STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interviews and record reviews, the facility failed to ensure the right to be free from abuse for two (Residents #2 and #3) of 4 residents reviewed for abuse. The facility failed to ensure Resident #2 was free from abuse. On 05/09/25, Resident #1 slapped Resident #2 in the face twice with an open hand because Resident #2 would not give Resident #1 her napkin. The facility failed to ensure Resident #3 was free from abuse. On 05/10/25, Resident #1 grabbed Resident #3 ' s arm and slapped it four times with an open hand, once with each word, while she said, I told you so. This failure could place residents at risk for abuse and psychological harm. Findings included: Record review of Resident #1's face sheet dated 06/27/22 with an original admitted [DATE] revealed a [AGE] year-old female with diagnoses including Alzheimer ' s, (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle wasting, Diabetes, high blood pressure, major depression, anxiety disorder, and abnormalities of gait and balance. Record review of Resident #1's quarterly MDS Assessment, dated 03/15/25, reflected a [AGE] year-old female who admitted on [DATE]. Her BIMS score of 03 indicated the resident had severe cognitive impairment with physical behavioral symptoms such as hitting or scratching occurring 1 to 3 days. She required supervision for oral hygiene and eating, moderate assistance with upper body dressing, and maximal assistance with toileting, showering, lower body dressing, footwear, and personal hygiene. She could walk, reposition herself, and transfer with supervision. She did not utilize a wheelchair or walker. She was frequently incontinent of bladder and bowel. She was taking an antidepressant and insulin. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan dated 07/02/22, reflected Resident #1 had potential to be physically aggressive r/t Dementia, Depression, and Poor impulse control Date Initiated: 01/10/2023 Revision on: 01/10/2023. Resident #1 had a behavior problem r/t yelling, hits, throws things and uses abusive language due to Alzheimer's with poor cognition. RP often will refuse to allow treatment or medications for the behaviors. 05/05/25 altercation with Resident #2. 05/10/25 altercation with Resident #3 Date Initiated: 01/13/23 Revision on: 05/14/25. Resident #1 was placed on 1:1, psyche services contacted, and new orders for medication were received and implemented. 05/10/25 Removed from situation, placed on 1:1, new order for Depakote 125mg twice a day for mood stabilizer. Consent was obtained from the RP when she came in to visit the resident. Date Initiated: 05/10/25. 05/05/25 Resident removed from the situation. Placed on 1:1 observation, social worker trying to get the resident to a local Psych Hospital. Date Initiated: 05/06/25. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 01/13/23. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Date Initiated: 07/10/22. The resident uses antidepressant medication (Prozac) r/t Depression Date Initiated: 07/10/22 Revision on: 10/31/22. She resided in the memory care locked unit. Record review of Resident #2's face sheet dated 04/18/25 with an original admitted [DATE] revealed a [AGE] year-old female with diagnoses including dementia (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle wasting, anxiety disorder, depression, and abnormalities of gait and balance. Record Review of Resident #2's admission MDS Assessment, dated 05/01/25, reflected her BIMS score of 03 indicated the resident had severe cognitive impairment. She required supervision with eating, lower body dressing, personal and oral hygiene, toileting, transferring, and repositioning. She required moderate assistance with upper body dressing and footwear. She utilized a manual wheelchair and could propel herself. She was frequently incontinent of bladder and bowel. She took antianxiety and antidepressant medications. Resident #2's admission care plan dated 04/18/25 reflected Resident #2 was an elopement risk/wanderer r/t poor cognition and psychosis. Date Initiated: 04/18/2025 Revision on: 04/18/2025. She resided in the memory care locked unit. Record review of Resident #3's face sheet dated 06/19/23 revealed a [AGE] year-old female with diagnoses including dementia and early onset Alzheimer ' s (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety and mood disorders, major depression, and lack of coordination. Record Review of Resident #3's quarterly MDS Assessment, dated 02/06/25, reflected her BIMS score of 05 indicated the resident had severe cognitive impairment. She required set-up with eating. She required maximal assistance with oral hygiene. She was dependent for dressing, personal hygiene, and toileting. She was independent for walking, transferring, and repositioning. She did not utilize a wheelchair. She was frequently incontinent of bladder and bowel. She took antipsychotic, antianxiety, anticonvulsant (seizure), and antidepressant medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's care plan dated 04/18/25 reflected Resident #3 was on palliative care with hospice services due to end stage disease process of Alzheimer's. Expected physiological signs of weight loss, skin breakdown or pressure injury, dehydration, fecal impaction and gradual /rapid loss of the ability to move about or become bedfast is expected. Date Initiated: 07/02/23 Revision on: 07/22/23. Dignity will be maintained, and the resident will be kept comfortable and pain free with in one hour of intervention over the next review period Date Initiated: 07/02/2023 Target Date: 06/11/2025. I/my family, anticipate that I will remain LTC (Long Term Care) after respite stay is completed so that all of my needs can be met on a daily basis with safety. Date Initiated: 07/02/23 Revision on: 07/02/23. The resident is physically aggressive r/t dementia, depression, poor impulse control. Date Initiated: 07/22/23 Revision on: 07/22/2023. She resided in the memory care locked unit. Observation of Resident #1 in the memory unit on 05/13/25 at 2:30 pm revealed she was in the restroom. Upon leaving the restroom, she was ambulatory with a slow gait and could walk without assistive devices. She made her way with the hospitality aide at her side to one of the sofas in the memory care activity room. She sat down without difficulty or losing her balance. The hospitality aide sat down beside her. She was talkative with the hospitality aide while sitting on the couch. She was touching herself in between the legs and smiling. She was trying to take her pants down even though she just came out of the restroom. She told the hospitality aide she needed to use the restroom again for a bowel movement. She was saying she forgot toilet paper when she was sitting on the couch. In an interview with the hospitality aide, she said she was currently 1:1 with Resident #1 because she either fell recently or hit someone else. She said she had worked at the facility for 4 weeks and said Resident #1 did not hit others very often. In an interview with LVN A on 05/13/25 at 5:54 pm, she said she worked at the facility for 3 years and was familiar with all of the residents in the memory unit, as she only worked in the memory unit. She said Resident #1 got physical faster and would usually strike first. She said Resident #1 got agitated for no obvious reason-she saw her hitting a window with a belt one time. She said she was not at the facility during the incident between Resident #1 and Resident #3, but she heard Residents #1 and #3 were arguing and one hit the other and Resident #1 was put on 1:1 and she has stayed on 1:1 status ever since. She said the doctors were also making medication changes on Resident #1. In an interview with the SW on 05/14/25 at 9:30 am, she said she had worked at the facility since June 2025. She said on 05/10/25 she called the RP to discuss Resident #1's behavior. She said the local psychiatric hospital called the daughter to tell her they could meet Resident #1's needs and the RP told them her mother did not need psychiatric care, and she demanded to speak with the doctor's there. The SW said she received a phone call from the local psychiatric hospital and was told the RP would not let the intake specialist at the local psychiatric hospital get a word in to explain the procedures and the phone call ended there. She said the local psychiatric hospital called her (the SW) and told her they had been aggressively spoken to by the RP and the local psychiatric hospital closed out the referral. The SW said a meeting was held with the RP, ADM, DON, and RD. She said the RP told her she did not want Resident #1 to be on psychotropics because they would make her too sleepy. The SW said the RP told her she was going to see if the other nursing home in town would take her. The SW said the RP was able to get a referral yesterday (05/13/25) to transfer Resident #1 to the other nursing home in town. The SW said the Ombudsman would meet with the SW, RP, ADM, and DON on Friday, 05/16/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN B on 05/14/25 at 1:43 pm, she said Resident #1's RP had not wanted her to be on any medications, and the facility was just recently able to try the medications (last 5 days ago). LVN B said she explained to the RP that it would take several days or even weeks for the medications to take effect. LVN B said the RP did not want Resident #1 to go to the local psychiatric hospital for evaluation and stabilization. LVN B said the facility told the RP if she did not allow them to try psyche or meds on Resident #1, they would have to transfer her due to not being able to meet her needs. She said the RP agreed this time. LVN B said the facility called the local psychiatric hospital back and they refused Resident #1 due to the way she treated them on the phone. She said she called the doctor and had to get consent for the medication Resident #1 needed. She said she called the RP to inform her and she gave consent. LVN B said Resident #1 was only on the Depakote for 3 days before Resident #1 slapped the arm of Resident #3. She said they were standing near each other when Resident #1 picked up Resident #3 ' s arm and said, I. Told. You. So., slapping lightly with each word as if she was reprimanding a child and was placed back on 1:1. She said she informed the RP and the RP told her she was scared Resident #1 would be thrown out (of the facility). LVN B said she called the doctor again and was placed on Zoloft and Trazodone. LVN B said Resident #1 remained on 1:1 until she was cleared by psyche. LVN B said the doctor saw Resident #1 in the facility on Sunday, 05/11/25 when he changed her meds. She said the RP came 2-3 times a week at lunch. She said staff in the memory unit got special training including the virtual dementia course. She said she told the RP about the course so she could try to better understand what Resident #1 was going through. She said Resident #3 did not seem to be effected or fearful and she did not recall the altercation at all. In an interview with the SW on 05/15/25 at 8:45 am, she said she reached out to a behavioral health hospital in the valley yesterday and they requested lab results for Resident #1, and she was still waiting for a call back at this time. In an interview with the DON on 05/15/25 at 1:00 pm, she said all staff received dementia training on computer based training and Virtual Dementia training. She said the families and community were also offered the virtual opportunity. She said the last virtual training was in November and done annually and as needed. She said Resident #1's RP had not done any of the dementia training that she knew of. The DON said everyone was invited to the dementia classes and courses via flyers, social media, and through their mass messaging for families. She said Resident #1 had a history of aggression. She said from Dec. 31, 2022, physical aggression was initiated by risk management (incidents & accidents). She said the facility was protecting other residents because they had Resident #1 on 1:1, doing/saying/watching to try to find a root cause, labs with urinalysis (UA), medication changes, and was currently trying to get her into a facility like a behavioral hospital to see if they could make medication changes or be able to help her with whatever therapy modalities they had such as group therapy. She said the facility may have found a place in the valley-they were waiting for a call back today. She said Resident #1 had been on 1:1 continuously since 05/05/25. The DON said the facility had Resident #1set up to transfer to the local behavioral hospital but they declined because her RP was hostile toward them. She said the RP came to the facility and met with the ADM, DON, SW and the RP 's SIL. She said during the meeting, the RP was reluctant and unsure and not understanding so she wanted to call the local behavioral hospital again, so they did and that was when the local behavioral hospital said they did not have a bed for Resident #1. The DON said the RP was upset at the news then agreed to let Resident #1 go somewhere and the meeting finished. She said encounters/incidents with Resident #1 started 10/2023 when she was yelling at another resident. She said the next encounters/incidents involving Resident #1's aggression was 12/3/0/24, 05/05/25 at 1:54 pm with Resident #2, and 05/10/25 with Resident #3. She said Residents #2 and #3 did not seem to be effected or fearful and neither recalled the altercations at all. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADM on 05/15/25 at 2:00 pm, he said he started working at the facility on 12/29/24. He said he first learned of Resident #1's aggression when she slapped Resident #2 in the face earlier this month. He said the 1:1 and in-services were immediate. He said the RP blocked the transfer to the local behavioral hospital because of her hostility towards them. He said he spoke to the RP and explained why the facility needed to get the help her mother needed that could not be attained at the facility. He mentioned the RP said I don ' t have time; I have a life when the facility asked if she or someone else could sit with Resident #1. He said the physician came in on Sunday 05/11/25 and met with him. He said the physician prescribed medication for insomnia and anxiety for Resident #1. He said he spoke with the RP Tuesday 05/13/25 and informed her of the 1:1 and she was upset and demanding to know how long she was going to be on the 1:1. The RP also told the other nursing home in town Resident #1 was on a 1:1 so they did not want to accept her and told the ADM he could lift the 1:1. He explained he could not for the safety of others. He said the facility was providing 1:1's and more education specific to the aggressors to keep others safe. He said he was interviewing the staff in the memory unit to make sure they knew who the abuse coordinator was, reporting immediately, and approved paid in-services utilizing videos on the company you tube page. He said he also discusses incidents in their daily morning meetings with the department heads. In an interview with the SW on 05/15/25 at 2:25 pm, she said the valley behavioral hospital was waiting for their clinical intake person to review the lab results for Resident #1 she sent this morning. She said she had not started a NOMOC because Resident #1 was LTC and she would be considered a transfer. She said if Resident #1 was denied at the valley behavioral hospital, the next behavioral hospital was near, and she would keep trying until she found a suitable fit for Resident #1. She said the RP told the other nursing home in town Resident #1 was a 1:1 and they declined. She said the RP wanted to speak with the Ombudsman face to face, and a meeting was set for 05/16/25 at 1:15 pm. In an interview with CNA C, LVN B, CNA D, and RN E on 05/15/25 at 2:45 pm, they all stated the Abuse Coordinator was the ADM. CNA C said she worked only in the memory unit and worked at the facility for [AGE] years. She said staff received in-services and seminars for training. She said they got the Virtual Dementia Training Annually. She said they also had courses on the electronic education courses such as abuse, transfers, infection control and more. She said some of the symptoms they were taught to look for if a resident was starting to become aggressive were pain, agitation, pacing. LVN B said if a staff member did not have dementia training, they had to take the all-day course. CNA D said staff they had to take the dementia course and testing for it. RN E said she was the instructor for the CNA ' s and hospitality aides at the facility. She said the courses included dementia, behavior managing, communication, falls, safety risks, sensory impairment, agitation, and being hypervigilant. They all said Residents #2 and #3 did not seem to be effected or fearful and neither did not recall the altercations at all. The RP was not available for interview after 3 good faith attempts to contact her. Record review of all staff in-service/training dated Record review of in-services: dated 05/05/25 All staff Abuse resident to resident. Record review of psychiatric physician note dated 05/08/25 revealed Resident #1 was released from 1:1 status. Record review of 15-minute monitoring of Resident #1 beginning 05/09/35 at 6:00 am through 05/11/25 at 12:00 pm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of PIR (provider investigation report) dated 05/09/25 revealed Resident #2 was sitting in her wheelchair holding a napkin. Resident #1 attempted to grab the napkin to no avail resulting in Resident #1 slapping Resident #2. Head to toe assessments conducted on both residents. No physical or emotional distress noted to either resident. Residents were immediately separated to make sure residents were protected including if Resident #2 felt safe, increased supervision for Resident #1 by placing her on 1:1, immediate notification to physician and RP ' s and removal of alleged perpetrator. Family conference was held with Resident #1 ' s RP. In-service for Abuse and Neglect initiated for all staff. No malicious intent was determined by Resident #1. Residents did not recall the interaction. A referral was made to the local behavioral health hospital for Resident #1. He said because of the communication between the local behavioral health hospital and RP, they failed to secure a bed. He said Resident #1 ' s RP expressed she did not want Resident #1 on medications because she would fall. The facility suggested the RP come in and sit with her mom and she said, I have a life and I don't have time to sit 1:1. The ADM said another family member was also present during the conference and expressed the same concerns. He said when the doctor was on site, he gave new orders for Resident #1's anxiety and insomnia. The ADM said the RP finally gave verbal consent for med adjustment. He said Resident #1 would stay on 1:1 supervision. The ADM said, However, another altercation occurred with Resident #3 on 05/10/25. No injuries noted to either resident. He said the SW, himself, and the DON were still working with family for further review on what to do next about Resident #1' s aggressions. Record review of progress note by LVN B dated 05/10/25 at 7:03 pm: COMMUNICATION - with Physician, Situation: Resident #1 was in the activity room and was standing next to Resident #2. Resident #1 grabbed Resident #3 by the left arm and hit her three times and said I told you so in Spanish. LVN B assessed the resident, removed her from other residents, ensured her safety and notified RP, DON, ADMN, MD. New order has been obtained for on-on-one monitoring and has been initiated. Doctor has been contacted and gave a new order for Depakote 125mg BID for mood stabilizer. UA culture was also ordered to rule out UTI. Consent was obtained from RP. Record review of the facility policy titled, In-Service Training, Nurse Aid reviewed 12/09/24 4. Annual in-services: d. address the special needs of the residents, as determined by the facility assessment. e. include training that addresses the care of residents with cognitive impairment; and f. include training in dementia management and resident abuse prevention. 9. Required training topics for all staff (including nurse aides) include: c. abuse, neglect, and exploitation of residents; g. behavioral health. Record review of the facility policy titled, Abuse, Neglect, and Exploitation dated 08/15/22 defined abuse as the willful infliction of injury or intimidation. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.