STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675599	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robert Lee Care Center	307 West 8th St Robert Lee, TX 76945

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #31) reviewed for care plans. The facility failed to implement a comprehensive person-centered care plan that addressed Resident #31's behaviors. This deficient practice could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs.Findings included: Record review of Resident #31's face sheet dated 12/31/25, revealed admission on [DATE] to the facility. Diagnoses included dementia with psychotic disturbance, delusions, hallucinations, and depression. Record review of Resident #31's quarterly MDS dated [DATE], revealed a BIMS score of 2 indicating severe cognitive impairment and disorganized thinking was also coded in this section. Mood was not coded. Behaviors section E - Rejection of care and wandering were both coded as a 1 which indicated these behaviors occurred 1 to 3 days during this look back period. Record review of Resident #31's Care Plan dated 4/16/2025, revealed there was no focus, goal, or intervention section for Resident #31's history of wandering or rejection of care. During an interview on 12/31/25 at 1:45 PM, with the DON she stated these behaviors should have been care planned because it was part of the resident's behavior and needed to be documented. The DON stated the MDS department was responsible for ensuring that it was care planned. The DON stated the purpose of the care plan was to provide the care for the resident and for everyone to know what the resident needed. The DON stated that it was necessary for the care of the resident. During an interview on 12/31/25 at 2:29 PM, with the MDS coordinator, she stated it was the responsibility of the MDS department to ensure the care plans were correct. The MDS coordinator stated there was no wandering or rejection of care, care planned for Resident #31. The MDS coordinator stated it should have been care planned for Resident #31's wandering to be able to keep an eye on her. The MDS coordinator stated the purpose of the care plan was to notify the staff of Resident #31's behaviors. The MDS coordinator stated the risk could be needs not being met. Record review of the facility Care Planning policy dated 03/2022, revealed 1. The IDT in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.7. The comprehensive person-centered care plan:b. Describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #3) reviewed for transfers in that: NA A and CNA B failed to safely transfer Resident #3 with a gait belt. CNA C and CNA D failed to demonstrate the skills to safely transfer the DON. These failures could place residents at risk for injuries due to not receiving the appropriate level of assistance to prevent accidents.Findings included: Review of Resident #3's admission Record, dated 12/30/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease (a neurological disorder causing movement and cognitive impairment), muscle weakness, and unsteadiness on feet. Resident #3 was on hospice. Review of Resident #3's admission MDS Assessment, dated 11/25/25, revealed:Resident #3 had a BIMS score of 3 of 15 (indicating severe cognitive impairment). He showed signs of delirium including inattention and disorganized thinking that fluctuated.Resident #3 had upper and lower range of motion impairment on both sides.Resident #3 used a wheelchair.Resident #3 needed substantial to maximum assistance with transfers. Review of Resident #3's Care Plan revealed:Initiated 11/28/25: Focus: Resident had an ADL self-care performance deficit related to activity intolerance, and Parkinson's Disease. Goal: Declines will be addressed promptly. Identified interventions included: Transfer with one assist. Initiated 11/28/25 Focus: The resident has Parkinson's. Goal: Discomfort or complications related to Parkinson's disease through review date will be addressed promptly. Identified interventions included: encourage daily exercise, mobility as tolerated. Observation on 12/30/2025 at 10:42 AM revealed Resident #3 was in the recliner, CNA B put a gait belt on Resident #3. NA A and CNA B locked the wheelchair and helped Resident #3 slide forward to the edge of the recliner. NA A held the gait belt in the back and slid her arm under Resident #3's arm. CNA B held the front of the gait belt and held Resident #3's pants by the waistband. The aides assisted Resident #3 in standing and pivoting to the wheelchair. Interview on 12/30/2025 at 11:14 AM NA A stated she was a new aide and received training on transfers prior to working the floor. NA A stated she was trained to make sure the gait belt was on, the wheels were locked, the resident had non-slip footwear on, and make sure the resident's knees touched the sitting surface prior to the resident sitting down. NA A said she thought the transfer went pretty well and they completed the transfer how they were shown. NA A said she might be wrong in putting her arm under Resident #3's arm. NA A said she thought being lifted by the arm felt tight and pressured and was not comfortable. Interview on 12/30/2025 at 11:43 AM CNA B said she worked at the facility for 4 years. CNA B said she received training in how to do a two-person gait-belt transfer. CNA B stated she was trained to have each aide stand on either side of the resident, put on the gait belt, make sure the resident was ready, that the resident had a good foot surface, then help them stand, pivot and sit down. CNA B said she was trained that an arm went under the resident's arm when assisting the resident to stand. CNA B stated she thought she did that and was confident in how she did. CNA B said pulling up a resident by the seat of the pants could cause a skin tear and could be uncomfortable. Interview on 12/31/2025 at 9:50 AM the PTA E stated she was at the facility for over two years. PTA E stated Resident #3 was receiving therapy services and they worked on standing and safety awareness. PTA E stated the level of assistance Resident #3 needed fluctuated from a one person to a two-person transfer. PTA E stated for two-person assistance, the staff needed to put a gait belt on, one staff stand in front of the resident while the other stood behind guiding the resident to the wheelchair. PTA E stated hooking under a resident's arm was not supposed to be done during transfers. PTA E said she was not sure about the consequences, but it could hurt the shoulder. PTA E stated she did see the aides transfer by hooking under the arms. PTA E said she did not usually transfer residents by the waistband of their pants. Interview on 12/31/2025 at 10:02 AM the PT stated a safe two-person gait-belt transfer looked like someone in front of the resident and someone behind the resident controlling the transfer from the resident's hips. The PT stated the therapy department did not do specific training with the aides on how to do a transfer, but they did talk to the aides constantly about what kind of transfer a resident needed. The PT said aides did not want to lift residents by the shoulders because the aides needed more control and it was not safe. The PT said aides needed to be careful with the arms because it could pull or dislocate the arm. The PT said using the gait belt in front and grabbing the waistband was not the safest and did not give enough control. Interview on 12/31/2025 at 10:21 AM the DON stated the facility did train aides to complete a two person gait belt

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs for 1 (Resident #3) of 4 residents reviewed for competent nursing staff, in that: NA A and CNA B failed to safely transfer Resident #3 with a gait belt. CNA C and CNA D failed to demonstrate the skills to safely transfer the DON using a gait belt. These failures could place residents at risk for injuries due to not receiving the appropriate level of assistance to prevent accidents.Findings included: Review of Resident #3's admission Record, dated 12/30/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease (a neurological disorder causing movement and cognitive impairment), muscle weakness, and unsteadiness on feet. Resident #3 was on hospice. Review of Resident #3's admission MDS Assessment, dated 11/25/25, revealed:Resident #3 had a BIMS score of 3 of 15 (indicating severe cognitive impairment). He showed signs of delirium including inattention and disorganized thinking that fluctuated. Resident #3 had upper and lower range of motion impairment on both sides.Resident #3 used a wheelchair. Resident #3 needed substantial to maximum assistance with transfers. Review of Resident #3's Care Plan revealed:Initiated 11/28/25: Focus: Resident had an ADL self-care performance deficit related to activity intolerance, and Parkinson's Disease. Goal: Declines will be addressed promptly. Identified interventions included: Transfer with one assist. Initiated 11/28/25 Focus: The resident has Parkinson's. Goal: Discomfort or complications related to Parkinson's disease through review date will be addressed promptly. Identified interventions included: encourage daily exercise, mobility as tolerated. Observation on 12/30/2025 at 10:42 AM revealed Resident #3 was in the recliner, CNA B put a gait belt on Resident #3. NA A and CNA B locked the wheelchair and helped Resident #3 slide forward to the edge of the recliner. NA A held the gait belt in the back and slid her arm under Resident #3's arm. CNA B held the front of the gait belt and held Resident #3's pants by the waistband. The aides assisted Resident #3 in standing and pivoting to the wheelchair. Interview on 12/30/2025 at 11:14 AM NA A stated she was a new aide and received training on transfers prior to working the floor. NA A stated she was trained to make sure the gait belt was on, the wheels were locked, the resident had non-slip footwear on, and make sure the resident's knees touched the sitting surface prior to the resident sitting down. NA A said she thought the transfer went pretty well and they completed the transfer how they were shown. NA A said she might be wrong in putting her arm under Resident #3's arm. NA A said she thought being lifted by the arm felt tight and pressured and was not comfortable. Interview on 12/30/2025 at 11:43 AM CNA B said she worked at the facility for 4 years. CNA B said she received training in how to do a two-person gait-belt transfer. CNA B stated she was trained to have each aide stand on either side of the resident, put on the gait belt, make sure the resident was ready, that the resident had a good foot surface, then help them stand, pivot and sit down. CNA B said she was trained that an arm went under the resident's arm when assisting the resident to stand. CNA B stated she thought she did that and was confident in how she did. CNA B said pulling up a resident by the seat of the pants could cause a skin tear and could be uncomfortable. Interview on 12/31/2025 at 9:50 AM the PTA E stated she was at the facility for over two years. PTA E stated Resident #3 was receiving therapy services and they worked on standing and safety awareness. PTA E stated the level of assistance Resident #3 needed fluctuated from a one person to a two-person transfer. PTA E stated for two-person assistance, the staff needed to put a gait belt on, one staff stand in front of the resident while the other stood behind guiding the resident to the wheelchair. PTA E stated hooking under a resident's arm was not supposed to be done during transfers. PTA E said she was not sure about the consequences, but it could hurt the shoulder. PTA E stated she did see the aides transfer by hooking under the arms. PTA E said she did not usually transfer residents by the waistband of their pants. Interview on 12/31/2025 at 10:02 AM the PT stated a safe two-person gait-belt transfer looked like someone in front of the resident and someone behind the resident controlling the transfer from the resident's hips. The PT stated the therapy department did not do specific training with the aides on how to do a transfer, but they did talk to the aides constantly about what kind of transfer a resident needed. 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