STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675564	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Giddings	1181 N Williamson Giddings, TX 78942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect the resident's right to be free from abuse for one (Resident #5) of 5 residents reviewed for abuse, in that:On 12/25/25 the facility failed to ensure that Resident #5 was not hit multiple times over the head with a plastic trashcan by Resident #4. Resident #5 suffered a laceration, received three staples to his head and required a less than 24-hour hospitalization. This failure could place residents at risk of harm, serious injury and hospitalization.Findings included:Record review of Resident #4's face sheet, dated 01/05/26 revealed a seventy-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses included dementia (severe cognitive decline (memory, thinking, reasoning) impacting daily life, caused by damaged brain cells), schizophrenia (a severe brain disorder causing hallucinations (like hearing voices), delusions (false beliefs), disorganized thinking, and unusual behaviors), and Parkinson's Disease (a progressive neurological disorder affecting movement).Record review of Resident #4' MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/07/25 revealed a BIMS score of 7 indicating severe cognitive impairment.Record review of Resident #4's care plan reflected a focus, undated, of inappropriate behaviors: Resident #4 had episodes of inappropriate behaviors and was at risk for further episodes and injuries AEB physical aggression: 12/13/25 Resident #4 allegedly kicked and punched the other resident who was on the ground after the resident had entered his room and on 12/25/25 resident to resident altercation with intervention dated 04/08/25 encourage to attend social activities of preference, explain procedures, using terms/gestures resident can understand, give medications per order, monitor labs, report results to MD, monitor and chart behaviors every shift and report progress to MD.Record review of Resident #4's care plan reflected a focus dated 04/02/25 reflected Resident #4 spends limited time in activities. Resident #4 had no involvement in activities and Resident #4 had refused to participate in activities one on one with interventions dated 04/02/25 encourage conversation when assisting/providing care, offer and assist Resident #4 with TV/radio as needed in room activity, and provide 1:1 assistance as needed to participate in activities.Record review of Resident #4's care plan reflected a focus dated 04/09/25 reflected dementia. Resident #4 was at risk for increased confusion and decline in ADLs as the disease progressed, focus dated 04/09/25 of Resident #4 had a diagnosis of schizophrenia and was at risk for manic (a period of abnormally elevated mood, high energy, and increased activity) episodes, focus dated 12/26/25 Resident #4 demonstrated behaviors that made having a trash can in the room unsafe (eg inappropriate use, hygiene concerns, or safety risks), focus dated 04/09/25 Resident #4 resided in the secure unit AEB elopement risk with intervention dated 04/09/25 administer medication as ordered by MD, assist resident with ADLs as needed, reassure Resident #4 when confusion increased, reorient Resident #4 daily as needed, verbal reminders and cues to assist Resident #4 with daily orientation.Record review of physician's order dated 04/03/25 (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
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F 0600 Level of Harm - Actual harm Residents Affected - Few	reflected Resident #4 placed on the secured unit due to risk of elopement.Review of the only Elopement Risk Assessment by former DON for Resident #4 dated 06/02/25 reflected no verbal expressions to leave facility and no history of elopement.Record review of Resident #4's progress note by LVN A dated 12/13/25 reflected Pt. [Resident #4] was allegedly kicking and punching another patient who was on the ground after the patient had entered Resident #4's room. Resident #4 was upset because the other resident wandered into Resident #4's room.Record review of Resident #5's face sheet, dated 01/05/26, revealed a 125 (erroneous date) year old man who was admitted to the facility on [DATE] and readmitted on [DATE]. His admitting diagnoses included altered mental status (a significant change in a person's usual brain function, leading to confusion, disorientation, reduced alertness, or odd behaviors), acute kidney failure (the sudden loss of kidney function, causing waste and fluid to build up in the body, with symptoms like reduced urination, swelling, fatigue, nausea, and confusion), and thrombocytopenia (deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury).Record review of Resident #5's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/07/25 revealed a BIMS score of 0 indicating severe cognitive impairment.Record review of Resident #5's care plan revealed a focus dated 12/26/25 scalp laceration (a cut through the skin of the scalp, which often bleeds profusely due to the rich blood supply in the area) impaired skin integrity (the skin's normal, healthy structure is compromised, making it vulnerable to damage, infection, and breakdown) related to head trauma (occurs from a violent blow, jolt, or penetrating object to the head) as evidenced by three surgical staples (small, often titanium fasteners used by surgeons to quickly close skin wounds or reconnect internal tissues) to the scalp (the skin and tissue covering the top of the head) and a focus dated 05/20/25 of Resident #5 resided in the secure unit AEB elopement risk, need for reduced stimuli, wandering.Record review Resident #5's progress notes dated 12/25/25 reflected CNA (name of CNA not noted) reported that Resident #4 attacked another resident. CNA stated that after hearing commotion in the hall she exited a room and entered the hall to observe Resident #4 holding a plastic trashcan over another resident's head hitting him multiple times, CNA stated she separated the two residents. Resident #4 went back to his room and closed the door and remained there. The other resident [Resident #5] was escorted to the lobby and remained there.Record review of Resident #5's hospital records dated 12/26/25 reflected discharge diagnoses scalp contusion and scalp laceration. The 3 staples need to be removed in 7 days.Record review of psych NP evaluation dated 12/26/25 of Resident #4 revealed facility requested for urgent psych consult for physical aggressive behavior. History of Resident #4 present illness reflected: Psychological: depression, emotional withdrawal, anxiety, irritable, hallucinations, mood swings, paranoia/delusions, agitated, anger and Physical - poor sleep, aggression, social isolation/withdrawal, short tempered/easily annoyed. Examination details reflected the visit was a follow up visit requested by the facility reporting that Resident #4 had a physical altercation with another resident who came into Resident #4's room and resulted in the other resident [Resident #5] being sent to the hospital for stitches. The other resident [Resident #5] had been coming to Resident #4's room repeatedly and had been warned by Resident #4 to leave Resident #4's room on multiple occasions. Resident #4 became frustrated and irritable and hit the resident [Resident #5] on the head with a trashcan. Resident #4 had always been withdrawn and isolated and usually stayed in his room. Resident #4 was very territorial about his environment. Resident #4 was known to the psych NP from a previous facility and Resident #4's behaviors had always been the same with little to no physical altercations which usually occurred when people came into Resident #4's personal space. Resident #4 can be redirected easily. Resident #4 got paranoid when (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	people came around his environment due to his diagnosis. Resident #4 did not leave his room to seek out trouble. Resident #4 could follow directions. Resident # was compliant with his medications and ADL's with minimal assistance.During an interview on 01/05/26 at 1:17 pm with CNA D she stated Resident #5 went by Resident #4's room. Resident #4 thought Resident #5 was trying to get in Resident #4's room. Resident #5 was using Resident #4's door to push from and propel his wheelchair. CNA D said she felt like Resident #4 was trying to protect his house because Resident #4 felt everyone was trying to come into his room and take his things. Resident #5 would try to get into Resident #4's room.During an interview on 01/05/26 at 1:52 pm with the psych NP he stated he was told about the altercation between Resident #4 and Resident #5. The psych NP said he did not have any concerns about Resident #4 getting into another altercation, Resident #4 tried to tell the other residents to get away from his room and Resident #5 did not listen to him. Resident #5 was kicking at Resident #4's door. If no one goes into Resident #4's room there were no problems, Resident #4 always stayed in his room. The psych NP said staff needed to redirect other residents away from Resident #4's room so Resident #4 did not get triggered.During an interview on 01/05/26 with the DOR at 2:31 pm she stated the secured unit had a host of issues and part of it was the staff not recognizing and not being able to pick up on resident cues. She said the staff need dementia and mental health training.During in interview on 01/05/26 at 3:38 pm with CNA E he stated Resident #4 will blow up if residents get in his face.During an interview on 01/05/26 with Resident #4 at 3:40 pm he stated Resident #5 came to his door all the time and he did not want him around. Resident #4 said they [the residents] came to his hallway and they fell all over the place and made noise and he did not want them around.During an interview on 01/05/26 at 4:41 pm with LVN B he stated he remembered an incident between Resident #4 and Resident #5. Resident #5 wandered into Resident #4's room and Resident #4 hit Resident #5 over the head with a trashcan. It was normal for Resident #4 to get aggressive when residents wandered into his room. LVN B said Resident #4 would push residents out. LVN B said Resident #4 naturally stayed in his room and dominated over his bedroom. LVN B said other residents were not cognitive enough to realize the threat of going into Resident #4's room.During an interview on 01/06/26 10:08 am with the Interim Administrator she stated after the incident between Resident #4 and Resident #5 on 12/25/25 Resident #4 was placed on 1:1 until the following day when the 1:1 was lifted by the psych NP. The Interim Administrator reflected they had no other interventions for Resident #4 other than the 1:1 and the removal of his trash can from his room. She said Resident #4 usually did not bother anyone except when residents went into his room. She said they explored putting a stop sign on his door but had not done this yet. She said that because Resident #4 had dementia and aggressive behaviors the secured unit was an appropriate setting for him. She said anything could happen with residents who have cognitive impairment, and she was not sure of any other interventions to put in place.Attempted interview on 01/06/26 at 11:48 am with Resident #5 via telephone translator. Translator was speaking Spanish to Resident #5 and Resident #5 said he did not understand and leaned away from the phone.Attempted interview on 01/06/26 at 3:40 pm with agency CNA F who witnessed the incident between Resident #4 and Resident #5 on 12/13/25. The facility did not have a phone number for agency CNA F. Telephone call was placed to the agency who employed CNA F and asked for agency CNA F's telephone number, and agency did not return the call.During in interview on 01/06/26 at 4:05 pm with CNA G she stated that she usually worked in the secured unit. She said Resident #4 did not want anyone in his space. She said if residents went down the hallway towards his room he got upset and would tell them to get away. She said they tried to quickly redirect residents away from his room, but the residents had a right to go where they wanted. Resident #4 explained to everyone to knock before you enter his room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	If you just opened the door, he would try to strike. She said they did in-services about resident-to-resident abuse but there was no specific in-service about dealing with Resident #4.During in interview on 01/06/26 at 4:47 pm with the SW she stated Resident #4 stayed to himself a lot. He would open the door for staff. The SW said Resident #4 had paranoid schizophrenia and if anyone went into his space, even if it was a staff member at his door, he went to the door and tried to provide safety for his space. She said one time he pushed someone away who was in a wheelchair and hit someone with a trashcan. She said Resident #5 wandered into Resident #4's room because Resident #4's room used to be Resident #5's room. She said a care plan was the focus of what goal you were trying to reach for that resident. She said she thought Resident #4 wanting to have his space to himself needed to be care planned because it caused a lot of altercations because of his paranoid schizophrenia. She said there should be interventions to make sure he stayed in the room by himself and to redirect any other residents who wandered close to his room. She said interventions about Resident #4 wanting his own space would be essential for the safety of the residents.During an interview on 01/07/26 at 12:29 pm with Resident #4's RP she stated that someone from the facility called and told her about Resident #4 hitting Resident #5 with a plastic trashcan. The facility told her someone tried to get into Resident #4's space. The RP said Resident #4 always had a chair behind his door to keep people out. She said Resident #4 did not leave his room. She said Resident #4 had a series of thefts when he was at a previous facility and he now did not want to leave his room for fear of his things being stolen. She said she was not concerned about him wanting to exit the facility. She said years ago he had left a facility but now she was not concerned at all about him wanting to leave.During an interview 01/07/26 at 2:08 pm with CNA H she stated she never really knew why Resident #4 was in the secure unit. She said he would not come out of his room CNA H said the only time Resident #4 had a problem was when residents would knock on his door. She had not had any dementia training and had worked in dementia units previously.During an interview on 01/07/26 at 3:42 pm with the SW stated Resident #4 was in the secured because of his paranoid schizophrenia. She said she had never seen him try to leave the facility and did not think he was an elopement risk. She said she was involved in care plans and did rounds visiting with the residents to monitor the effectiveness of the residents care plans. She said the facility had an audit tool to review care plans. She said she was focused on the social services section.During an interview on 01/07/26 at 4:57 pm with the DON she stated she began working at the facility on 11/24/25. She said that Resident #4 wanted his own space and did not bother anyone until someone got in his personal space. She said Resident #4 was in an area where residents were wondering. She said residents were going to forget Resident #4 did not like people at his door and go down there even if you told residents not to go down there. She said interventions should have been updated to address Resident #4's altercations with other residents. She said a possible negative effect of the interventions in his care plan not being updated could be that his care needs would be unsatisfactory. She said the IDT team was responsible for making sure that Resident #4's care needs were addressed on his care plan. She said the care plan was the process that helped a facility look at the needs and address the needs of the residents. She said the care plan should paint a picture of how to take care of the residents and if it was not updated to the behaviors of the residents, the residents might not have their needs meet. She said there was a discussion about putting a Velcro stop sign on Resident #4's door but that did not happen. She said besides placing him on 1:1 after the 12/25/25 incident and the Velcro stop sign discussion; she did not remember any other interventions.During an interview on 01/07/25 at 6:53 pm with the Interim Administrator she stated that she began working in the facility on 12/21/25 and Resident #4 was already in the secured unit. She said (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	she knew that there were twelve residents in the secured unit, and she knew a few of their names and which residents were often sitting in the TV area and some of the residents' behaviors but not all their behaviors. She said the facility had not had an administrator for a period of time and she did not know of anyone else who knew the facility policy and procedures, but she would assume that the DON was responsible for knowing information about the secured unit.Record review of the facility policy Secured Unit Care Program admission Criteria and Process dated January 2026 revealed the goal of the Secured Unit Care Program is to meet the individual needs of residents living with dementia. The program provides a safe, supportive environment that maximizes independence while delivering person-centered care tailored to each resident's abilities, preferences, and needs. The following criteria are generally required for participation in the Secured Unit Care Program. If one or more criteria are not fully met, an exception for admission may be considered at the discretion of the Administrator and Director of Nursing. All exceptions will be reviewed on an individual, case-by-case basis. The resident demonstrates an elopement risk that can be safely managed within the Secured Unit Care Program environment, as identified through the facility's elopement risk assessment process. Each resident admitted to the Secured Unit Care Program will have a physician's order documenting the need for participation in the program. An admission interview will be conducted with the resident and/or family or party responsible to gather information related to the resident's history, preferences, and routines.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for two of eight residents (Resident #4 and Resident #5) in thatThe facility failed to report to Health and Human Services alleged abuse that occurred on 12/13/25 when Resident #4 allegedly kicked and punched Resident #5. No injuries reported. This failure could place residents at risk of abuse, neglect, pain, and diminished quality of life.Findings included: Record review of Resident #4's face sheet, dated 01/05/26, revealed a seventy-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses included dementia (severe cognitive decline (memory, thinking, reasoning) impacting daily life, caused by damaged brain cells), schizophrenia (a severe brain disorder causing hallucinations (like hearing voices), delusions (false beliefs), disorganized thinking, and unusual behaviors), and Parkinson's Disease (a progressive neurological disorder affecting movement). Record review of Resident #4's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/07/25 revealed a BIMS score of 7 indicating severe cognitive impairment. Record review of Resident #4's care plan reflected a focus, undated, inappropriate behaviors: Resident #4 had episodes of inappropriate behaviors and was at risk for further episodes and injuries AEB physical aggression: 12/13/25 Resident #4 allegedly kicked and punched the other resident who was on the ground after the resident had entered his room. Record review of Resident #4's care plan reflected a focus dated 04/09/25 reflected dementia. Resident #4 was at risk for increased confusion and decline in ADLs as the disease progressed, focus dated 04/09/25 of Resident #4 had a diagnosis of schizophrenia and was at risk for manic (a period of abnormally elevated mood, high energy, and increased activity) episodes. Record review of Resident #4's progress note by LVN A dated 12/13/25 reflected Pt. [Resident #4] was allegedly kicking and punching another patient who was on the ground after the patient had entered Resident #4's room. Resident #4 was upset because the other resident wandered into Resident #4's room. Record review of Resident #5's face sheet, dated 01/05/26, revealed a 125 (erroneous date) year old man who was admitted to the facility on [DATE] and readmitted on [DATE]. His admitting diagnoses included altered mental status (a significant change in a person's usual brain function, leading to confusion, disorientation, reduced alertness, or odd behaviors), acute kidney failure (the sudden loss of kidney function, causing waste and fluid to build up in the body, with symptoms like reduced urination, swelling, fatigue, nausea, and confusion), and thrombocytopenia (deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury). Record review of Resident #5's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/07/25 revealed a BIMS score of 0 indicating severe cognitive issues. Record review of Resident #5's care plan revealed a focus dated 05/20/25 of Resident #5 resided in the secure unit AEB elopement risk, need for reduced stimuli, wandering. During in interview on 01/06/26 at 10:08 am with the Interim Administrator she stated agency CNA F was the CNA who witnessed the alleged altercation referred (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to in Resident #4's progress note dated 12/13/25. During an interview on 01/06/26 at 12:42 pm with LVN A he stated he was called by a CNA, he could not remember her name, to come to the hallway outside of Resident #4's room. Resident #4 was standing over Resident #5 and it looked like Resident #4 kicked Resident #5. LVN A assessed the residents and there were no injuries. LVN A said he made a facility incident report and entered a progress note in Resident #4's PCC (electronic health record) and he did not know what happened after that. LVN A said he had been trained in resident-to-resident altercations. He said it sounded like the incident was a resident-to-resident altercation and a resident-to-resident altercation was considered abuse. He said the resident-to-resident altercation was reportable to State. Attempted interview on 01/06/26 at 3:40 pm with agency CNA F who witnessed the incident between Resident #4 and Resident #5 on 12/13/25. The facility did not have a phone number for agency CNA F. Telephone call was placed to the agency who employed agency CNA F and asked for agency CNA F's telephone number, and agency did not return the call. During an interview on 01/07/26 at 1:40 pm with LVN A he stated he did not notify the Administrator of the incident on 12/13/25 when Resident #4 allegedly kicked Resident #5. He said he should have told the Administrator. The Administrator was the Abuse and Neglect Coordinator, and allegations of abuse and neglect should be reported to the Administrator. He said he was trained in abuse, neglect, and exploitation and the facility did regular in-services on abuse, neglect and exploitation. He said allegations of abuse and neglect should be reported immediately and it was the responsibility of everyone in the facility to report allegations of abuse and neglect. He said the possible negative effect of not reporting abuse and neglect could be serious injury or maybe death. During an interview on 01/07/26 at 2:08 pm with CNA H she stated she had been trained in abuse, neglect, and exploitation and if she saw any abuse, neglect, or exploitation she was responsible for reporting it to the Administrator who was the abuse coordinator. The negative effect of not reporting abuse was that the person who was doing the abuse could continue to do it or the abuse might get worse. During an interview on 01/07/26 at 3:42 pm with the SW she stated that she would have reported the incident on 12/13/25 of Resident #4 allegedly kicking Resident #5 to the State. She said she was trained in abuse and neglect and if she was aware of any abuse or neglect, she would report it immediately. She said she would report it to the Administrator who was the abuse and neglect coordinator. She said it was the responsibility of everyone at the facility to report any abuse or neglect. She said the possible negative effect of not reporting abuse and neglect was the neglect could continue. During an interview on 01/07/26 at 4:57 pm with the DON she stated the incident on 12/13/25 was not reported because the nurse did not make anyone aware of the incident. She said it was documented in Resident #4's PCC progress notes but the nurse did not report it to her or the Administrator. The DON said it should have been reported to the State because it was an allegation of abuse. She said it was the responsibility of the abuse coordinator to make sure all allegations of abuse and neglect were reported to the State. The negative effect of not reporting abuse and neglect was that it could have a negative effect on the residents' care. During in interview on 01/07/26 at 6:43 pm with the Interim Administrator she stated that she was trained in abuse and neglect and when to report abuse and neglect. The interim Administrator said the nurse did not inform leadership of the alleged incident between Resident #4 and Resident #5. She said the nurse should have contacted the abuse and neglect coordinator and reported the incident. She said the nurse did not do what he was supposed to do. She said if she had known about the incident she would have investigated and made sure, they had enough evidence and if they had enough evidence she would have reported it to the State. She said there was no due diligence because the nurse did not do what he was supposed to do. Review of facility policy titled Abuse, Neglect, Exploitation, and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Misappropriation Prevention, Reporting, and Investigation Policy, dated 01/2026, reflected: Policy Statement The Nursing Facility (NF) ensures that all residents are free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and involuntary seclusion, in accordance with Texas law and federal CMS regulations. The Facility maintains a zero-tolerance policy and will immediately protect residents, initiate investigations, and report all alleged or suspected incidents as required by the Texas Health and Human Services Commission (HHSC) and Centers for Medicare & Medicaid Services (CMS).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all alleged violations are thoroughly investigated for 5 of 9 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for abuse and neglect.The facility failed to thoroughly investigate an alleged neglect incident reported by Resident #1 on 12/14/2025 when Resident #1 alleged staff were not performing peri-care appropriately.The facility failed to thoroughly investigate an alleged neglect incident reported by Resident #2's family member on 12/21/2025 when Resident #2 fell and was allegedly left on the floor for over an hour.The facility failed to thoroughly investigate an alleged abuse incident reported by Resident #3 on 12/23/2025 in which Resident #3 stated a pillow was placed over his face by staff around the time of his admission in April 2025.The facility failed to investigate an alleged resident-to-resident abuse incident between Resident #4 and Resident #5 that was documented in Resident #4's progress notes dated 12/13/25.This deficient practice placed all residents at risk of harm from abuse/neglect due to not having a thorough investigation done for an abuse and or neglect allegation. Findings included:1.Record review of Resident #1's admission record, dated 01/05/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Cerebral Palsy (a neurological condition that affects movement, posture, and muscle coordination), diverticulosis of intestine (a formation of small pouches in the lining of the colon/large intestine), schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often with hallucinations and delusions), and chronic obstructive pulmonary disease (a chronic lung disease that limits airflow and causes ongoing respiratory symptoms).Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 15 indicating no cognitive impairment. Section GG - Functional Limitations reflected Resident #1 required maximal assistance for toileting hygiene. Section H - Bladder and Bowel reflected Resident #1 was Always incontinent for both bladder and bowel.Record review of Resident #1's care plan, date initiated 09/21/2025 and last revised 12/30/2025, reflected Resident #1 was at risk for decline in ADL functions and injury with interventions that included Toileting: Provide (total assistance FOR INCONTINENT CARE).Record review of the provider investigation report, dated 12/30/2025 and signed by the DON, reflected Resident #1 complained about not being properly cleaned during pericare. Provider response listed on the investigation report was Staff in-serviced on conducting proper pericare and provider action taken post-investigation was Check-offs for staff and in-services. Provider investigation report included safe surveys performed on residents dated 12/16/2025, 12/17/2025, and 12/18/2025. No new safe surveys were provided. In-services provided were dated 12/15/2025 and 12/16/2025 and were titled Resident on Resident, Abuse & Neglect; Reporting Guidelines, and ANE Res Rights. No in-services or new checkoffs were provided related to the investigation. 2. Record review of Resident #2's admission record, dated 01/05/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Parkinson's disease without dyskinesia (a progressive neurological condition that primarily affects movement but without the involuntary, erratic movements), muscle wasting and atrophy (the thinning of muscle mass), and muscle weakness.Record review of Resident #2's Quarterly MDS, dated [DATE], reflected a BIMS score of 06 indicating severe cognitive impairment. Section J - Health Conditions reflected Resident #2 had not incurred any falls since the previous assessment.Record review of Resident #2's care plan, date initiated 10/10/2024 and last revised on 01/03/2026, reflected Resident #2 was at risk for falls.Record review of Resident #2's nurses notes dated 12/21/2025 and written by LVN A reflected, Pt was found off the bed on her knees on the floor holding on to the table. Pt was assessed with no injuries noted and was (continued on next page)

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	675564	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed back into the bed. Pt was assessed by the nurse with no injuries noted. Doctor and family were notified. The patient had notified the family. Nuero[sp?] checks have been started.Record review of the provider investigation report, dated 12/29/2025 and signed by the DON, reflected Resident #2's family member reported a fall occurred and no one assisted for an hour. Provider response listed on the investigation report was call light in reach, frequent monitoring and provider action taken post-investigation was staff in-serviced on abuse and neglect. Provider investigation report included safe surveys performed on residents dated 12/16/2025, 12/17/2025, and 12/18/2025. No new safe surveys were provided. In-services provided were dated 12/15/2025 and 12/16/2025 and were titled Resident on Resident, Abuse & Neglect; Reporting Guidelines, and ANE Res Rights. No in-services were provided related to the investigation.3. Record review of Resident #3's admission record, dated 01/05/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included cognitive communication deficit (a problem with communication caused by cognition rather than a language or speech deficit), unspecified injury at C4 level of cervical spinal cord, sequela (an unspecified injury to the spinal cord in the neck region that causes residual symptoms such as pain), and pressure ulcer of sacral region, stage 4 (full-thickness tissue loss that exposes muscle, tendon, or bone to the base of the spine).Record review of Resident #3's Quarterly MDS, dated [DATE], reflected a BIMS score of 06 indicating severe cognitive impairment.Record review of Resident #3's undated care plan reflected no care plan associated with the allegation.Record review of the provider investigation report, dated 12/29/2025 and signed by the DON, reflected Resident #3 stated around admission time CNA went into room to provide care and CNA placed pillow over his face. Provider response listed on the investigation report was Abuse monitoring completed, in-services provided to staff and provider action taken post-investigation was in-serviced staff when and who to report abuse and neglect to. Provider investigation report included safe surveys performed on residents dated 12/16/2025, 12/17/2025, and 12/18/2025. No new safe surveys were provided. In-services provided were dated 12/15/2025 and 12/16/2025 and were titled Resident on Resident, Abuse & Neglect; Reporting Guidelines, and ANE Res Rights. No in-services were provided related to the investigation.4. Record review of Resident #4's face sheet, dated 01/05/26 revealed a seventy-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses included dementia (severe cognitive decline (memory, thinking, reasoning) impacting daily life, caused by damaged brain cells), schizophrenia (a severe brain disorder causing hallucinations (like hearing voices), delusions (false beliefs), disorganized thinking, and unusual behaviors), and Parkinson's Disease (a progressive neurological disorder affecting movement).Record review of Resident #4's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/07/25 revealed a score of 7 indicating severe cognitive impairment.Record review of Resident #4's care plan reflected a focus, undated, inappropriate behaviors: Resident #4 had episodes of inappropriate behaviors and was at risk for further episodes and injuries AEB physical aggression: 12/13/25 Resident #4 was allegedly kicked and punched the other patient who was on the ground after the patient had entered his room. Record review of Resident #4's care plan reflected a focus dated 04/09/25 reflected dementia. Resident #4 was at risk for increased confusion and decline in ADLs as the disease progressed, focus dated 04/09/25 of Resident #4 had a diagnosis of schizophrenia and was at risk for manic (a period of abnormally elevated mood, high energy, and increased activity) episodes.Record review of Resident #4's progress note by LVN A dated 12/13/25 reflected Pt. [Resident #4] was allegedly kicking and punching another patient who was on the ground after the patient had entered Resident #4's room. Resident #4 was upset because the other resident wandered into Resident #4's room.5. Record review of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5's face sheet, dated 01/05/26, revealed a 125 (erroneous date) year old man who was admitted to the facility on [DATE] and readmitted on [DATE]. His admitting diagnoses included altered mental status (a significant change in a person's usual brain function, leading to confusion, disorientation, reduced alertness, or odd behaviors), acute kidney failure (the sudden loss of kidney function, causing waste and fluid to build up in the body, with symptoms like reduced urination, swelling, fatigue, nausea, and confusion), and thrombocytopenia (deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after injury).Record review of Resident #5's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 12/07/25 revealed a score of 0 indicating severe cognitive impairment.Record review of Resident #5's care plan revealed a focus dated 05/20/25 of Resident #5 resided in the secure unit AEB elopement risk, need for reduced stimuli, wandering.During an interview on 01/07/2026 at 1:40 pm, LVN A stated he did not notify the Administrator of the incident on 12/13/25 when Resident #4 allegedly kicked Resident #5. He said he should have told the Administrator. The Administrator was the Abuse and Neglect Coordinator, and allegations of abuse and neglect should be reported to the Administrator. He said he was trained in abuse, neglect, and exploitation and the facility did regular in-services on abuse, neglect and exploitation. He said allegations of abuse and neglect should be reported immediately and it was the responsibility of everyone in the facility to report allegations of abuse and neglect. He said the possible negative effect of not reporting abuse and neglect could be serious injury or maybe death.During an interview on 01/07/2026 at 04:56 PM, the DON stated she began working at the facility on 11/24/25. She stated she had been trained on abuse, neglect, exploitation and the investigation process. She stated she was responsible for performing the investigations when the ADM is not available and was responsible from 12/17/2025-12/24/2025. She stated she did not have much responsibility in the investigation related to Resident #1. She stated the previous administrator was working on the investigation when he was terminated from the facility. The DON stated Resident #1 alleged unknown staff at an unknown time did not perform peri-care appropriately and left feces in her vaginal area. The DON stated throughout the investigation they interviewed Resident #1, filed a report with state agency, and verbally talked about peri-care with nursing staff. She stated no formal in-service was done and had an attendance record. She stated the ADON did random monthly skills checkoffs with staff. The DON stated there were not any safe surveys performed to ensure other residents felt safe. The DON stated a new skin assessment was not completed in the chart during the investigation. She stated she was responsible for the investigation for Resident #2. She stated she did a 1:1 in-service with the nurse related to falls, but she did not do in-services with any other staff related to the allegation. She stated there was not a formal skin assessment performed, but just a narrative note from the nurse that stated no injuries. She stated she is unsure how long Resident #2 was on the floor. The DON stated she did not conduct safe surveys with other residents throughout the investigation. The DON stated she was responsible for the investigation for Resident #3 related to an unknown staff member placing a pillow over his face around the time of his admission to the facility. She stated she interviewed Resident #3, but he was not sure of who it was, only that it was a female agency staff, or when it occurred. The DON stated she had on-going in-services related to abuse and neglect from a previous deficiency that she just continued. She stated she did not start a new in-service or safe surveys. She stated she did not attempt to identify the alleged perpetrator. The DON stated she missed a variety of things throughout her investigation. She stated she felt like she was doing what she was trained for investigations but looking back she missed some things. The DON stated if an allegation did not have a thorough investigation, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then something could be missed. She stated the incident on 12/13/25 that was documented in Resident #4's progress notes by LVN A was not reported to the State and was not investigated. The DON stated that it was not reported or investigated because LVN A did not make anyone aware of the incident. It was reported in progress notes, but not to the abuse and neglect coordinator. She said it was the abuse coordinator's responsibility to make sure everything gets reported to the state and everything gets investigated. She said the incident was an allegation of physical abuse and should have been both reported to the state and investigated.During an interview on 01/07/2026 at 7:00 PM, the ADM stated she started at the facility on 12/24/2025. She stated she was not involved in the investigations for Resident #1, Resident #2 or Resident #3. She stated she was responsible for the investigations after her hire date. The ADM stated each self-reported incident should have a new in-service started related to the allegations. She stated she expected each self-reported incident to have new safe surveys for the residents. The ADM stated a skin assessment was expected to be documented under the correct form and not in a narrative format in the nurses' notes. The ADM reviewed the facility self-reported investigations for Resident #1, Resident #2, and Resident #3 and stated the investigations were not thorough investigations. She stated for the investigation related to Resident #1, she would expect to see an in-service related to peri-care, skills observations and checkoffs, and interviews with other residents about peri-care. She was unable to locate any of the expected information in the investigation provided. The ADM stated for the investigation related to Resident #2, she would expect to see a personalized in-service for all staff, a new skin assessment and new safe surveys with other residents. She stated the provided in-service was dated prior to the allegation being made, the safe surveys were undated and appeared to be copies of safe surveys used for previous self-reported investigations, and no skin assessment was performed other than the narrative provided by the nurse. The ADM stated for the investigation related to Resident #3, she would expect to see a psychiatric consult, a new skin assessment, new in-services with abuse/neglect posttests, and new resident safe surveys. She stated the skin assessment was not performed until 2 days after the allegation was made, a new BIMS assessment was not done until 6 days after the allegation and a new brief trauma assessment was not completed until 7 days after the allegation was made. The ADM stated those assessments should have been completed the day the allegation was made. She stated the in-services and safe surveys appeared to be copies from previous self-reported investigations. The ADM stated if a thorough investigation is not completed when an allegation is made, then it puts the residents at risk for abuse and neglect and not getting the proper care they need, possible infection control issues, and quality of life issues.Review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention, Reporting, and Investigation Policy, dated 01/2026, reflected: Policy Statement The Nursing Facility (NF) ensures that all residents are free from abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and involuntary seclusion, in accordance with Texas law and federal CMS regulationsThe Facility maintains a zero-tolerance policy and will immediately protect residents, initiate investigations, and report all alleged or suspected incidents as required by the Texas Health and Human Services Commission (HHSC) and Centers for Medicare & Medicaid Services (CMS).Staff Training RequirementsStaff shall receive:.Retraining following incidents or identified trends.