STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care and services in accordance with professional standards of practice for 1 of 7 residents (Resident #1) reviewed for quality of care.1.The facility failed to ensure Resident #1 was assessed for injury following a fall from bed on 4/12/2026 during incontinent care. Resident #1 was discovered to have a tibia/fibula fracture on 4/19/2026.2. The facility failed to ensure Resident #1's care needs were addressed for bed mobility and incontinent care.3. The facility failed to transfer Resident #1 back to bed with a Hoyer lift instead of grabbing her arms and legs and putting her back in bed. An IJ was identified on 4/27/2026. The IJ template was provided to the facility on 4/27/2026 at 4:26pm. While the IJ was removed on 4/28/2026, the facility remained out of compliance at a scope of isolated and a severity level of No actual harm with the potential for more than minimal harm that is not immediate jeopardy because (e.g.) all staff had not been trained on skin assessments, Kardex, Bed Mobility/Repositioning/Incontinent care, Post Fall Assessments, and Notifying Nurse with Changes.These failures could place residents at risk for not receiving appropriate care and treatment and or decline in their health. Findings included:Record review of an admission Record for Resident #1 dated 4/27/2026 indicated she was an [AGE] year-old female that admitted to the facility on [DATE] with diagnoses that included: hemiplegia affecting left nondominant side (unable to move one side of the body), chronic obstructive pulmonary disorder (lung disease), convulsions (involuntary shaking or muscle spasms).Record review of a Quarterly MDS Assessment for Resident #1 dated 3/13/2026 indicated she was not assessed for cognition due to being rarely or never understood. Staff Assessment for mental status indicated Resident #1's BIMS was 03 which indicated severe cognitive impairment. She was dependent on staff for transfers, bed mobility, and hygiene.Record review of a care plan for Resident #1 initiated on 3/03/2021 indicated: ADLs assistance needed, I require total assistance with ADL's with interventions that included: Staff will assist me with all ADL's unable to perform independently.Record review of a Care plan for Resident #1 initiated on 10/23/2023 indicated: I require a Hoyer left for transfers due to immobility/paralysis with interventions that included: Staff x2 for transfers.Record review of a Care plan for Resident #1 initiated on 3/03/2021 indicated Potential for injury related to history of falls and is at risk for further fall related to: cognitive impairment safety awareness, and due to frequently moving around in my bed and chair after being repositioned. Interventions included: Enlist family input regarding fall history and possible factors to help decrease falls. Ensure staff are aware of safety needs of the resident. Keep bed in lowest position with brakes locked. Review continued need for safety devices/fall risk factors per policy.Record review of facility incident report for Resident #1 dated 4/12/2026 at 3:55pm written by LVN D indicated: Resident #1 was lying on the floor on her back next to bed. CNA A and LVN E present. No signs or symptoms of distress or discomfort or pain noted. Immediate Action taken: Assisted up with 2 staff members onto bed and checked for injuries with none noted and incontinent care given. CNA A statement: While turning resident to give incontinent care, resident started rolling off side of bed, I jumped onto bed and held onto resident to prevent her falling completely onto floor. Resident knees did touch the floor. I laid resident on floor and called for assistance. Record review of (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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Nursing Progress Notes for Resident #1 dated 4/12/2026 at 4:50pm written by LVN D indicated: CNA reported while turning resident to give incontinent care, resident started rolling off side of bed, I jumped onto bed and held onto resident to prevent her falling completely onto floor. Resident knees did touch the floor. I laid resident on floor and called for assistance. Writer entered room and cna and another nurse was present and writer checked resident for injuries then resident assisted back into bed x2. Again, checked for injuries. Nonenoted, but did note blanchable redness on lateral right arm. Incontinent care given. Notified residents sister, MD and DON and hospice nurse of incident. Vital signs 97%-97.6-16-118/73(LR)-72. Will continue to monitor. Record review of hospice visit note for Resident #1 dated 4/13/2026 at 8:50am written by Hospice RN G indicated Resident #1 had mild pain as evidenced by facial grimacing using the painad scale (pain scale used in advanced dementia) with a score of 2. Resident #1 was at high risk for falls. Record review of Skin Assessment for Resident #1 dated 4/15/2026 at 1:57pm completed by LVN D indicated that Resident #1 had no alterations in skin integrity noted. Record review of hospice visit note for Resident #1 dated 4/16/2026 at 11:47am written by Hospice RN G indicated Resident #1 had mild pain as evidenced by facial grimacing using the painad scale with a score of 2. Resident #1 was at high risk for falls. Record review of Nursing Progress Notes for Resident #1 dated 4/19/2026 at 5:37am written by RN J indicated: Patient observed with 1+ edema to right foot, pedal pulses palpable and strong bilaterally yellowish coloring noted to right shin. Hospice notified, awaiting call back from on call nurse. Record review of Nursing Progress Notes for Resident #1 dated 4/19/2026 at 9:20am written by LVN D indicated: Called hospice and spoke with nurse and informed her that resident right lower extremity is warm to touch and resident was flinching to touch. Resident received scheduled pain medication per orders. Pedal pulses were present and right foot continues with swelling. Resident was afebrile. Record review of hospice visit note for Resident #1 dated 4/19/2026 at 2:57pm written by Hospice RN H indicated Resident #1 had mild pain as evidenced by facial grimacing and pulling and pushing away using the painad scale with a score of 5. Resident #1 was at high risk for falls. Resident #1 had bruising and swelling to right lower leg. Hospice RN H called and spoke with Resident #1's family member who reported bruise had been there and related to fall Resident #1 had. Hospice RN H advised RN F to administer as needed dose of pain medication and a verbal order to obtain an xray of the right lower extremity was given. Record review of Radiology Results Report for Resident #1 dated 4/19/2026 at 3:52pm indicated: minimally displaced fracture of the distal tibial shaft and minimally displaced fracture of the mid fibular shaft.Record review of Nursing Progress Notes for Resident #1 dated 4/19/2026 at 3:10pm written by RN F indicated: Resident had scheduled x-ray due to previous fall, pain meds given for pain (resident showed signs of pain). Hospice nurse contacted and results faxed, waiting for phone call to be returned regarding results. Resident currently in bed resting with bed in lowest position and call light within reach. Record review of Physician Progress Note for Resident #1 dated 4/19/2026 at 9:44pm written by the Medical Director indicated: The patient sustained this fracture after a fall last week. Sheis at high risk for surgical complications due to her baseline status, including being bed/chair-bound and unable to follow directions or participate in therapy. The plan is to manage conservatively at the facility. Focus on pain management; increase Norco to TID and add PRN morphine. Record review of facility order summary for Resident #1 dated 4/28/2026 indicated Resident #1's pain medication was increased on 4/19/2026 with a new order for Morphine Sulfate solution 20mg/ml (milligram/milliliter)give 0.5ml by mouth every 4 hours as needed for pain and Norco tablet 5-325mg give 1 tablet by mouth three times a day for pain monitoring. Record review of after visit summary dated 4/21/2026 indicated Resident #1 was seen in office by the Orthopedic physician for a closed fracture of right tibia and fibula. The Orthopedic Physician ordered for Resident #1 to have a splint and to follow up with him in 2 weeks. Review of video footage 1 taken in Resident #1's room on 4/12/2026 from 3:53pm to 3:56pm revealed CNA A was providing incontinent care and turned Resident #1 onto her right side. After turning Resident #1 onto her right side, CNA A let go of Resident #1 to pick up supplies from the floor and Resident #1 rolled off of the bed and onto the floor. CNA A (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	climbed across Resident #1's bed and attempted to pick Resident #1 up by lifting Resident #1 under her arms. CNA A was not able to lift Resident #1 back on to the bed and lowered Resident #1 back down to the floor. CNA A then went to the door and called for the nurse. Review of video footage 2 taken in Resident #1's room on 4/12/2026 untimed revealed LVN E enter the room with CNA A with Resident #1 still lying on the floor. LVN E placed a pillow under Resident #1's head and CNA A and LVN E waited for LVN D to enter the room. Once LVN D entered the room, without assessing Resident #1 for injury LVN E lifted Resident #1 under her shoulders and CNA A lifted Resident #1 under her knees and placed Resident #1 back in the bed. LVN E then left the room. LVN D left the room [ROOM NUMBER] seconds after Resident #1 was placed back in bed without properly assessing Resident #1. CNA A remained in the room with Resident #1 and proceeded with incontinent care. Review of video footage 3 taken in Resident #1's room on 4/12/2026 revealed CNA A continued to provide incontinent care to Resident #1 and turned Resident #1 onto her left side then left the room to gather more supplies. Review of picture 1 of Resident #1's right leg and foot dated 4/13/2026 at 1:44pm indicated swelling to Resident #1's right foot. Review of picture 2 of Resident #1's right leg and foot dated 4/14/2026 at 9:48pm indicated swelling to Resident #1's right foot with possible bruising to the lower right leg. Review of picture 3 of Resident #1's right leg and foot dated 4/17/2026 at 5:44am indicated swelling to Resident #1's right foot with possible bruising to the lower right leg. Review of video footage 4 taken in Resident #1's room dated 4/17/2026 at 1:48pm indicated swelling and yellow discoloration to Resident #1's right lower leg and foot. Review of picture 4 of Resident #1's right leg and foot dated 4/17/2026 at 9:01pm indicated swelling to Resident #1's right foot with bruising and yellow discoloration to the right lower leg. Review of video footage 5 taken in Resident #1's room dated 4/18/2026 at 3:03pm indicated swelling and yellow discoloration to Resident #1's right lower leg and foot. CNA K and CNA L were discussing Resident #1 was showing signs of pain by facial grimacing. Review of video footage 6 taken in Resident #1's room dated 4/19/2026 at 4:19am indicated swelling and yellow discoloration to Resident #1's right lower leg and foot. CNA M was providing care and touched the discolored area to Resident #1's right lower leg, Resident #1 flinched and pulled her leg back from CNA M's touch. During an observation and attempted interview with Resident #1 on 4/27/2026 at 9:00am upon entering Resident #1's room observed Hospice RN G assessing Resident #1. Resident #1 observed to have a blue splint to her right lower leg. Resident #1 was nonverbal due to cognition and not able to answer questions. During an interview on 4/27/2026 at 9:15am CNA O said she had worked at the facility since January 2026. She said Resident #1 was a 2 person assist for all ADLs. She said she had not noticed any discoloration or swelling to Resident #1's right leg. During an interview on 4/27/2026 at 11:46am a Family Member said she had saved the video footage from Resident #1's fall. Said she sent the video footage of Resident #1's fall, to LVN D on 4/12/2026. She said LVN D said she was going to show the video to the Administrator and DON. She said she watched all the video footage from 4/12/2026 through 4/19/2026 and there was no other incident that would have caused Resident #1's fractures. During an interview on 4/27/2026 at 12:50pm the Administrator said she had not seen the videos because she was not supposed to have anything to do with a family's electronic monitoring. She said she knew the videos had been sent to Resident #1's family member that were also employees, which was the housekeeping staff. She said she did not know the video had been sent to LVN D. After watching the videos with the Surveyor, she said she did not have words because she was thinking. During an interview on 4/27/2026 at 1:16pm the DON said she had not seen the videos of Resident #1's fall. After watching the videos with the surveyor, the DON said she felt like Resident #1 was assessed appropriately. She said while Resident #1 was on the floor and the nurses were standing in the room that they could have assessed Resident #1 with their eyes before moving her off the floor. She said CNA A should not have tried to move Resident #1 without first notifying the nurse of the fall. She said she did not see anything inappropriate in the video. During an interview on 4/27/2026 at 6:38pm the Medical Director said he was the medical director at the facility and the medical director of the resident's hospice company. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	He said he could not determine how the resident had received the fracture to the Tibia/Fibula. He said he had not seen the videos of Resident #1's fall. He said if the facility had notified him that Resident #1 was having any increased pain, swelling or discoloration he would have ordered x-rays at that time. During an interview on 4/28/2026 at 8:40am ADON C said that she had seen about 5-6 seconds of the video of Resident #1's fall on 4/12/26. She said LVN D had the video on her phone and showed it to her about 3 days after the fall. She reviewed the videos with the Surveyor and said if she had seen all of the video footage CNA A would have been terminated that day. She said the CNA should never have tried to pick the resident up and put her back in bed without first notifying the nurse. She said LVN E and CNA A should have never picked Resident #1 up off the floor the way they did and placed her back in bed when Resident #1 required a Hoyer lift for transfers. She said prior to moving Resident #1 she should have been assessed for pain and injury while she was still on the floor before moving her back to bed. During an interview on 4/28/2026 at 8:50am Hospice RN G said Resident #1's Family Member had sent her the video of Resident #1 fall on 4/12/26. She said she showed the video to the DON on 4/16/26. She said the video she had was from the time of Resident #1's fall to the time when CAN A and LVN E picked Resident #1 up and placed her back in the bed. She said the DON was concerned with how Resident #1 had fallen. She said she saw the resident on 4/13/26 and 4/16/26 and did not notice the discoloration or swelling. During an interview on 4/28/2026 at 10:50am CNA A Said during incontinent care she rolled Resident #1 over on her right side. She said she let go of Resident #1 to pick up supplies and Resident #1 fell off the other side of the bed. She said she panicked and tried to pick Resident #1 up and tried to put her back in bed. She said when she could not get Resident #1 back in bed she called LVN D. She said LVN D and LVN E assessed Resident #1 and then she and LVN E transferred Resident #1 back to bed by picking her up and putting her back in bed. She said that was not the proper way to do it because Resident #1 used a Hoyer lift for transfers. She said Resident #1 was not showing pain, bruising, or swelling to her leg. She said she should have put a pillow under her head and went and got the nurse and she knew that prior to the fall, but she panicked. She said she had not worked Resident #1 since the fall and was instructed not to go back in her room. Said she was aware of the video of the incident. Said no one had talked to her about the video. She said she had seen the video because LVN D had shown it to her. Said she was still currently employed at the facility and said she was supposed to work her next shift 4/29/26. She said she had been educated of the procedure for a resident fall prior to Resident #1's fall. During an interview on 4/28/2026 at 11:28am CNA K said she did not remember any discoloration or swelling to Resident #1's right leg during the 7 days from 4/12/2026 through 4/19/2026 while caring for Resident #1. She said on 4/18/26 she voiced a concern at the nurse's station, but she did not report any pain to the nurse. She said CNA L was telling her that by Resident #1 grimacing that was a sign of pain. She said she did not see Resident #1's leg discolored and was not sure how she missed that because she could clearly see it in the video. She said she did not even know Resident #1 had a fall on 4/12/2026. She said on 4/17/2026 she did not report any swelling or discoloration. She said she saw the discoloration in the video on 4/17/2026 but on that day, she did not notice it on Resident #1. She said the only thing she noticed was some bruising on Resident #1's right upper arm. She said she did not report the arm bruise either. She said she should have reported the bruise to her right upper arm to the nurse and upper management. During an interview on 4/28/2026 at 11:44am CNA L said she did not remember any swelling or discoloration to Resident #1's leg. She said after watching the videos with the Surveyor she said she knew Resident #1 was in pain on the 4/17/2026 and 4/18/2026 and told CNA K to go and report it to the nurse. She said she did not know if CNA K had reported the pain to the nurse. She said she thought that was enough to tell CNA K to let the nurse know that Resident #1 was in pain. She said looking back on it, she said she should have told the nurse herself. During an interview on 4/28/2026 at 2:23pm LVN P said she was the treatment nurse at the facility. She said the floor nurses were responsible for doing the weekly skin assessments if the resident did not have a skin issue. She said she had not assessed Resident #1's skin between 4/12/2026 and 4/19/2026. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/27/2026 at 3:45pm the DON said she had reviewed the video on 4/16/2026 when the Hospice RN G showed her the video. She said she did not report what she had seen on the video to the Administrator. She said the CNA had been terminated on 4/27/2026 after reviewing the video with the Surveyor. During an interview on 4/29/2026 at 10:24am LVN E said she was at the nurse's station and CNA A came and said Resident #1 was on the floor and she notified LVN D. She said she went into the room and Resident #1 was lying on the right side of the bed on the floor on her back. She said she put pillow under Resident #1's head. She said she did not see any blood or signs of pain until LVN D got there. She said then LVN D came in and took over and they got her on the bed. She said it happened very quickly and was not sure how much LVN D assessed Resident #1 while she was on the floor. She said CNA A and her lifted Resident #1 by the back, and CNA A had Resident #1 lower body, and she was lifted back on to the bed. She said she was aware that Resident #1 required a Hoyer lift for transfers. She said it was bad judgement on her part for transferring Resident #1 that way, but she was letting LVN D take the lead. Said she left the room after placing Resident #1 back on the bed. She said she just checked to make sure there was no head injury and Resident #1 was not expressing any pain. Said she did not think things were handled appropriately, she said CNA A should not have tried to pick Resident #1 up and place her back in bed by herself. She said she should have assessed Resident #1 and then gotten a Hoyer lift to place Resident #1 back in bed. During an interview on 4/29/2026 at 10:47am LVN D said on 4/12/2026 she was on break and they came and got her and CNA A told her while changing Resident #1 she rolled off the bed. She said by the time she got in there CNA A and LVN E were already there. She said they looked at Resident #1 and then placed her back in the bed. She said when she spoke with Resident #1's Family Member she told her CNA A had attempted to put Resident #1 back in bed. She said she educated CNA A not to move a resident until they were assessed by the nurse. She said Resident #1 was on the floor on the side of the bed when she entered the room. She said she went down to look at Resident #1 and said y'all let's get her up but she did look at her while she was on the floor. She said LVN E was behind her arms and CNA A was under her thighs and they picked Resident #1 up and placed her back in bed. She said she was aware that Resident #1 was supposed to be a Hoyer lift transfer. She said they should have used the Hoyer lift to transfer Resident #1 back to bed, but she could not say why they did not. She said after Resident #1 was back in bed, she looked over her and made sure she was ok. She said she did medicate Resident #1 for pain following the fall. She said at the time she did not know Resident #1 had fallen and thought it was a near fall. She said looking back at the incident she did not think her assessment was appropriate. She said she did a skin assessment on 4/15/26 and said she looked at the skin but maybe did not look at every inch of Resident #1's skin. She said the family sent her a video of CNA A attempting to pick Resident #1 back up and place her back in bed. She said the family tried to send her more videos, but she just deleted them and did not watch them. She said she did show the video to ADON C. She said the family said they sent the video to Hospice RN G. She said she did not ensure the video was sent to management. She said she did have a conversation with the DON about the video. She said the DON told her she heard about the video. The DON interrupted the interview at that time, and the nurse left the room. During a follow up interview on 4/29/2026 at 11:20am she said she should have used the Hoyer lift to get her up and she should have done a more in-depth assessment of Resident #1. She said looking back on the incident she would handle the incident differently. During an interview on 4/29/2026 at 11:57am the Administrator said moving forward her expectation that any resident that falls and they are a Hoyer transfer that the resident was to be assessed for safety and overall condition. Record review of facility policy titled Falls-Clinical Protocol dated March 2018 indicated: .2. In addition, the nurse shall assess and document/report the following: a. Vital Signs; b. Recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. change in cognition or level of consciousness; e. Neurological status; f. Pain. 5. The staff will evaluate and document falls that occur while the individual is in the facility; for example when and (continued on next page)

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Direct care staff, including nursing assistants, will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the nurse. The facility Administrator was notified on 4/27/2026 at 4:26 PM that an Immediate Jeopardy situation had been identified due to the above failures and the IJ template was given at that time. The facility's plan of removal was accepted on 4/28/2025 at 12:10 PM and included: The facility failed to assess Resident #1. All nurses to be educated by ADON on facility policy titled, Falls, regarding resident assessment post falls and prior to getting resident off the floor. Assessment will include but not limited to, complete vitals, range of motion to R/O fractures or injuries, change in LOC, pain, start neuros on all unwitnessed falls, monitor qshift X 72 hours. This to be initiated started 4/27/26 and will cont. until all nurses can verbalize proper assessment. Nurses will be educated before their next shift and all new hires and agency staff. Residents were assessed by charge nurse on 4/12/26, 4/13/26, 4/14/26, 4/15/26, 4/19/26, and 4/27/26 by charge nurse. Skin assessment was done on 4/12, 4/15, and 4/27 by charge nurse. All documented in the resident's chart. Inservice provided to nurses including completing the Skin assessment and ensuring assessments accurately reflect resident's current condition. Nurses will be educated by Treatment nurse/ designee starting on 4/28/26 and will be completed before next scheduled shift including new hires and agency staff Inservice provided to CNAs to include notifying nurses of any change in residents' skin condition. CNAs will be educated by ADON/designee starting on 4/28/26 and will be completed before next scheduled shift including new hires and agency staff Resident #1 care needs were addressed for bed mobility and incontinent care Care plan reflects dependent in bed mobility and incontinent care with 1 person assist updated on 4/27/26 by MDS nurse. Competency on facility's incontinent care, which includes supplies gathered, supplies within reach and proper bed mobility during incontinent care will be done with all CNAs. CNAs will be checked off by the ADON or designee starting 4/27/26 and will be completed before their next scheduled shift. An audit will be done on all residents' care plans to reflect proper care and information on the Kardex. This will be started on 4/27/26 by DON, MDS, ADON and continue until complete with expectation to be completed by 4/28/26. CNAs will utilize the Kardex in the POC for how to care for residents that is updated and maintained by MDS nurse or designee. CNA will be educated to utilize the Kardex by ADON starting on 4/27/26 and will be completed before next scheduled shift including new hires and agency staff. The facility failed to transfer Resident #1 back to bed with a hoyerAll CNAs and nurses to be educated on using Hoyer lift pads and machines, safe and proper techniques to transfer residents to/from bed/ chair/ floor provided by DOR or designee. Educated initiated 4/27/26 and will continue until all cnas and nurses are complete and before their next scheduled shift, including new hires and agency staff. Inservice was provided to CNA involved in incident on 4/12/26. CNA was termed on 4/27/26. Inservice with 2 nurses involved in the incident will be done by DON or designee before their next scheduled shift regarding assessment and transferring resident via hoyer lift. Since 4/1/26 to date, there have been no other falls with major injuries. An audit of falls since 4/1/26 to be completed by DON, ADON or designee on 4/28/26 to ensure proper assessment was complete. Will be completed by 4/28/26 any concerns immediately brought to medical director. On 4/17/2025, the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: Record review of in-service dated 4/27/2026 titled Post Fall Assessment and Fall Clinical Protocol (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	with 17 nursing signatures. The in-services consisted of Assess resident before any resident is assisted off the floor. Assessment includes vital signs, range of motion to rule out fractures or injuries, changes in level of conscious, and pain. Start neuros on unwitnessed falls, monitor for 72 hours.Record review of in-service dated 4/27/26-4/28/26 titled Skin Assessment with 5 nurse signatures. The in-service consisted of Completing the skin assessment and insuring assessment accurately reflect resident current condition. Record review of in-service dated 4/27/26-4/28/26 titled Notifying nurses with changes with 23 nursing signatures. The in-service consisted of CNAs will notify charge nurses in residents skin condition/any changes/bruising. Record review of Resident #1's care plan reflected changes made on 4/27/26 to 1 person assist for bathing, bed mobility, meals, and 2 person assist with Hoyer transfer. Record review of 17 CNA Competency Assessments for Perineal Care dated 4/27/26-4/28/26. Record review of attestation dated 4/27/26 I attest that care plans were reviewed by DON, MDS, and ADONs. ADL care plans were updated as needed, including updating the Kardex. signed by the DON, ADON B, ADON C, and MDS. Record review of in-service dated 4/27/26-4/28/26 titled Kardex with 23 nursing staff signatures. The in-service consisted of Utilize the Kardex in the POC for how to care for residents. Record review of in-service dated 4/27/26-4/28/26 indicated 23 nursing staff had signed the in-service titled Hoyer Lift Pad and Machine. The in-service consisted of Hoyer lift pad and Machine safe and proper technique to transfer resident to/from bed/chair/floor (in the event an incident occurs). Record review of 1-1 Inservice for Hoyer lift transfers dated (add date) indicate LVN D and LVN E attended the re-education. Record review of an attestation dated 4/28/26 I attest that falls between 4/1/2026-4/27/2026 were reviewed by myself, Director of Clinical Services and ADONs for post fall assessment by the charge nurse signed by the DON, ADON B, and Adon C. Record review of in-service dated 4/27/2026 titled Bed Mobility/Repositioning/Incontinent Care Safety with 17 nursing signatures. The in-service consisted of 1. Ensure all necessary supplies are gathered, placed at bedside, within reach, prior to initiating care. 2. Ensure safe placement of resident prior to initiating care ie: middle of the bed. 3. Ensure to provide assistance per each resident's specific level of need. Ie: 2 person assist with bed mobility, Hoyer transfer. During interviews on 4/28/2025 between 12:10pm and 3:30pm the following 24 staff (MDS, RN Q, CNA R, CNA S, CNA T, CNA M, CNA U, LVN P, CNA O, CNA K, CNA L, CNA V, MA W, CNA X, LVN Y, MA Z, MA AA, CNA BB, CNA CC, LVN DD, CNA EE, RN FF, ADON B, ADON C) were able to appropriately describe: Bed Mobility/Repositioning/Incontinent Care Safety, Hoyer lift pad and Machine safe and proper technique to transfer resident to/from bed/chair/floor, Kardex for level of care, notifying nurses with changes, Skin Assessments, and Post Fall Assessments An IJ was identified on 4/27/2026. The IJ template was provided to the facility on 4/27/2026 at 4:26pm. While the IJ was removed on 4/28/2026, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because (e.g.) all staff had not been trained on skin assessments, Kardex, Bed Mobility/Repositioning/Incontinent care, Post Fall Assessments, and Notifying Nurse with Changes.