STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675471	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that it was not possible or the resident preferences indicated otherwise for 4 of 4 residents (Resident #1, Resident #2, Resident #3, Resident #4) reviewed for nutrition status. 1.The facility failed to follow dietary recommendations for Resident #1. Resident # 1 lost 8.2 lbs. from 12/03/2025 to 01/12/2026 which was a significant weight loss of 5.0%. 2. The facility failed to follow dietary recommendations for Resident #2. Resident #2 lost 16.9 lbs. from 12/04/2025 to 01/12/2026 which was a significant weight loss of 5.5% in 1 month. 3. The facility failed to follow dietary recommendations for Resident #3. Resident #3 had a re-opened left dorsal foot graft site with a low albumin level. 4. The facility failed to follow dietary recommendations for Resident #4. Resident #4 lost 11.6 lbs. from 07/10/2025 to 01/12/2026which was a non-significant weight loss of 7.9% in 6 months. These failures could place residents at-risk for loss of weight, inadequate nutrition and delayed wound healing.Findings include: 1. Record review of Resident #1's face sheet, dated 02/20/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #1 had diagnoses which included atrial fibrillation (a heart rhythm disorder), heart failure (impairment of the heart's ability to fill with and pump blood), hypertension, (high blood pressure) hyperlipidemia (high levels of fats in the blood), celiac disease (an autoimmune disorder that leads to malnutrition) and cystic fibrosis with intestinal manifestations (occurs when dehydrated mucous results in chronic constipation and malabsorption). Record review of Resident #1's Annual comprehensive MDS, dated [DATE], revealed BIMS score of 15, which indicated no cognitive impairment. Section K: Nutritional Approaches revealed no dietary modifications required. Record review of Resident #1's EMR, accessed 02/20/2026, revealed a height of 63 inches and weight of 138.1 lbs. on 12/03/2025 and 129/9 lbs. on 01/12/2026. Record review of Resident #1's Nutrition/Dietary, dated 01/30/2026 at 10:31 p.m. by the Registered Dietician, revealed recommendation for ice cream BID (twice daily) with lunch and dinner. Record review of Resident #1's physician's orders, reviewed 02/20/2026, revealed: Diet: No Fried foods, Regular texture, thin consistency, Gluten free diet. Breakfast with Oatmeal, bacon or sausage links. No beans or cabbage, dated 07/23/2026, with no changes or reviews since. Resident #1's EMR revealed no order for ice cream BID with lunch and dinner and no documentation that the physician was notified to accept or decline the recommendation. Record review of Resident #1's care plan, with target date of 05/12/2026, revealed Focus area: The resident has a potential nutritional problem and is at risk for Malnutrition related to celiac disease. Goal: The resident will comply with recommended diet through review date. Interventions: Registered Dietician to evaluate and make diet change recommendations PRN, Monitor/record/report to MD PRN signs and symptoms of malnutrition, Provide, serve diet as ordered. During an interview on 02/20/2026 at 10;40 a.m., Resident #1 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she had never received ice cream with lunch or dinner or at any other time that she recalled. The resident stated she was aware of weight fluctuations and noted she received diuretics. During an observation of the lunch meal on 02/20/2026 from 12:16 p.m. - 1:20 p.m., revealed Resident #1 did not have an ice cream with her lunch and tray ticket showed no evidence of an ice cream with lunch. 2. Record review of Resident #2's face sheet, dated 02/20/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Chronic Obstructive Pulmonary Disease (a progressive lung disease causing severe breathing issues), hypertension (high blood pressure), Diabetes Type II (a chronic metabolic disorder where the body develops insulin resistance causing high blood sugar levels), heart failure (impairment of the heart's ability to fill with and pump blood), and Benign Prostatic Hyperplasia (enlargement of the prostate gland caused by age-related hormone changes). Record review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score 15, which indicated no cognitive impairment. Section K: Nutritional Approaches revealed unable to complete interview. Further review Section K: Nutritional Approaches: no dietary modifications required. Record review of Resident #2's EMR, accessed 02/20/2026, revealed a height of 61 inches and weight of 308.7 lbs. on 12/03/2025 and 291.8 lbs. on 01/12/2026. Record review of Resident #2's physicians orders, reviewed 02/20/2026, revealed: Diet: Regular texture, thin consistency, Double meat portions, dated 07/16/2025, with no changes or reviews since that date. Record review of Resident #2's Nutrition/Dietary note, dated 01/30/2026 at 10:33 p.m., revealed recommendation for sugar free health shake 1 can QD (daily) between meals. Resident #2's EMR revealed no order for sugar free health shake 1 can QD (daily) between meals and no documentation the physician was notified to accept or decline the recommendation. Record review of Resident #2's care plan, with target date of 04/21/2026, revealed Focus area: The resident has a nutritional problem or potential nutritional problem and is at risk for malnutrition related to diabetes diagnosis, malnutrition risk. goal: The resident will not develop complications related to obesity, including skin breakdown, ineffective breathing patters, altered cardiac output, diabetes, impaired mobility through review date. Interventions: Provide and serve diet as ordered, Registered Dietician to evaluate and make diet change recommendations PRN. During an interview on 02/20/2026 at 12:16 p.m., Resident #2 stated he had not received a health shake between meals and has never received a health shake that he recalled. 3. Record review of Resident #3's face sheet, dated 02/20/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #3 had diagnoses which included peripheral vascular disease (a slow-progressing condition involving the narrowing or blockage of blood vessels outside of the heart), chronic ulcer of left foot, protein-calorie malnutrition (a severe nutrient deficiency leading to reduced body mass and poor immune function), anemia (a condition marked by lack of healthy red blood cells causing reduced oxygen transport) and hypertension (high blood pressure). Record review of Resident #3's Annual comprehensive MDS, dated [DATE], revealed a BIMS Score of 5, which indicated severe problems with thinking and memory. Section K: Nutritional Approaches revealed the resident received a therapeutic diet. Record review of Resident #3's EMR, accessed 02/20/2026, revealed a height of 64 inches and weight of 175.1 lbs. on 12/04/2025 and 168 lbs. on 01/08/2026 Record review of Resident #3's physicians orders, reviewed 02/20/2026, revealed Diet: No added salt, regular texture, thin consistency, no shrimp, lobster or mango fruit, dated 04/21/2025, with no changes or reviews since that date. Record review of Resident #3's Nutrition/Dietary note, dated 01/30/2026 at 10:36 p.m., revealed recommendations for ice cream with lunch and Prostat (a concentrated liquid protein drink designed to treat wounds) 30 cc BID for low albumin. Resident #3's physicians orders revealed no order for ice cream with lunch or Prostat 30 cc's BID for low albumin. Record review of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3's care plan, with target date of 04/16/2026, revealed Focus area: Receives regular diet. Goal: Will maintain stable weight without significant change through next review period. Interventions: House shake (with sugar) one time a day for weight maintenance, med pass two time a day for weight stability 90cc, Fortified cereal with breakfast, provide diet as ordered, provide nutritional supplement as recommended/ordered, RD to evaluate and follow as appropriate. During an interview on 02/20/2026 at 9:45 a.m., Resident #3 stated she had not received ice cream with her lunch and had not received a protein drink twice a day. During an observation of the lunch meal on 02/20/2026 from 12:16 p.m. - 1:20 p.m., revealed Resident #3 did not have an ice cream with her lunch and diet ticket showed no evidence of ice cream with lunch meal. 4. Record review of Resident #4's face sheet, dated 02/20/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #4 had diagnoses which included metabolic encephalopathy (a brain dysfunction caused by systemic imbalances), cerebral infarction (blocked blood flow to the brain leading to tissue death), Parkinsonism (a progressive nervous system disorder that affects movement), and dysphagia with gastrostomy status (difficulty swallowing with a feeding tube). Record review of Resident #4's quarterly MDS, dated [DATE], revealed short-term and long-term memory deficit and severe impairment for daily decision making. Section K: Nutritional Approaches revealed resident received a mechanically altered diet and had a feeding tube. Record review of Resident #4's EMR, accessed 02/20/2026, revealed a height of 66 inches and a non-significant weight loss of 11.6 lbs. (7.9%) over 6 months with a weight of 156.6 lbs. on 07/10/2025 and 145 lbs. on 1/12/26. Record review of Resident #4's physicians orders, reviewed 02/20/2026, revealed Diet: Pureed texture, thin consistency, cue as needed for small bits and sips for pleasure feeding related to metabolic encephalopathy, Parkinsonism, dated 09/26/2025, with no changes or reviews since that date. Record review of Resident #4's Nutrition/dietary note, dated 01/30/2026 at 10:42 p.m., revealed recommendation included Med pass 2.0 (a high calorie, high protein nutritional supplements) 120cc BID to prevent any further weight loss. Record review of Resident #4's care plan, with target date 05/19/2026, revealed Focus area: Requires tube feeding related to dysphagia, Jevity 1.5 - 300cc every 6 hours to provide 1800 kilocalories every 24 hours, pleasure feedings-pureed texture. Goal: Will maintain adequate nutritional and hydration status as evidenced by weight stable, no signs or symptoms of malnutrition or dehydration through review date. Interventions: Provide pleasure feedings encouraging small bites and sips of fluid, RD to evaluate quarterly and PRN, monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed. An interview with Resident #4 was attempted on 02/20/2026 at 10:50 a.m., Resident # 4 was not cognitively able to respond to interview questions pertaining to oral intake. During an interview on 02/20/2026 at 12:08 p.m., LVN A stated Resident #1 did not receive an ice cream with her lunch meal, Resident #2 did not receive a health shake between his meals, Resident # 3 did not receive ice cream with her lunch meal and Resident #4 did not have an order for Med pass 2.0 twice daily. During an interview on 02/20/2026 at 12:28 p.m., the Food Service Supervisor revealed the RD provided the dietary recommendations to the DON for review with the MD and obtained orders as approved. The Food Service Supervisor stated the nursing department was responsible for putting the order into the EMR and once the order was placed, the FSS was notified by the nursing department and would apply to the ticket. The Food Service Supervisor stated she had not received any dietary recommendations for Resident #1, Resident #2, Resident #3 or Resident #4 for the January 2026 recommendations. During a phone interview on 02/20/26 at 12:51 p.m., the Registered Dietician stated she provided the facility with her recommendations within 24 hours of her visit and expected recommendations to be acted upon with the physician within 72 hours. The RD stated her next scheduled visit was 02/23/26 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and she would review all recommendations with the DON. The Registered Dietician stated that is important for recommendations to be addressed with the physician to avoid any weight loss or wound healing concerns. During an interview on 02/20/2026 at 1:00 p.m., the ADON stated she had been assigned to ensure the dietary recommendations were acted upon, and she was still working on them. The ADON stated she was fairly new at the facility and was still learning the processes. During an interview on 02/20/2026 at 1:25 p.m., the DON stated the dietary recommendations should be provided to the physician as soon as possible and stated the physician had a folder at the nurse's station that recommendations were placed if not immediate and were faxed to his office if quicker attention was required. The DON stated that she had assigned the dietary recommendations to her new ADON but failed to provide sufficient monitoring to ensure the recommendations were addressed with the physician. The DON stated the physician rounds weekly and reviewed the folders at each visit. The DON stated it was her responsibility to ensure the physician was notified of the dietary recommendations and completed timely. The DON stated failure to act on recommendations could result in compromised nutrition and weight loss. The DON stated Resident #1, Resident #2, Resident #3 and Resident #4 had no adverse effects due to the delay in processing the dietician's recommendations and noted that all residents with dietary recommendations could be adversely affected by weight loss or delayed wound healing. During an interview on 02/20/2026 at 1:35 p.m., the Administrator stated she expected the nursing staff to act on the dietary recommendations as soon as possible to prevent weight loss. The Administrator stated she had been working at this facility for approximately 3 months and would follow up with the DON regarding the dietary recommendations. During an interview on 02/23/2026 at 12:08 p.m., the physician for Resident #1, Resident #2, Resident #3 and Resident #4 stated he was not notified of the dietary recommendations completed by the RD on 01/30/2026. The physician stated the nursing staff placed recommendations in his folder that was left at the nurse's stations for his review or sometimes would fax them to his office if the recommendation pertained to a significant weight loss or gain. In review of the recommendations for the identified residents, the physician stated no adverse effects were identified for these residents, noting Resident #1's weight was within normal limits and resident was on diuretic therapy and weight fluctuations would be expected; Resident # 2 was morbidly obese and was on diuretic therapy, with expected weight fluctuations; Resident #3 was already receiving a nutritional supplement twice daily and the foot wound was a chronic condition, noting delay in starting Prostat would not significantly affect the wound healing process; and Resident #4 received his primary nutrition via a feeding tube and the Med pass twice daily was a supplement due to poor oral intake. Record review of the facility's policy titled Consultant Recommendations and Follow Up, reviewed 06/23/2025, revealed 4. The recommendations will be followed up on within 72 hours, and 6. If a physician does not respond or choose to follow the recommendations, this must be documents in the nurse's notes and on the recommendation sheet.