cognitive impairment. The MDS revealed Resident #34 had hemiplegia, constipation, traumatic brain injury, depression, anxiety and a seizure disorder. Resident #34 was incontinent of bowel and bladder and took antidepressants and diuretics daily. Record review of a care plan dated 11/02/2025 revealed Resident #34 had no care plans for hemiplegia, constipation, traumatic brain injury, depression, anxiety or seizure disorders. There were no care plans for Resident #34's incontinence or use of antidepressants and diuretics. During an interview on 02/24/2026 at 12:20 p.m., CNA B stated she did not read the residents' care plans because she was not sure how, but it would be nice to know specific things about the residents before taking care of them. She stated if she knew details like a resident taking a fluid pill she would know that she needed to check on them more frequently either to assist them to the bathroom or provide incontinent care. During an interview on 02/24/2026 at 1:00 p.m., the MDS Coordinator stated it was her sole responsibility to complete all comprehensive and acute care plans. She stated she had corporate consultants that periodically reviewed her assessments and care plans but no one in the facility reviewed them for completion. She stated not having a care plan completed could lead to missed care or all residents being treated the same with no attention to resident specific issues. She stated all coded MDS items and any other resident specific information should be care planned for each resident. The MDS Coordinator stated she had been working the floor because of staffing issues which put her behind on her MDSs and care plans. During an interview on 02/25/2026 at 11:00 a.m., the DON stated it was the MDS nurse's responsibility. She stated all major diagnoses, conditions, medications, and falls should be care planned with interventions to alert the staff of the potential of these situations recurring and to give instructions on what to do in those cases. The DON stated that not care planning important information could lead to the residents not receiving personalized care. During an interview on 02/25/2026 at 2:00 p.m., the Administrator stated she expected the staff to follow the interventions decided on by the MDS coordinator and interdisciplinary team. She stated the interventions were in place to keep everyone safe and well cared for. She stated not having the items care planned would not necessarily cause any ill effect to the residents. Record review of the Care Plans, Comprehensive Person-Centered policy, dated March 2022, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.the comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;.and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.the interdisciplinary team reviews and updates the care plan. at least quarterly.